UNIVERSITY OF KWAZULU-NATAL

An Exploration of the management and leadership system in a public health hospital in Durban

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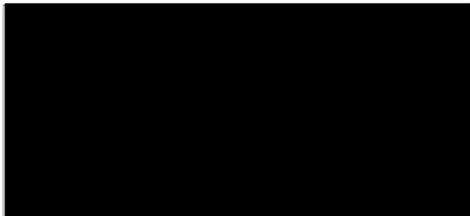

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Abbreviations and Acronymns

CEO - Chief Executive Officer of the hospital

CSH – Critical Systems Heuristics

CSM – Critical Systems Method

DHO – District Health Office

Exco – Executive Committee of the hospital. Used interchangeably with Managers

HO – Head Office. Used interchangeably with Provincial Department of Health (PDH)

HTS – Health Technology Services

PHO – Provincial Head Office

Abstract

This is a study on the leadership of health care in a South African Government hospital using systems thinking and specifically Critical Systems Heuristics (CSH) as the key methodology. The aim of the study was to determine whether a deeper understanding of managers and clinicians underlying values and motivators which supported their decision making, could serve as a platform for improving their working relationship towards better health outcomes. Government hospitals are not functioning optimally. Millennium Development Goals have been missed, staff morale is poor, patient care is sub optimal. Instead of exploring conventional management solutions, this study interrogates systemic issues of the working relationship between managers and clinicians. A purposive sampling method was used to select ten key decision makers, five managers and five clinicians, at Wentworth hospital in Kwa-Zulu Natal. In depth interviews were done using a semi-structured questionnaire. Data was compared and synthesised into known systems models. Results showed that each group assigned different levels of importance to sub systems within the overall system. Managers focused more on the pragmatic facts of what is now, while clinicians were focussed more on future possibilities for improvements. This revealed sources of frustration with the decision-making process and identified potential conflict resulting from their different views. Results also indicate that the District Health Office and Provincial Health Department exercise considerable direct control over the hospital decision making system, contrary to the intention of the Government Health Policy Framework. It is recommended that the two groups engage each other from a values perspective with new understanding of underlying motivators and perspectives of what is primary and secondary for each, and to adopt a learning approach which encourages co-operative decision making. Similarly, the DOH need to be engaged on how they can facilitate full use of existing expertise of these two groups instead of imposing unwanted and unhelpful decisions on them. Additional research with a larger sample of hospitals is recommended to test suggested improvements in the system. A systems thinking approach to the interface between DOH and hospitals is also recommended.

Contents

Acknowledgements iii

Abbreviations and Acronymns i

Abstract ii

List of Figures Page vii

CHAPTER 1: INTRODUCTION 1

1.1 Introduction 1

1.2. Motivation of the study 1

1.3 Focus of the study 2

1.4 Problem statement 2

1.5 Research Sub-Questions 2

1.6 Objectives 3

1.7 Methodology in short 4

1.8 Background to the research 4

1.8.1 Catalyst for this research study 4

1.8 2 Practical experience – observations from prior hospital visits 4

1.8.3 Decision making processes amongst key leadership 5

1.8.4 Management interventions in organisational change 6

1.9 Summary 6

CHAPTER 2: LITERATURE REVIEW 8

2.1. Introduction 8

2.2 Context of the Health Policy Framework 8

2.3 Performance of the Government Health System 9

2.4 Organisational structure of a typical government hospital 10

2.5 Management and leadership factors which influence decision making and performance 12

2.6 An international perspective on hospital management. 14

2.7 Learnings from the latest leadership studies 16

2.7.1. The effect of the changing environment on leadership 16

2.7.2. Emphasis on broader leadership roles 17

2.7.3. Leading in the 21st century 18

2.8 Examples of some successful interventions 19

2.9 Background on Systems Thinking 20

2.10 Conclusion 22

CHAPTER 3. RESEARCH METHODOLOGY 24

3.1 Introduction 24

3.2 Aims of the Study: Specific to the inter relationship between managers and clinicians. 25

3.3 Research Design and Methods 25

3.3.1 Chosen design and method 25

3.3.2 Advantages and risks of using the systems approach 26

3.3.3 The value of Critical Systems Heuristics (CSH) as a methodology for this research 28

3.4. Research Paradigm 31

3.5 Study Setting 32

3.6 Population and sample of the study 32

3.6.1 Choice of sample 32

3.7 Sampling method 32

3.8 Construction of the instrument 33

3.9 Data Collection 33

3.10 Data Analysis 33

3.11 Reliability and validity of the study 34

The author established comparisons and similarities across respondent's accounts to ensure different perspectives are represented and included ample verbatim descriptions of participant's accounts to support findings Reliability has been ensured through adherence of the CSH protocol (Slevin, 2002). 34

3.12 Bias 34

3.13 Ethical considerations 34

3.14 Summary 35

CHAPTER 4: PRESENTATION OF RESULTS 36

4.1 Introduction 36

4.2 Initial Mapping of the System 37

4.2.1 Rich picture of the Wentworth Hospital decision making system 37

4.2.2 Rich picture findings of clinician's perspective of the system 38

4.2.3. Managers (Exco) perspective of the system 40

4.2.4 Conclusion of initial mapping 41

4.3. Clinicians and managers responses to Ulrich's 12 questions. 43

4.3.1 Theme of sources of motivation for the system. 43

There is a high degree of frustration with this relationship which is not supportive, and instead undermines the efficiency of the hospital. Consequently, it consumes manager's attention, and diverts it away from everyday management of the hospital. 44

4.3.2 Theme of Control 46

4.3.3 Theme of knowledge 47

4.3.4 Theme of legitimacy 49

4.4 Conclusion 50

CHAPTER 5: DISCUSSION 51

5.1 Introduction 51

5.2 Contrasting perspectives of the system using Ulrich's eternal triangle 51

5.3 Factors which might change the boundary judgement of the system 55

5.3.1 Managers perspective of the system 57

5.3.2 Clinicians perspective of the system 58

5.4. Factors which might cause conflict in the Exco/clinicians relationships 59

5.5 CSH results interpreted as a Kolbian Learning Cycle 61

5.5 A unifying theory on systems thinking 64

5.6 Conclusion 64

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS 66

6.1 Introduction 66

6.2 Conclusion 66

6.3 Implications of the research 66

6.4 Limitations of the study 67

6.5 Recommendations to solve the research problem 68

6. 6 Recommendations for future studies 71

6.7 Summary 72

References: 74

Downe-Wamboldt, B.1992. Content analysis: method, applications, and issues. 76

Long, T. & Johnson, M. 2000. Rigour, reliability and validity in qualitative research *Clinical Effectiveness in Nursing*, 4(1), 30-37. https://doi.org/10.1054/cein.2000.0106 76

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APPENDIX 1 Organogram for Wentworth Hospital 81

APPENDIX 2 Questions for Masters Dissertation for Mr RA Reimers 82

APPENDIX 3. Summary of responses to "IS" and "OUGHT" questions 86

3.1 Summary of Clinicians responses to “IS” and “OUGHT” questions 86
3.1.1 What is the Purpose of the hospital? 86
3.1.2 Who is the Client or Stakeholder? 86
3.1.3 Staff Morale & Communication incl Measures of Success 87
3.1.4 Control of Resources 88
3.1.5 Decision maker over measures of improvement and accountability 89
3.1.6 Relevant knowledge which is consulted 90
3.1.7 Professional Involvement and guarantee of the right expertise being used 91
3.1.8 Sources of legitimacy, including representation of those affected but not involved 91
3.2 Critical Self-evaluation amongst clinicians. Analysis of heir reflections of the “Ought” system vs the “Is” system 92
3.2.1 Sources of motivation 92
3.2.2 Sources of control 93
3.2.3 Sources of knowledge 94
3.2.4 Sources of legitimacy 94
3.3 Summary of managers (Exco) responses contrasting “IS” and “OUGHT” 95
3.3.1 Purpose 95
3.3.2 Who is the client? 95
3.3.4 Measures of improvement 96
3.3.5 Control of resources 97
3.3.6 Who are the decision makers? 98
3.3.7 Conditions and environment for accountability. 99
3.3.8 Relevant knowledge which is consulted 99
3.3.9 Professional involvement and guarantee of the right expertise being used. 99
3.3.10 Sources of legitimacy, including representation of those affected but not involved 100
3.4 Critical self-evaluation amongst managers. Analysis of their reflection of the “OUGHT” system versus “IS” system. 100
3.4.1 Sources of motivation 100
3.4.2 Sources of control 101
3.4.3 Sources of knowledge 102
3.4.4 Sources of legitimacy 103
APPENDIX 4 Informed Consent Letter 3C 104
APPENDIX 5 105

APPENDIX 6......106
Appendix 7......107

List of Figures **Page**

Figure 1: Typical organogram for a government hospital………………………… 11
Figure 2: The Eternal Triangle…………………………………………………...........30
Figure 3: Rich picture of the Wentworth Hospital decision making system………..37
Figure 4: Ulrich's Eternal Triangle of Boundary Judgements with authors table showing the importance which respondents placed on the value drivers for the system………………………………………………………………………………52
Figure 5. The system interpreted from the perspective of managers & clinicians…55
Figure 6. Primary and secondary boundaries……………………………………… 59
Figure 7. Kolbian Learning Cycle and modes of learning…………………………… 61

List of Tables **Page**

Table 1. Contrasting Managers & Clinicians responses in the United Kingdom National Health Services Research 16

Table 2. Characteristics of two organisations. Contrasting beliefs create constraints…………………………………………………………………………….. 18
Table 3. Contrasting Phases of Kolb's Learning Cycle with CSH……………….63

CHAPTER 1: INTRODUCTION

1.1 Introduction

The chapter provides a brief introduction to the study, reviewing the contextual problem and how the answers to specific objectives might benefit the respective stakeholders.

It also provides some background as to how the study originated and had personal meaning to the author.

Finally, as a contribution to leadership studies, it extends traditional management decisions and organisational improvement approaches to a broader systems thinking review. The intention was to present a different lens to similar issues provided by other studies, in the hope that this will contribute to real improvements.

1.2. Motivation of the study

The motivation of the study was to identify potential improvements in the leadership and working relationship of key decision makers in a government hospital, to benefit overall health care outcomes.

The hospital system consists of many stakeholders. Although not all were specifically interviewed, they were frequently mentioned by respondents. The main influencing stakeholders mentioned in this study were identified as:

- The community which the hospital intends to serve.
- Patients being treated by the hospital – sometimes outside their defined community.
- Executive managers who mainly do planning, coordination and financing.
- The clinical managers who co-ordinate and are involved in executing health practices in face-to-face patient interaction.
- The general staff of the hospital, such as nurses, administration and support services.
- The government district and provincial health department to whom the hospital report.

1.3 Focus of the study

The study focussed on the influences of systems thinking on leadership and decision making. The approach was to see the whole in context of its parts, how the two key stakeholder decision making groups viewed that system differently and display different values and motivators for decision making. Rather than finding specific management solutions, systems thinking provides the platform for improving the overall system, as a way of improving working relationships and better outcomes.

1.4 Problem statement

The hospital health care system is operating below par and is hampered by the working relationship of two key leadership groups. Managers and clinicians. Many management issues have been identified by previous studies, and recommendations made. (Doherty, 2013; Von Holdt & Murphy, 2007; Dalmas, 2012). However, little has changed in practice. Plowman et al (2007) contrast traditional organisations which have mechanistic highly prescribed sets of rules and hierarchical authority structures, and those organisations with a more holistic emergent self-organisation approach. The latter focus on creating the conditions for success through collective goal setting, a style of leadership which motivates and influences followers, and sense-making of what is meaningful by helping people understand what is happening in the organisation.

In order to close the chasm in the hospital decision making system which operates with a silo and control mentality (authors own observation and collaborated by Von Holdt & Murphy, 2007; Doherty, 2013 amongst others). There was a need to explore whether a better, deeper understanding of the groups underlying motivators, values and perceived roles, could become the platform for meaningful engagement and dialogue around improvements in the system.

The problem statement for this research was therefore: How could the working relationship of managers and clinicians be improved by understanding the underlying values and motivators for their decision making?

1.5 Research Sub-Questions

The kind of questions which might lead to a better understanding of these system dynamics are: Adapted from Ulrich (2000, 2001, and 2005).

- What is participants differing understanding of the system and what constitutes effectiveness?
- What kind of monitoring and measurement is meaningful?
- What are the perceived roles of participants in the system and are they valued?
- What is the purpose of the system and what do participants find motivating?
- Do participants recognise that their perspectives of the system might be limited and therefore need the input of others?
- What are levels of control and freedom to make decisions by participants?
- What are the controls of resources for effectiveness?
- What are the kind of expertise and knowledge required for success?
- What are participant's reflection of their perspectives in comparison with what could be. i.e. What is missing?
- What perspectives are primary and secondary? Midgley (1998) found that it is at the boundaries between what people consider as primary and secondary to the system where conflicts might arise.
- Where might there be agreement between the two groups, and where might there be differences that could lead to conflict?
- Is there a possibility that knowledge sharing and learning can take place as a precursor to improvement or change? What can help to break the practice of independent decision making between these two groups? Lucas (2006) found that knowledge transfer "is highly dependent upon employee perception of one another."

The managers and clinician groups are the subject of this study within the health care management system, which is not working optimally. Importantly that the above questions also address change and future possibilities. i.e. What is now and what could be in the future?

1.6 Objectives

The thrust of the research is directed at a deeper understanding of underlying motivators for the two key decision- making groups. The objectives are therefore to:

- Identify from what perspective the two groups view the system.
- Compare different views of the decision-making system.
- Identify what is of primary or secondary importance for each group.

- Surface underlying values and motivators for decision making.
- Identify what constitutes effectiveness for the present system.
- Identify what constitutes improved effectiveness.
- Identify what each group thinks should change.
- Identify factors which inhibit the groups working relationship.
- Identify what enhances the two groups working relationship.
- Identify potential areas of conflict between the two groups.

1.7 Methodology in short

A systems thinking approach was used, employing Ulrich's Critical Systems Heuristics. Qualitative in-depth, face-to-face interviews were done.

1.8 Background to the research

1.8.1 Catalyst for this research study

The author was involved in management training of District Clinical Specialist teams in 2013 and 2014 in KwaZulu-Natal. To familiarize himself with the working environment of these teams, he visited three hospitals in 2012 in conjunction with Prof R Taylor. These were Eshowe, Hlabisa and Lower Umfolozi in Empangeni, all in KwaZulu-Natal. This involvement, together with personal observation of the dire situation in government hospitals, was the initial motivation for better understanding the hospital management system, and how this might be improved.

1.8 2 Practical experience – observations from prior hospital visits

Despite the limited sample of hospitals visited during that familiarization process, several issues surfaced which have been confirmed by independent local and international research (Von Holdt & Murphy, 2007; Dalmas, 2012; Doherty, 2013), suggesting that the issues listed below are not isolated cases. These initial observations were the catalyst for this current research project.

The observations most relevant to this paper, were the following:

i) Two key decision making groups in the hospital seemed to work in silos, with relatively little formal interaction or joint planning. The managers group, consist of the CEO, medical manager, nursing manager, finance manager, human resource manager, logistics manager. The second group was made up of the senior clinicians, consultants, doctors and chief matron.

ii) Clinicians saw managers as authority figures who did not know what they were doing' and were not part of the same team. Managers felt that clinicians did not see the bigger picture and frequently undermined their authority.

iii) There was an overwhelming focus on administration, statistics and procedures in the hospitals as a whole. A large number of people were required to attend frequent meetings instead of doing their jobs. Measurement of outcomes dominated charts on the walls rather than discussion on solving underlying root causes of poor health delivery. Little attention was given to the people element of the organization and understanding what is needed to motivate people to do their jobs well.

iv) Several inefficiencies were noted in poor utilization of theatres, unnecessary length of stay of patients, and lengthy delays in equipment repair. It is unclear how much effort was being directed at addressing these issues in depth, nor how the hospitals were utilizing their rich tacit knowledge base from across different functions.

1.8.3 Decision making processes amongst key leadership

From the researchers own observations, which are supported by Dalmas (2012) and Doherty (2013), decisions by managers and clinicians seem to be taken independently of each other. There was a degree of 'suspicion' of one another. Each held power in separate areas. The former over finance and resources, the latter over decisions regarding patient care. Many decisions were determined in reaction to data and statistics, instead of understanding the underlying causes. There was some anxiety about being transparent about issues and problems. Planning by management was done largely without the input from clinicians.

Initial observations suggest that both managers and clinicians were already aware of the fact that they are working in silos, and that each group is 'protecting' their turf. Day-to-day pressure of work and demands from the district and provincial health services caused these groups to focus on immediate delivery of their own respective objectives and the needs at hand. Seemingly little time was spent on addressing the underlying causes affecting the relationship between these groups of people.

1.8.4 Management interventions in organisational change

Many interventions in the organisational systems have sought to improve outcomes. However, Wheatly and Kellner-Rogers in their article "Bringing life to organizational change" (1998) quote surveys in which CEO's report that 75% of their organisational change efforts do not yield the promised results. They suggested that we need to understand who people are and what's going on inside the relational and networking elements within the organisations which characterise all living systems, before effective change can be brought about. They went on to say that people within the same organisation do not see things the same way, and that we need to understand what is important and meaningful to people and allow this diversity of perceptions to become part of the change process. Too many organisational processes have been designed by so called external experts, who then have to figure out how to get these solutions accepted by the organisation. The alternative is to find the solutions within the system itself through the contributions of its participants.

Margaret Wheatley and Debbie Frieze (2011) suggested that complex organisations were becoming more difficult to be controlled by leaders. Such organisations where problems are complex and interconnected (and hospitals certainly qualify for such complexity), were less aided by controls, but rather by mobilising the full skills, insights and knowledge of a cross section of leaders for co-operative and interactive leadership. The "host" type leader becomes curious about what the broad organisation knows about itself, and the underlying motivations of their people which might lead to more effective contributions towards organisational goals.

These initial articles suggested that a different approach might be needed, and that a more holistic understanding of the human interactive system might be helpful in suggesting ways of improving outcomes.

1.9 Summary

The study objectives addressed real issues which could affect health care issues in a practical way. The study was highly relevant and has a bearing on relieving stress for the two key decision makers, the hospital staff in general as well as the beneficiaries of heath care from the hospital.

The study was intended to surface new information and provide an additional perspective to the question of leadership and decision making from a systems thinking

perspective. In this respect it adopted a different angle to the same issue other management and relational studies have already taken.

The chapter two provides a broad review of current literature regarding the performance of the health care system, as well as the latest thinking on organisational leadership, and the difference which systems thinking adopts in identifying issues and areas for improvement.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

This chapter reviews the state of the South African hospital system and the influencing factors on performance. The author reviews the shortcomings of the new integrated health system objectives in improving quality health outcomes for the broad population, and how these are influenced by organizational structures and hospital leadership.

The chapter provides a perspective of the South African hospital management decision making system and compares this with some overseas examples where similar challenges are encountered. This suggests that many of the problems encountered are broad based and systemic in nature.

A number of leadership studies suggest that the changing complex environment demands a new approach to leadership and decision making (Schuyler, Baughter & Jironet, 2016; Sowick, Andenoro, McNutt & Murphy 2015; Schriberg & Schriberg 2011). While there are a few hopeful examples of innovative leadership in hospital situations, the magnitude and breadth of the challenge demands greater understanding of the situation. The analysis suggests that far from simply improving decision making processes, a number of human and social factors play a key role in unintended outcomes, and these need to be addressed at a more fundamental level.

2.2 Context of the Health Policy Framework

The post-apartheid era from 1994, ushered in a new health system to correct the imbalances and redress the historical inequities previously skewed by race. The transformation policy was designed with an integrated health system in mind. It was addressed mainly through policy and legislative change, but also through a substantial grants system (Chopra, Lawn, Sanders, Barron, Abdool Karim, Bradshaw, et al., 2009). The focus was to give greater attention to primary health issues, for example disease prevention, reduction of health risks through health education and early diagnosis and treatment management. In addition, it provided for equity in health service delivery and access to affordable and appropriate services.

The foundation of the new approach is the District Health System, which seeks to implement primary health care at community level through a clinic infrastructure

programme and local hospitals. Primary care allows for early disease prevention by early diagnosis and treatment management through clinics, and then referrals to secondary or tertiary care. This would ensure an integrated approach to health care focusing on overall health not just illness (Dookie & Singh, 2012).

Further integration of this health system would be driven by community involvement, where health needs and health management would determine services in response to local conditions, not a top down approach. The plan was to provide a connection between health and health care by linking social and economic systems. Community participation was seen to be foundational in the health decision making process at hospitals through governance and accountability to community structures, so integrating health services (Luckett & Grossenbacher, 2003). Furthermore, these communities would be empowered by providing transparent policy decisions and equitable resource allocations.

Central concepts to this strategy are:

- integration of services
- accountability and governance
- community participation and empowerment.

The recurring themes in the literature which document this policy framework are on meeting people's needs through a holistic and participatory approach – in other words people first.

2.3 Performance of the Government Health System

Despite the admirable transformational framework, the recurring theme from various reports in recent years is the persistently poor outputs and outcomes of the health system (Coovadia, Jewkes, Barron, Sanders, Mc Intyre, 2009; Harrison 2010; Chopra, et al. 2009). Admittedly the AIDS epidemic has brought increased demands on the system, stretching both human and financial resources. Yet, the slow and often inconsistent progress in establishing a functional district health system (DHS), has also been a result of poor planning, stewardship, leadership and management, as well as insufficient political will and leadership. The central policy of integrated services, accountability, governance, and community participation, has not been clearly established. "*In many places clinic committees and hospital boards have yet to be set up and where they have, are often under resourced and dysfunctional. With insufficient*

local political accountability, communities have lacked any real ability to change the quality of health care” (Coovadia et al, 2009, p831).

There are many contributing factors to poor health delivery in South Africa. These include external environmental factors, budgetary constraints, and historical inequities. This summary highlights management and decision- making issues and although not comprehensive, indicates issues which warrant concern. The concerns raised, provide the platform for further investigation of causes and possible interventions specifically in management and leadership decision making within hospitals. Below is a summary of existing knowledge and perspective on the way hospital systems function.

Government hospitals face specific challenges, being resource poor and facing shortages of clinical staff. The situation is exacerbated by constantly changing internal and external environmental factors. While many good policies and procedures exist, results are below expectation. Chopra et al., (2009) indicates that progress in health outcomes have been insufficient or even reversed. Millennium goals are under threat or are being revised.

The State has tried to respond mostly through policy, legislative change and high health care expenditure. However, there is a persistent gap between policies and programmes, and building the management capacity to implement these. There is an over emphasis on numbers, measurements and process. These have become the determining measure of team performance and productivity. Underlying elements of effectiveness such as the group’s experience overall, satisfaction, commitment, trust in management, communication and shared norms are not receiving the attention they deserve (Adham, Delghoshaei, Seyedin, Salehi, 2012).

Problems associated with hospital management and quality care have been raised repeatedly. Van As (2011), reports that wellbeing indicators in South Africa are poor due to weakness in implementation and shortfalls in management. Theatres are run at a mere 30-40% utilization versus the international ideal of 70-80%. Doherty (2013) goes as far as saying that hospitals in South Africa are in crisis. This means that growing complexity is outpacing practices in management sophistication and organization.

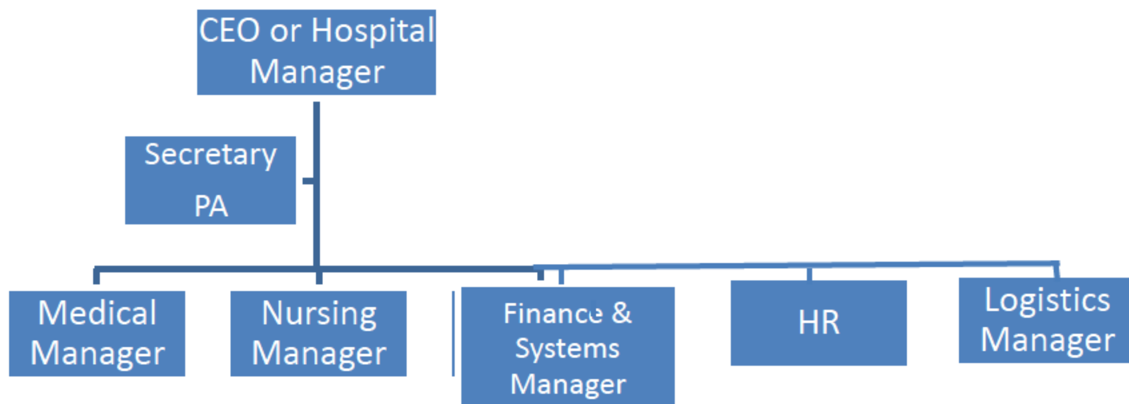
2.4 Organisational structure of a typical government hospital

Historically, public sector hospitals were managed by medical superintendents. From 1994, Government shifted its strategy towards strengthening management capacity.

The aim was to improve sustainable health delivery and meet government's transformation policy, including the District Health System (Pillay, 2008). In many instances the newly appointed CEO's or hospital managers as they are sometimes called, do not have a medical degree, which, based on the authors observation, raises suspicion amongst clinicians about their understanding and motivations of such a CEO with regards to clinical care (Author's observation).

The hospital management team has a medical manager (doctor) to whom the medical staff – typically clinicians, pharmacists, etc. report to. This position is designed to represent the interests of the clinicians on the management team. The organisational structure below in Figure 1 is typical for hospitals visited by the author, like Eshowe Hospital (level 1), Bethesda Hospital (level 1), Lower Umfolozi Hospital (level 2), and also Wentworth Hospital (level 2) - the subject of this study.

Figure 1: Typical organogram for a government hospital – adapted from Appendix 1



(Source: Wentworth Hospital, Appendix 1)

The above structure represents the operational board of the hospital, where key decisions are made. The medical manager represents the clinicians, doctors, laboratory and pharmacy on the management board. The nursing manager is typically responsible for the wards and nursing college, if there is one. Variations of this model exist. Some hospitals have a separate public relations or communications manager. Some have a separate pharmacy manager, but essentially the model separates the direct involvement of clinicians from the management team. If we regard the management team and clinical teams as two power bases in the hospital, the latter

have now lost their seat at the decision-making table. From the authors own visits to the above hospitals, it was clear that this is a source of discontent amongst clinicians, since they do not see themselves as adequately represented at board meetings. See a more detailed organogram in Appendix 1.

Hospital leadership does not consist of one homogeneous group. The hospital management system cannot be approached in a simplistic command and control manner which is typical of mechanistic thinking. Doherty (2013) describes health care institutions in South Africa as professional bureaucracies with an entrenched silo system of management hierarchy. Under the silo system, doctors, nurses and administrators report in separate lines to the CEO, and then wait for decisions to travel up and down these hierarchies. There is no single locus of control that integrates decision making and authority at the level of the department, unit or ward. Historically clinicians look after patients while managers look after the organization which treats them.

2.5 Management and leadership factors which influence decision making and performance

Lack of managerial capacity is one of the shortcomings in the South African health system. Coovadia et al. (2009) allude to the fact that inexperienced managers have struggled with challenges associated with transformation, in addition to there being a serious shortage of training, support and supervision.

Harrison (2010) describes how the centralisation of controls at provincial level, and lack of delegation of authority to hospital managers, is resulting in competent managers frustrated by a lack of autonomy, leaving. They are replaced by junior, less competent managers. Budgetary and expenditure controls and devolution of staffing decisions to local hospital level, intended in the DHS framework, are not being implemented. Similarly, there is a sense of exclusion from decision-making experienced by senior clinicians at hospital level.

At a minimum, hospitals are stressed institutions. On the one hand, within hospitals themselves, different functions are fragmented into silos. Clinical staff are responsible for using resources, but often have no idea of, or direct involvement in budgets. "*The result is that managers in one section of a hospital, for instance human resource or nursing management, will make decisions according to their understanding of rules and procedures and requirement of their own department, and ignore the disruptive*

impact on other departments" (Von Holdt & Murphy, 2007. P 323.). This results in a lack of co-operation, teamwork, and at times conflict.

On the other hand, there is a dysfunctional relationship between hospital management and head office, where management are held accountable for results, but often don't have authority to make decisions. Much focus of the system is on numbers and charts, is a further indicator of problems in the decision- making system (Doherty, 2014). Much energy is spent on setting standards, record keeping and turn-around times. While these are all good management practices in themselves, they become problematic when the underlying causes in management culture, teamwork, commitment and open sharing of knowledge are neglected. By raising the profile of processes and measurement, these are given a life-like importance of their own, while what is important for improvement of health outcomes is lost. Statistics and numbers represent linear mechanistic view of the system without taking into account the cause and effect elements behind them. Many unintended consequences resulting from this focus are ignored. The hospital system consists of many complex interrelated activities with several feedback loops, which result in non-linear behavior, but these are not the focus for managers. Hospitals need both the application of good processes on the one hand, as well as the understanding of intangible influences of how key decision makers engage with these processes, to help improve outcomes (George, 2006).

Hospital management are burdened by incessant, and often inappropriate demands from district managers. They are preoccupied with meeting these bureaucratic demands. This is aggravated by weak internal administrative support, meaning that their attention is constantly diverted to solving these issues, instead of dealing with more strategic issues, role clarification and transformative leadership (Doherty, 2014)

Most of the decisions that affect quality of care are taken at the clinical level. However, manager's pre-occupation with administrative demands means they are somewhat distant physically from what happens at the level of face-to-face health delivery, spending relatively little time in the hospital itself. Medical managers who should bridge the gap between clinicians and management in terms of awareness and understanding of clinical issues, are themselves often burdened with administrative duties, therefore not fully representing the day to day issues faced by clinicians. Due to the shortage of staff many rural hospitals do not have a clinical manager, with the result that clinicians report directly to a non-clinical manager who is focused on administrative management issues (Doherty, 2014).

2.6 An international perspective on hospital management.

Several international studies corroborate the findings in South Africa that i) a 'co-operation' gap exists between managers and clinicians, ii) that there is a lot of emphasis on performance management.

In Malta (Dalmas, 2012), management was found to be too detached from the operational levels of hospitals and needed to be more visible. In addition, they also needed to adjust their priorities to include things important to clinicians. On the other hand, medical doctors had almost complete autonomy over patient care but had almost no control over resources. Experience showed that looking at the human interactive system more holistically, would bring better results.

"*The better the working partnership between clinical and managerial colleagues within a hospital, the better the potential for delivering patient care of the highest quality" (Dalmas, 2012, P 140).*

A remote relationship and infrequent direct communication between clinicians and the CEO in Ireland, suggested poor co-ordination. In cases where clinicians were represented on the board by another clinician (similar to the medical manager in South Africa), much of the communication was filtered. The fact that clinicians were at the heart of the hospital function, required that managers interact with them more frequently. On the other hand, while clinicians wanted a more integrated approach, this provided them with a dilemma regarding their independence. The recommendation was therefore to avoid dominance of one group over another, and that a new management body was needed incorporating clinical directors (McDermott, 2002).

In the United Kingdom, New Zealand and Australia, (Degeling, Zhang, Coyle, Xu, Meng, Qu, et al., 2006) found an oppositional stalemate between managers and clinicians in hospitals, while in China, where the hospitals senior manager was medically qualified, this was not the case.

Clinicians acknowledge the need to provide health care across organizational and professional boundaries in The Netherlands. However, few were involved in structured information exchange let alone joint decision making. Some saw this approach as an attack on their independence and professionalism. Multi-disciplinary meetings were not seen as productive hours since they did not get reimbursed for them (Elissen, Van Raak, Paulus, 2011).

In Swedish hospitals managers felt that doctors had too much status. They were hard to manage, did what they wanted to do, and did not stick to rules despite knowing little about the health system as a whole. They were 'troublesome' to CEO's, making it difficult to manage them (Von Knorring, de Rijk, Alexanderson, 2010).

Management reforms in the UK and USA in the 80's sought to introduce business practices based on incentives to address inefficiencies and rising costs. Even after decades some of these structures and guidelines are still not attuned to clinical practice. There have been many disagreements between governing bodies and medical staff (Doherty, 2013 citing Ham & Dickenson, 2008).

Edwards (2003) refers to poor relationships and even conflict between managers and doctors as a common feature of many healthcare systems and that there was a need for better mutual understanding. So much so that in the United States hospitals were concerned about the disaffection amongst physicians. Reference is also made to Davies and Harrison (2003) who indicated that there has been a shift away from tacit understanding between these two groups to scientific-bureaucratic model with emphasis on systemisation of work. The study recognised the need for these two groups to work in partnership to improve relationships.

In a quantitative study comparing attitudes and perceptions amongst managers and clinicians in the United Kingdom National Health Services (NHS), with a similar study in 2002, they concluded that in many ways the results on the overall perceptions of local doctor-manager relationships in 2016 reflect those from the 2002 survey. In the study 72% of chief executives rated the quality of doctor-manager relationships as 4 or more on a Likert scale, whereas only 50% of clinical directors did. 80% Of chief executives thought that this relationship would improve over the next year whereas only 35% of clinical directors did. Below is just a sample of the results to illustrate the disparity between their views.

Table 1. Comparative Management and Clinicians responses from the NHS questionnaire

Issue	Directorate Managers	Clinical Directors
Doctors are adequately involved in hospital management activities	66%	53%
Doctors have sufficient influence on hospital management	81%	41%
Doctors view the management decision-making process as fair	53%	37%
Management are good at providing feedback to doctors about service delivery	64%	30%
Barriers for more effective relationship between the two – Lack of trust	28%	27%

This must beg the questions i) why there is such disparity in their views when they are working in the same institutions? ii) why there has been so little change in 14 years despite everyone understanding the issues and having many management interventions? This study will seek to provide greater understanding of the deeper motivational elements which result in these views.

2.7 Learnings from the latest leadership studies

2.7.1. The effect of the changing environment on leadership

We live in a multi-dimensional and complex world in which leadership is no longer as straight forward as it used to be. Universal accessibility to information and knowledge means that followers may be more knowledgeable in certain areas than their leaders and are encouraged to broadcast their thoughts. Emerging values and social structures invite everyone to exercise independent thinking and self-determination which means that followers are less dependent on leaders than before. Relationships and division of power between leader and follower is not as clear cut as before (Schuyler et al., 2016).

The NHS National Institute for Health Research study (2013). confirmed that organisations which achieved high levels of engagement with clinical staff were more likely to perform well. Nevertheless, ‘heroic’ models of leadership were still dominant. Their research suggested that engaged leadership was a good predictor of organisational performance and noted from Gronn (2002) a growing interest in distributed leadership.

When leaders interact with a group of highly competent followers, they can no longer afford to remain focused on their authority to make decisions, nor be locked into highly hierarchical or structured problem-solving processes. They need to become ‘bilingual’, able to make important decisions, yet also talk the language of human motivation and empowerment. “They need to be the kind of leader who knows that they are hosting other people’s potential … by creating the conditions for people to come together and be thoughtful again” (Schuyler et al., 2016 interviewing Margaret Wheatley P31). Where there is a loss of dialogue there will be a loss of mutual trust.

Followers and colleagues are looking for clues from their leaders that they are worth following. Old style leadership traits like courage, resolute decision making, intelligence and decisive speech, now need to be replaced by clues which show that the leader is aware of the new social and cultural context. This recognizes that there are leaders at different levels of the organization which need to be heard – executive leaders, line leaders and network leaders. Each have a distinct role to play and need to be harnessed. Sowick,et al. (2015) citing Ashley & Morrison, speak of strategic leadership being based more on decision support rather than decision making, while in the concept of Leader-Member exchange (LMX) Schriberg & Schriberg (2011, p. 75) quote Graen & Uhl-Bien (1995) “*High quality exchange between leaders and subordinates resulted in higher performance, less turnover, and greater organizational commitment, amongst others*”. The danger is that workers are so pressed by the urgency of everyday tasks that they become disconnected, exhausted and demoralized. The leaders’ role is to actively create opportunity for meaningful engagement, even reflection on how to do things better.

2.7.2. Emphasis on broader leadership roles

Leaders should be much more than to be decision makers, approve budgets, and ensure compliance with guidelines. They are ultimately responsible for the health of the organization and long- term sustainability akin to a healthy dynamic living system. Their role is to build organizational capacity to solve problems in the context of the future, not just problems per se. This must incorporate the building blocks for a learning organization in which people are valued and their potential is developed, not where they are simply used as a resource. This building of collective capability is about building trust and being willing to take risks together just as in a sports team (Schuyler, 2016 citing Peter Senge). Close leadership, where there is regular direct interaction,

behavior such as coaching, relating directly to followers and giving meaningful feedback is paramount (Popper, 2011).

Great leadership involves the process of moving the organization from a stressed reactive mode to a health anticipatory mode. "*A good hockey player plays where the puck is. A great hockey player plays where the puck is going to be*" (Sowick, Andenoro Mc Nutt & Murphy, 2015, p. 109, quoting Gretzky, 2014). This approach is related to sustainability, and requires engagement with the future not just the current job. It also requires a shifting the organization to be future focused. "Tomorrows healthcare leaders will need to go beyond the limits of the system within which they operate today to perceive what those systems might become" (Sowick et al., 2015 p 115, quoting the World Economic forum 2013). The NHS National Institute for Health Research (2013) noted from Hong (2013) that outside health the role of leadership in fostering a positive 'service climate' which links staff well being through good employment practice to customer (patient) outcome had been noted in the business and management literature.

2.7.3. Leading in the 21st century

Three themes emerge for the future.

The first is the need for transformation through a combination of purpose, attitude and new ways of working. Underlying this change is a shift from knowledge (and the ownership of knowledge) to broad based ability (not just a few individuals), to behavior which is mutually supportive and innovative. While interviewing Robert E. Quinn, Schuyler et al., (2016), he suggested the following model for the positive organization

Table 2. Characteristics of two organisations. Contrasting beliefs create constraints

Set of Beliefs (A) Conventional organisation	Set of Beliefs (B) The positive organisation
People make assumptions	People sacrifice for good
They act with self-interest	They show compassion & respect
They engage in conflict	They make spontaneous contributions
They become alienated	They build social networks
They fail to learn	They live in high quality connections
They react to constraints	They experiment, get feedback and express voice
They comply with demands	They become generative

They prefer the status quo	They envision possibilities
They fail to see opportunities	They expand the resources
They compete for limited resources	

(Source: Schuyler et al., p. 55/56)

The second is the recognition of the value of people and their potential. This requires a shift away from seeing people as resources, to seeing how healthy relationships can transform organizational performance. As people thrive, organisations thrive. This suggests a much softer leadership style. Some call it servant leadership or partner leadership. This is not to say that performance issues should be forgotten. Rather they go hand in hand. Schuyler et al., (2016) quote Keller & Prince (2011) "*Executives at companies undergoing transformation revealed that organisations focusing on both performance and health rated themselves as nearly twice as effective as those focusing on health alone, and nearly three times as effective as those focusing on performance alone".*

The third is the recognition of contextual and situational leadership rather than a broad based 'fits all' approach. This recognizes that leadership is often shaped by the cultural, situational and social needs of the followers. In effect leadership style here should assess what those needs might be. If we relate this to Maslow's hierarchy of needs then a group of followers in crisis might very well need a leadership style which is decisive and directive. However, if the follower's needs are near the top of the hierarchy as defined by self- actualization, the leadership style would need to be very different indeed (Popper, 2011).

2.8 Examples of some successful interventions

Several attempts have been made to improve the relationship between managers and clinicians as a means to improve decision making in hospitals. For example, in poorly resourced hospitals clinicians have extended their roles to include managerial tasks. In these situations the boundaries between the clinical role and the managerial role are not clearly delineated. They simply get on with the job out of necessity. Studies in district hospitals in KZN and North West Province, (Couper & Hugo, 2002) found forms of non-hierarchical leadership based on collegiality, good interpersonal relationships amongst others. In some of these hospitals the senior management team included clinical heads.

The Hospital Transformation Project at Baragwanath Hospital was able to achieve decentralized management authority and set up improved clinical governance systems (Doherty, 2011).

In the UK some clinical directors retain clinical responsibility by also managing a unit on a part time basis – usually 20% of their time. Another study in the UK found that 'hospitals with the greatest clinical participation in management scored about 50% higher on important drivers for performance (Mountford & Webb, 2009).

Initiatives started in Malta to increase the involvement of their clinicians in hospital management roles have resulted amongst others in: i) trust and respect on both sides between managers and clinicians; ii) common focus on shared values, goals and organizational values; iii) the integration of the executive management of the hospital business with the clinical/medical management of services; iv) comprehensive team building and organizational development exercises to improve cross professional collaboration between staff (Dalmas, 2012 p. 142).

A recent study in seven OECD countries (Rotar, Botje, Klazinga, Lombarts, Groene, Sunol, et al., 2016) found that medical doctors are increasingly involved in both management and strategic levels of governance. This was associated with better health outcomes. While their management roles were not always formalized, their consultation and opinions in management decisions mattered, and resulted in better performance of hospitals.

While some clinicians may not be inclined towards managerial tasks, there are many others whose leadership resource in this regard remain untapped as evidenced by the above examples. This does not mean one should argue in favour of clinical management per se. Nevertheless, the sharing, engagement and joint decision making involving clinicians, does suggest a possible way of improving overall health outcomes. Some new thinking in this area is being explored. Leadership and management studies are already offered to clinicians at post graduate level in countries like Denmark and the UK, indicating a possible trend for the future. However, as clinicians are pulled into management decisions they in turn need to recognize aspects of corporate accountability, funding constraints and hospital guidelines.

2.9 Background on Systems Thinking

A Systems Approach was selected for this study, and it is therefore important to provide some background to this field of research. A systems approach was chosen

because it was felt that understanding of leadership and decision making needed to be rooted in the context of the bigger whole, rather than focussing on specific solutions. A systems approach essentially seeks to understand the whole, by understanding its parts, ensuring better decisions are made.

But why not a conventional management analysis? Management analyses are strongly directed toward results and objectives, and measures for closing that gap. Systems thinking interprets what is and explores possibilities and improvements yet to be determined.

Michael Jackson in "Creative Holism for Managers" (2011), makes a strong case for systems thinking to be applied to complex situations with interconnected problems.

"*Fundamentally, simple solutions fail because they are not holistic or creative enough. They are not holistic because they concentrate on the parts of the organization rather than on the whole. In doing so they miss the crucial interaction between the parts"* (Jackson 2011 P xiv).

In systems thinking the whole is more important than the parts, and the parts are only important in the sense of what they contribute to the whole. Greater understanding is needed of the interaction between the parts and how they have both positive and negative influences, rather than the parts in themselves. So, another solution orientated approach for specific processes will be avoided in this study.

The hospital decision making system is also as much a social system as it is a process system. The influences of peoples' perceptions and motivations will have a direct effect on the processes.

Note: More justification for the systems approach is given in Chapter 3.

Several systems methodologies could be considered for this research.

Beer's Viable System Model could be useful to understand the linkages between various sub-systems within the hospital decision making process, like operational support, co-ordination, synergies between sub-systems and environmental factors to aid development and innovation (Beer 1984). However, this approach relies heavily on sequential interactions and connections of sub-systems. It would be too broad and not be sufficiently focussed on the specific interactions, consequences and influences of two key human decision-making groups on each other, namely managers and clinicians, and then the effect of that relationship on the broader system.

The rise of humanism and individualism recognises the importance which subjective individuals can exercise on effectiveness of a system. This gave rise to Checklands'

Soft System Approach (SSM). The SSM is well suited to this study because it is applied best where the human element is central to the messiness of the situation, and the outcome uncertain. It also emphasises that systems need to be seen from the eyes of the beholder and encourages a wide range of possible perspectives. The mnemonic of CATWOE in defining the root issue is similarly useful in complex situations (Checkland, 1985). It is also strongly aligned to Kolb's Learning Cycle, as a basis for knowledge building and improvement of the system, and will be useful to apply to the research analysis (Luckett & Grossenbacher 2003). However, it has some limitations in this situation because it seeks some form of shared accommodation of the situation and does not provide sufficiently for potential disagreements on outcomes or even conflicts of interests.

Ulrich's Critical System Heuristics (CSH) was chosen as the most appropriate methodology for this study. It is strongly rooted in people as the key influencers in a system which is complex and messy. The methodology brings to the surface hidden motivations for decisions and behaviour, but without necessarily seeking consensus on these issues. It therefore allows for free expression of participant's views without the pressure of working towards an outcome. It also provides the platform for growth in knowledge and learning as a potential platform for improvements in the system.

The CSH methodology is discussed in greater depth in chapter 3.

2.10 Conclusion

While the stress of the government health system can be attributed to many factors, the two key influencing groups, managers and clinicians, are not working together optimally. It is at this level of leadership which determines the ability of the organization in dealing with its many challenges. By determining the factors for their (non) collaboration, recommendations can be made for ways of improving health outcomes.

Von Holdt et al., (2007) suggest that there are two factors which reduce this stress in the hospital system. I) the presence of social capital – the long tradition of high quality hospitals impacted positively on patient care, morale and personal health; ii) a good relationship between the CEO and clinicians, and where the CEO had established a strong management team, displayed confidence, and adopted an innovative approach. This will be important to keep in mind in the research.

Organisational effectiveness is a direct result of the influence of individuals (Zheng, Yang, McLean, 2010). So, understanding the motivators and values of individuals is

needed before addressing organizational effectiveness. If individual values and organizational values match, much greater sharing and utilization of individual's knowledge can be expected. The first step is to expose the root causes of individual pursuit and goals at the expense of shared pursuit and goals. Adopting a new process or approach is never easy but is enhanced when members understand the process objectives and are invited to take part in the process development.

The question remains, how do we get two powerful decision- making groups to better see the need for each other? The way forward is to see the organization and its team and complex system (Chapman, 2005). The extraordinary demands and complexity of the health care system needs to be met with a response which leverages the full knowledge of what the organization knows about itself. Multiple perspectives are needed through greater participation and commitment from its members. For knowledge sharing to be practically meaningful, it may need interpretation and not be conveyed through a third party. This is specifically true for functionally specialized knowledge. This kind of knowledge needs engagement and a behavior of mutual co-operation.

The Chapter 3 will explore a methodology which addresses both the relevant contextual perspective for leadership as well as in depth understanding of the underlying influences which affect the working relationship between these two groups.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

The authors own observation, corroborated by Doherty (2014) was that much emphasis in the current system of health management has been placed on an analysis from a typical business management perspective. The language of measurement, performance, outcomes, provides great importance to statistical objectives and ways to manage these. There is seemingly little recognition that more attention should be given to systemic issues, in which multiple complex factors interact to create messy and often unintended consequences. Too often, specific outcomes are being pursued without looking at the whole system. This study will seek to understand some of these systemic issues, specifically from a human interactive systems thinking point of view.

Why a systems thinking approach? Systems thinking is characterized by attempting to view things holistically, to seek out influences, inter-connections, and interrelationships. Systems thinking as a methodology falls into the action research paradigm and generally seeks to find ways to improve situations rather than provide precise solutions to problems. So, the significance of this study is to identify how a systems approach can be used to improve the relationships of these two groups in their specific context.

The research design parameters here, were governed by the interpretation that the most significant problematic situation relates to fairness in the relationships between the vested parties. They are overwhelmed by their own perspectives and as a consequence tend to over-ride the concerns of others. In his work Jackson (2010) recommends CSM as a methodological approach to this type of problem.

Despite the rich choice of available management and leadership material and many laudable and clear recommendations from these, leadership challenges and poor performance persist in the health system both locally and internationally. There are relatively few examples of successful interventions from a purely management decisions perspective.

The purpose of a systems thinking approach is to:

i) Explore a broader perspective of the system of decision making and its influences rather than trying to find specific solutions for specific scenarios.

ii) See the bigger picture of the issues involved and to raise awareness of different viewpoints of the same issue. Understanding the bigger picture enables people to reflect on their own actions, modify behavior and reduce unintended consequences to enhance the overall capacity of the system (Chapman, 2004).

iii) Help surface awareness of deeper patterns which govern surface issues and sensitize people to how their 'thinking' affects others and has consequences on the system as a whole. (Jackson, 2011).

3.2 Aims of the Study: Specific to the inter relationship between managers and clinicians.

- The main aim is to understand the mindsets, systemic and inter-relational, contextual elements which enhance or inhibit the working relationship between managers and clinicians, and what recommendations could be made to improve this. This relates to what is really important to each group as indicated in the objectives on P 3.
- How a systemic analysis of the decision-making process, and therefore how a broader perspective (Objectives P 3) could help to provide a better perspective of the issues and bring awareness of own actions on the system as a whole.
- How awareness of own deeper values and motivators could bring understanding of how their 'thinking' affects others positively and negatively, and therefore potentially modify behaviour.

3.3 Research Design and Methods

3.3.1 Chosen design and method

In keeping with the aims of the study to uncover in depth understanding of personal views and motivations of respondents, a qualitative approach was chosen in the systems thinking tradition. While the respondents all worked at the same hospital, each respondent is unique to their specific perspectives of their jobs and influence in the hospital. Data was analysed for description and themes, and then interpreted drawing on personal reflection and past research (Creswell, 2009)

A semi structured, face-to-face in-depth interviewing technique was chosen. The semi structured method allowed for consistency across all interviews while at the same time

allowing for additional probing where necessary. The in-depth interviewing technique enabled deeper probing to understand what lies below the surface. The face-to-face technique was important to allow the researcher proximity and intimacy with the respondents for better interpretation of their responses.

The chosen methodology was a systems thinking approach since this would provide necessary context of the data, and specifically the Critical Systems Heuristics (CSH) approach as a sub branch of systemic analysis. CSH is particularly suitable for surfacing deeper motives and values behind decision making as already outlined in the aims of the research.

Content analysis was used to interpret to provide understanding of respondents' views, motives and values. "*Content analysis is a valid research method that provides a systematic and objective means to make valid inferences from verbal, visual, or written data in order to describe and quantify specific phenomena*" (Downe-Warmbolt, 1992,p. 314). The data was then synthesized into known systems models.

The specific interview method used:

i) Exploratory questions ("what; describe") to form an initial understanding for drawing a rich picture.

ii) Ulrich's 12 boundary questions, each in the "IS" and "OUGHT" mode. It will be noted that these questions are exploratory and descriptive in nature, in keeping with the objective of surfacing deeper motivators for behavior. (Ulrich, 2001)

A full set of questions is attached in Appendix 2.

3.3.2 Advantages and risks of using the systems approach

One of the biggest obstacles to co-operation and learning is the presumption of knowing best. (Chapman, 2004) Systems thinking helps to raise awareness of people's tendencies towards one preferred viewpoint through a process of deliberate self-inspection, thereby helping them grasp the bigger picture. It enables people to see the interrelationship of processes and decisions, thereby enabling them to better manage complexities. This happens when people stop advocating only their own ideas, and take on board the experiences and thoughts of others (Ng, 2004). The complexity of the interrelated consequences of the health system suggests that everything is connected to everything else. Simple, linear quick-fix solutions will not be enough. While each new intervention which emphasizes another management fad does assist in finding partial solutions, the mere fact that they tend to focus on parts of the

organization and not the whole, means that they do not tackle the growing interrelated complexity of its many parts. A systemic approach is needed which looks at the interaction of all its parts, in terms of process, structure and the influence of the human element.

Equally important is the recognition that one participant, one group, or one function in the organization, does not have a complete picture of the system. Their limited understanding is defined by the boundaries which each participant draws for the system – the things which are important and those which are not. Different interest groups make plans and decisions based on their worldview, which at times may conflict with the worldview of another group. This is very evident amongst clinicians and managers, who have entrenched their respective positions regarding the organisation's function based on their values or boundary judgements.

The hospital decision making system can be described as principally a human interactive system, where interpersonal relationships, values and individual motives play as much a role as the functional processes and procedures. While the systems approach gives understanding of the key decision points, it may not give sufficient importance to potential negative feedback loops and unintended consequences of individual decision makers against intended interventions (Jackson, 2011).

Many senior leaders, both managers and clinicians feel they have advanced to their positions because of their experience and past practices. However, this attitude closes the door to understanding other perspectives (Chapman, 2009). The barrier to systems thinking is not an intellectual one, but there may be an unwillingness to lay aside their own assumptions about what works and what does not. On the one hand this is a willingness to reflect on their personal objectives – this is potentially a personal and emotional step to take. On the other hand, it involves a willingness to work with colleagues who have a different view from their own (proven) approach.

Two of the obstacles to adopting a systems thinking approach which Chapman found in the United Kingdom Government services were that i) the dominance of turf wars and negotiations between departments, effectively making end user performance secondary to other considerations; ii) the loss of professional integrity and autonomy under the knife of efficiency in policy-making and resistance and protection of vested interests by some professional and intermediary bodies (Chapman, 2009).

The literature review so far suggests that it is unlikely to be different within the government hospital management system in South Africa.

A systems thinking approach could also be seen as insufficiently precise and lacking in rigor, because it is an interpretative approach which places too much emphasis on the researchers' judgement. While a systems thinking approach seeks to study social systems objectively, this may be an over simplification of the true complexity of social reality. Models of behavior are largely constructed by the researcher and these may lack the rigor of precise data.

A systems thinking model seeks to suggest potential improvements, but because of the limitations of both the researcher as well as the complexity of the true social interactions, the model may be less predictive of improvements than desired. So, a systems approach can be criticized for acting principally at the level of ideas and changing people's world views, but does not recognize that this is difficult without first changing structures and identify the influencing factors that determine world views (Jackson, 2011).

3.3.3 The value of Critical Systems Heuristics (CSH) as a methodology for this research

CSH seeks to unravel several deep and underlying influencing factors within the system (Ulrich, 2005). A brief paraphrase of the methodology follows below (Ulrich, 2005).

'Critical' in this context refers to questioning assumptions – there is no single right way of interpretation. We cannot assume that boundaries imposed selectively by ourselves or someone else are necessarily correct.

'System' refers to the broader, or whole system, looking beyond the rational definition of the system as defined by either managers or clinicians as 'experts' in the field. It is the agreement or disagreement of these broader system boundaries which limit degree of buy-in and makes them a source of conflict.

'Heuristics' refers to the art of exploring, discovering or unfolding these factors. The hospital system is not abstract or robotic. Humans are involved, each bringing with them their 'entrenched' views, values and judgements. The value of the methodology is to surface what is hidden, sometimes hidden even to the very ones who hold a particular view.

Participants in the hospital decision making system are quick to take positions on issues. Often their positions are determined by the reference system or assumptions participants have established for themselves. CSH seeks to provide context and

understanding for why participants in the system take these positions, as well as how limited these reference systems might be. Participants may be aware of the assumptions that precede these positions – sometimes called boundary judgements, or they may not. However, by bringing these boundary judgements to the fore, they are encouraged to reflect on both their own and the boundary judgements of others, which brings about two potential benefits. i) Participants have the potential to be 'emancipated' by truly understanding the underlying assumptions which cause them to take the positions they do. ii) They obtain understanding and clarity about the boundary judgements of others. This exposure to alternative boundary judgements offers the possibility of seeing how limiting their own boundary judgements are, and broadening their perspective of the bigger system by taking into account both their own as well as the boundary judgements of others. This shared reference system then provides possibilities of better communication and tolerance.

CSH does not seek consensus on drawing the system boundaries. The purpose is to engage the parties concerned to reveal the values which cause different parties to draw the boundaries where they are. Within this discourse it allows for conflicting points of view. All parties have clear understanding of each other's thinking and motivation, and everyone has been given a voice (Ulrich, 2003). The result is that things are brought into the light rather than being hidden. Participants understand what their own evaluations depend on and where they and others stand. Uncertainty is removed regarding each other's positions, and a meaningful conversation can take place (Ulrich, 2005).

Every system has both internal and external influences and needs to adapt to both to be sustainable. CSH looks at both influences. The internal influences of key decision makers in the hospital system are clear. They rest in 'experts' power, knowledge and influence. CSH also looks at the influence of those affected but not necessary involved; - those external to the decision making of the system. This addresses the legitimacy of the system in the eyes of these externally affected.

CSH does not rely on expert robustness to justify its results. All views are legitimate in the eyes of those expressing them. They see the system as it affects them, whether that is a limited view or not. The robustness of the results cannot therefore be questioned by the absence of expert knowledge of the outside affected. Everyone is given a voice and can express a view which is valid in their own eyes.

The mutual recognition of boundary judgements other than one's own, may also help in developing improvements in the system (Ulrich, 2003; 2005). Boundaries are defined by those who may be considered as the decision makers. As participants realise that different groups of people have different ethics and values on the same issues, the initial boundaries may be expanded to involve decision makers who were originally not considered as experts for the sake of decision making. Depending on the boundary definitions of different groups, improvements might look different for different groups (Midgley, 1998). Clinicians and managers working in silos, may of course be 'happy' with the boundaries they have drawn without considering the bigger inclusive system. However, does this behavior provide the best outcome for the system? In analyzing the responses of these stakeholders CSH encourages them to see a distinction between their own boundary judgements and those of the 'other' group. This puts the concerns and differences into clear perspective. One may suggest improvements and concrete actions to the joint group to see whether some of the concerns can be addressed. While there may not be consensus on the proposed improvements, all is not lost. The process will have unearthed the causes of conflicts and provide a foundation for mutual understanding of differences from which tolerance can grow for future common action (Ulrich, 2001).

Participants boundary judgements are revealed within four categories or influencing factors within the system (Ulrich 2001).

i) Clients, or sources of motivation
ii) Decision makers or sources of power
iii) Professionals or sources of knowledge
iv) Witnesses or sources of legitimacy

These represent the different aspects to be considered in the system, as well as who is involved. They accurately reflect the forces at play within the hospital decision making system.

The eternal triangle developed by Ulrich shows further interdependence of three elements which define the system. The position which either clinicians or managers take within the system are defined both by facts, albeit incomplete, as well as perceptions, which are influenced by their values.

Figure 2: The Eternal Triangle

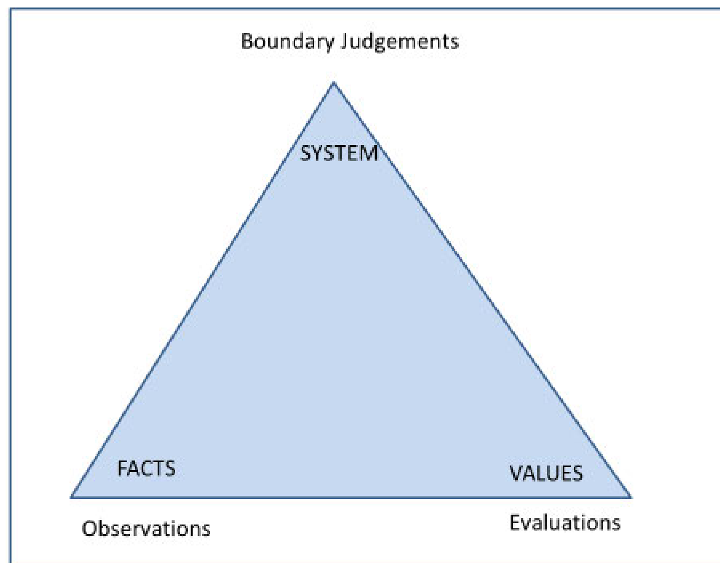


Figure 2 identifies both the facts and values which are considered to define the system of the participants. The question which needs to be asked is what facts change if we expand the boundaries, or how do evaluations change in the light of new facts. This in turn leads to possible improvements in the system.

3.4. Research Paradigm

CSM falls into the action research paradigm. The context of the research was 10 respondents who worked together but each with a unique position and perspective of the hospital system. These were defined by: i) which 'discipline' they represented, either managers or clinicians, and ii) by the challenges and expectations from their individual job positions which were all different. Hence an interpretative and constructivism paradigm was chosen in order to contextualize their different responses and views to provide the basis for in-depth understanding of their behaviours.

3.5 Study Setting

The hospital used for the research study was Wentworth Hospital, in the eThekwini district, KwaZulu-Natal, South Africa. It is classified as a district hospital, which means that more acute cases are referred to a more sophisticated hospital in the district.

It was chosen after discussion with several people who know the hospital environment (Dr Anna Voce; Dr Neil Moran), and because it was functioning reasonably well. A hospital with many problems may have skewed the focus of the research more to other operational issues instead of the leadership and decision- making process between managers and clinicians. See an organogram of the hospital in Appendix 1. It was also important to avoid choosing a hospital which had large gaps in key personnel positions, or a hospital which was so small that some dual manager/clinician positions were held by one person.

Permission was obtained from the Department of Health to conduct the research. See Appendix 7 for letter of consent.

3.6 Population and sample of the study

3.6.1 Choice of sample

Respondents were chosen jointly by the researcher and the CEO of Wentworth hospital, but largely guided by the CEO. The criteria for choosing respondents was i) that they should be in leadership positions and be involved in key decision making and planning for the hospital; ii) that they should fairly represent the two separate groups for the study, managers and clinicians.

The following respondents were chosen:

Managers: Dr Kader, CEO of the hospital; Dr Zulu, Medical Manager; Mrs Khanyesi, Nursing Manager and Matron; Mr Magoza, Human Resources Manager; Mrs Bekwa, Finance Manager.

Clinicians: Dr Mayesa, Clinical manager of wards; Dr Oyebola, Clinical Manager MOPD and A&E; Dr Ntunka; Gynaecology and Paediatrics; Sister TerBlance, Operations Manager of wards; Sister Newton, Operations manager of wards

3.7 Sampling method

CSM requires the researcher to identify the stakeholders and position them in one of four groups. These are the clients, decision-takers, designers and witnesses. I purposefully selected the position of decision-makers in this research as the group

most central to the research objectives. Purposive sampling was used to identify participants in the situation that would generate appropriate data to fulfill those objectives (Patton, 2002).

3.8 Construction of the instrument

Ulrich (2001) developed a generic instrument using a set of twelve questions which I have adapted to the context I am investigating. Questions used to construct the rich picture were constructed by the researcher. Both sets of questions are available in Appendix 2.

3.9 Data Collection

Interviews were arranged with members individually and conducted by the researcher through semi-structure and in-depth interviews. Each member received the title of the research proposal plus the questions for the initial rich picture mapping, but not the detailed questions used in the CSH methodology.

Each interview lasted for approximately 90 minutes mostly in the respondent's offices or in a private office on location at Wentworth hospital. All interviews were conducted by the researcher himself. Data was collected until the researcher had an in-depth understanding of the thoughts and views of the respondent and no new data was emerging (Watling & Lingard, 2012). None of the respondents were known to the researcher prior to doing the research. Interviews were recorded and subsequently transcribed. In addition, the researcher made rudimentary notes. Some interviews were interrupted by emergency medical issues which needed immediate attention. All interviews were conducted within the space of a month in late 2016. The names of participants have been kept confidential. Each respondent was given a code, so that at no point would they be identified by name in the analysis. Note that due to the small number of respondents, quotes which would clearly reveal the identity of the respondent have been omitted where possible to maintain confidentiality.

Quotes referenced with (CL) refer to clinicians and while those referenced with (M) refer to managers.

3.10 Data Analysis

The author read the transcripts multiple times, initially to get a general understanding of the content, and then subsequently in order to arrange the data according to the respondent groups, managers and clinicians, and also into themes according to the

CSH 4 main themes of motivation, control, knowledge and legitimacy (Creswell, 2009). And synthesised into known systems models.

The author then compared responses of the two groups to identify the degree of importance they assigned to each theme. This was judged largely by the amount that was said by respondents, their engagement with the theme, and willingness to share on the topic. At times it was clear that respondents were very emotive about one theme but not another.

3.11 Reliability and validity of the study

The author established comparisons and similarities across respondent's accounts to ensure different perspectives are represented and included ample verbatim descriptions of participant's accounts to support findings Reliability has been ensured through adherence of the CSH protocol (Slevin, 2002).

Validity was further ensured through assurance of respondent anonymity, a clear decision trail, meticulous record keeping, audio recording and transcripts of the interviews which are on record for verification, and interpretation of data which is consistent and transparent (Long & Johnson, 2000).

3.12 Bias

The researcher was aware of his own bias as a consultant with regards to identifying poor management practices. An attempt was made to minimize this by using consistent questions for all respondents and limiting his own comments. In addition, some time was spent between interviews reflecting on methods used and comparing responses from different respondents and discussing these with peers. Furthermore, all interviews are recorded and can be verified (Sandelowski, 1993).

The study was self-funded.

3.13 Ethical considerations

Informed consent form and ethical approval attached in Appendix 3.

Both the electronic and written data recordings are stored in a secure environment which ensures confidentiality and will then be destroyed after five years.

3.14 Summary

The review of the current the hospital system speaks repeatedly about influences of motivation, power and knowledge as the cause for the chasm between the way clinicians and managers see this system. The methodology used in this research sought to bring to the fore the boundary judgements these elements impose on each group's view of the system. It also enables each group to 'see' the perspectives of the other group, thereby encouraging them to adopt a broader systemic view rather than a narrow territorial view.

The research methodology and design followed a well proven approach of systems analysis and was chosen appropriate for the research aims. The purpose of using a systems approach was to understand the context of the group's decisions and leadership styles, as well as understand underlying personal assumptions and values which informed their behaviours.

The data analysis used appropriate and well referenced methods to ensure that the data is both valid and overcomes the natural bias of the researcher.

Findings needed to link clearly to the aims of the research and provide fresh perspectives which might assist in improving the overall relationships of the two groups concerned and lead to better health outcomes.

CHAPTER 4: PRESENTATION OF RESULTS

4.1 Introduction

The presentation of results sought to present a systematic analysis of themes that would enable comparison between the responses of managers and clinicians. The findings are presented largely in a manner that they ‘speak for themselves’ and include several verbatim quotes, plus the researcher’s interpretation of these. (Creswell, 2009). The themes follow the CSH suggested theming.

The data here is a synthesis of a more complete write up in Appendix 3, which itself is a summary of the full transcripts which have been safely filed but are available on demand.

The help the reader navigate this chapterfindings are presented in the following manner:

Initial mapping of the system

- Rich picture of the system
- Clinicians perspective in the rich picture
- Managers views in the rich picture
- Conclusions of rich picture.

Responses to Ulrich’s 12 questions

Theme of motivation

- Questions on purpose
- Questions on clients and stakeholders
- Questions internal communication and staff morale

Theme of control

- Questions on resources
- Questions on (i) decision making and (ii) accountability (two responses combined)

Theme of knowledge

- Questions regarding expert consultation
- Questions regarding professional involvement and responsibility for ensuring this.

Theme of legitimacy.

Questions about secures legitimacy, who the witnesses are for this, and what worldview determines improvements.

Conclusion

4.2 Initial Mapping of the System

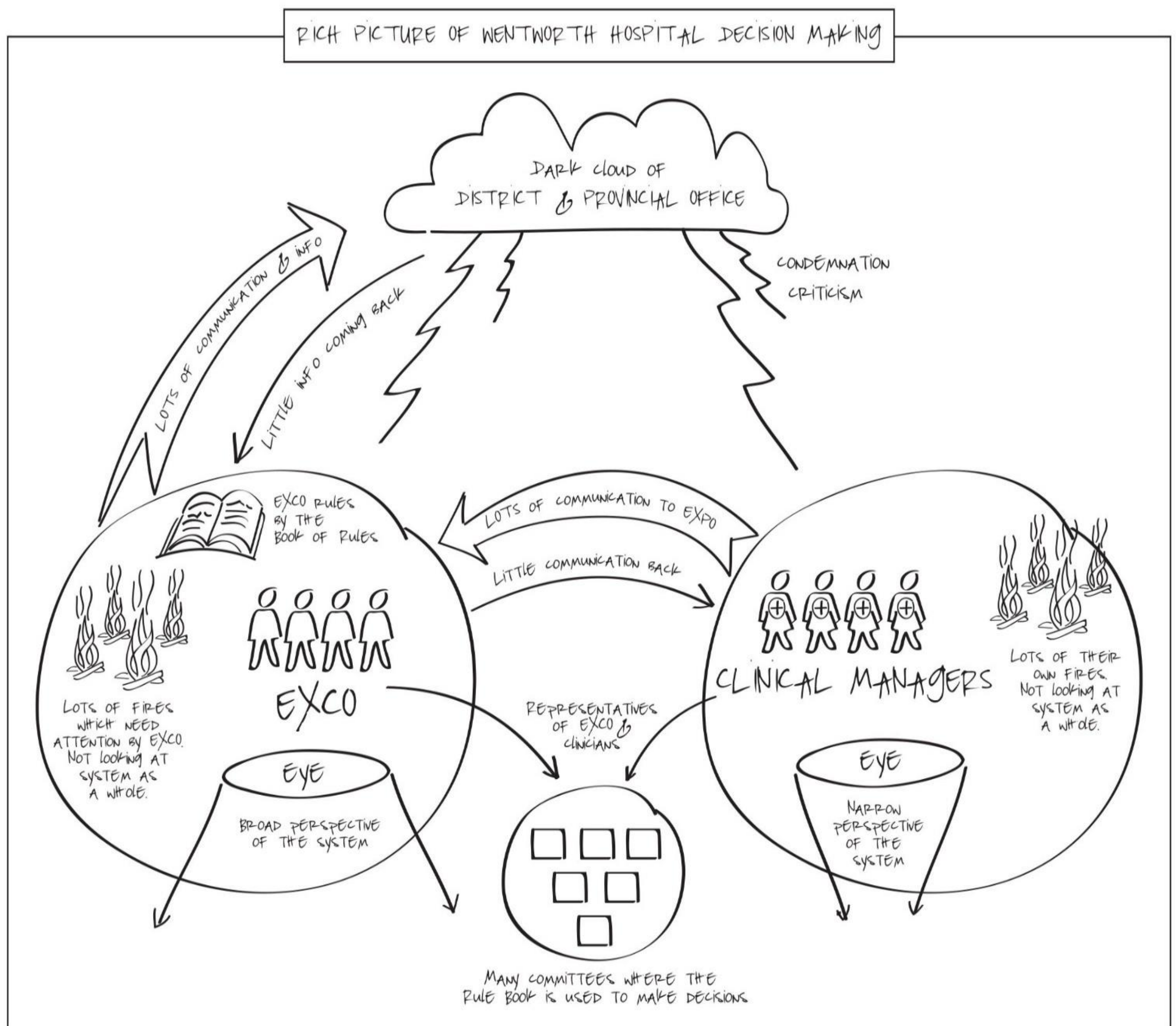
4.2.1 Rich picture of the Wentworth Hospital decision making system

The purpose of the Rich Picture in Figure 3 is to obtain an initial perspective of the system. It represents the current and surface ‘facts’ in Ulrich’s eternal triangle, and an overview of the system. It also highlights several issues and relationships which may need further probing to obtain a deeper understanding of the underlying motivators for these perspectives.

The initial ‘facts’ are that the relationship between Exco and clinicians is generally good. Clinicians are well represented on Exco by means of a CEO who is a doctor, a medical manager who is a doctor, and a nursing manager who understands the needs of clinicians. Clinicians also understand the limitation placed on Exco by budgetary constraints and understand that Exco’s objective is to satisfy their needs under difficult circumstances. Nevertheless, there are also different perspectives of the system from these two groups. This suggests that the managers and clinician’s groups have some understanding of the overall interactive decision making, but that there are some elements which need further exploring.

Figure 3: Rich picture of the Wentworth Hospital decision making system

Source: From initial research by the author.



4.2.2 Rich picture findings of clinician's perspective of the system

Clinicians have a relatively narrow view of the system, revealing a focussed view on their immediate job needs, specifically staff shortages and lack of (functioning) equipment which lead to frequent crises. They see themselves as people 'on the ground' who best understand what type of equipment is needed. They want durable and 'fit for purpose' equipment, whereas the system demands that the cheapest or readily available equipment is bought. They see the role of managers as enablers for clinicians to do their work, but this is not always happening.

“You make your prescription, and pharmacy will tell you no this drug is out of stock, and that it can even be a key drug for a patient” CL4.

“(Role of managers) is to provide the necessary resources for clinicians to carry out this core function. We know what we want, but (you) give me something that’s of little quality. They buy the cheapest even if it is not the right decision” CL5.

Their ‘lens’ of the system is mostly inward focussed, and seen from their own point of view. They work hard on achieving results under difficult circumstances, but recognise that team work and co-operation within and across clinical groups is essential to achieve results.

“There are different managers but we have to work as a unit and when there is a shortage somewhere we have to see how we have to respond to that” CL4.

“It requisitions go to Cash the Flow (committee) and then, if it’s not approved, I don’t hear anything. I’ll only hear ‘okay’ if I ask. I have to ask. Nobody comes back to me to say why it is not approved…although the issue has been brought up on many occasions, it still seems not important from the management side” CL2.

Clinicians say they experience systemic obstacles, both logistical and procedural. These include on the job issues like delays in getting results and shortages of drugs, as well as planning and communication issues over which they have little control, both within the hospital, as well as with/from the district and province.

“(communication) from the district and the province. It’s one of the big challenges which we do have … its last minute” CL1.

Communication is seen to be flowing mainly one way, from clinicians to Exco, and then from there to the district, with little coming back.

“Information should flow upwards and downwards” CL4.

“So, there is that lack of communication still that we are not resolving. Although the issue has been brought up on many occasions, it still seems not important, from the management side” CL2.

On respective roles of managers and clinicians in achieving results, they feel that they are the ones who get things done, and therefore need more help from Exco as enablers. While the relationship with Exco is good, they want more direct interaction with them. A meeting requested between the CEO and doctors requested last year, has still not taken place. At times managers are seen to pay lip service to requests, but don’t action any change.

"That's why I say, you need a management who comes down, and regular visits will improve (things). Because sometimes you need to hear the problem from the source" CL1.

"The staff, especially the lower categories of staff, feel that management doesn't take their considerations… what they say, into consideration. They feel it's like, if they are doing a survey, it's just a paper exercise and nothing ever gets done about that" CL3.

Too often managers make decisions without consultation. This does not necessarily apply to all Exco members, but there is an expectation that all Exco members should truly understand the hospital system if they are going to make decisions on their behalf.

"there should be consultation because the management they take decision but if you take your decision without consulting, then you take the wrong decision because people in their area, they are the experts in those area" CL2.

We've got a lot of committees, which most of the problems have been identified, it's just that maybe the solution hasn't been put in place CL1.

4.2.3. Managers (Exco) perspective of the system

Figure 3 shows that Exco share some of the systemic issues mentioned by clinicians, such as staff shortages (particularly the doctor/patient ratio, and shortage of necessary equipment) which result in constant crises.

"But, at the end of the day, if you do not have enough resources, we cannot provide. Though we do provide, but at the end of the day, we get punishment" (Criticism from our principles) M1.

In addition, they also mention several broader external systemic issues. These are the demands and impositions by Head Office (HO) and the province which occupy a great deal of their time; the strict procedures, moratoriums on staff appointments, budgetary and decision making constraints (to buy equipment); additional programmes required by province (without providing additional budgets for these); constraining administrative protocols.

They recognise their roles as facilitating the jobs for clinicians and providing leadership. They believe they are doing this well. The fact that the CEO is a medical doctor helps in understanding the real issues clinicians face.

"All their (clinicians) concerns are addressed and addressed in the Exco" M1

"So, whenever they (clinicians) come and shout at our doorstep and say 'Management, we need this,' we jump like a bullet " M3.

Yet a mixed picture emerges. Planning is mentioned infrequently as part of their roles, although there was much discussion about ‘putting out fires’, reacting to requests from clinicians, and addressing crises due to unforeseen circumstances. They are ‘ruled’ by administrative procedures and protocols which dominate all decision making. Their biggest concerns are the ones to do with the central procurement procedures Health Technology Services (HTS) which are not working. An inordinate amount of time and energy is used to manage this broken system.

“The biggest challenge for now, in the department (HO), I think when it comes to maintenance. So, if any of the medical equipment breaks down, they have to be taken through to HTS for repair. We find that the turn-around time with this component, is very, very long. You can lose years”M4.

“Medical equipment. It is a big challenge to us because purchasing of equipment that is greater than R5 000 has been centralised. So, you just send your needs every year and then you wait, you wait and wait and wait until you wait no more. You don’t get, you don’t get. As it is, it’s so hard. It is so very hard” M3.

In addition to working under serious budgetary and staff constraints, the province also load them with additional programmes for which no additional budget is provided. Many EXCO members have been thrust into their positions without preparatory training but are expected to perform.

“More programmes that are being introduced but with no funding” M5

Exco believe that they are communicating well with clinicians and staff, but depend much on structure and process for this to happen.

“Whatever is discussed in Exco, will be cascaded down through the meetings. So, whatever that is discussed, they come with concerns, concerns are discussed, they give feedback” M.

“But, from where I am standing, from what I have seen, there seems to be a good relationship (with clinicians) because you meet with the people on a regular basis. Because with the structure, the way the structure is, we have managers all over the hospital ” M2.

4.2.4 Conclusion of initial mapping

- Managers and clinicians regard the important elements of the system as those which relate to their own responsibilities and goals. Nevertheless, clinicians see

themselves to be fairly represented on Exco by the medical manager and CEO, but largely see the rest of Exco far removed from the important issues at the coal face. This is a potential source of frustration and misunderstanding.

- There are divergent views on the value of administrative protocols, statistics, and numerous meetings. Exco see these as an important part of their jobs and as a way of controlling the system. Clinicians recognise their need, but question the value which they add.
- The system is hampered by frequent crises. Both groups recognise this as an issue. Much energy is spent on crisis management, managing day-to-day problems and unforeseen circumstances. This is time consuming, consequently less time is spent on solving the fundamentals and improving the overall system.
- Communication and flow of information within the system is assumed to be good by Exco, but clinicians see this flow of information as skewed towards Exco, with relatively little in return. Information is seen to flow upwards, but not always downwards. More frequent face-to-face interaction between Exco and clinicians at all levels would reduce the perceived 'distance' between these two groups.
- Clinicians and managers share the view that external influences are hampering the systems performance. The district and province as well as the HTS procurement system imposed by the province, are not seen to be helping the hospital, rather the reverse. Communication from these entities is poor, causing much frustration and demotivation. They are seen as the common 'frustration' by both Exco and clinicians. To some degree this is causing these two groups to band together.

The rich picture provides a good entry point for the study. However, it also has some limitations, particularly in explaining the reasons behind some of the views expressed. Other aspects of the system are not mentioned, and could have come to the fore if probed. Relatively little is said about elements of governance and community involvement as set out in the Health Policy Framework. The fact that they were not mentioned, could indicate that they are not considered to be important to the system as seen by these two groups.

4.3. Clinicians and managers responses to Ulrich's 12 questions.

All respondents were asked the same 12 questions suggested by Ulrich's CSH approach. There was further probing by the researcher where a subject evoked a lot of interest, or where potential areas of dissatisfaction were detected. E.g. "Can you tell me more; what else? Can you elaborate on that"; etc. Additional probing varied for each respondent.

Respondents were asked to describe the current system under "IS" and the ideal or desired system under "OUGHT". The "IS" answers were interpreted mainly as 'facts' in relation to Ulrich's eternal triangle, while the "OUGHT" answers were interpreted mainly in relation to 'values'. A more extensive summary of clinicians and managers responses for each question can be found in Appendix 3.

4.3.1 Theme of sources of motivation for the system.

Three sets of questions defined this perspective: the purpose of the system; who is the client or stakeholder; what are the measures of success?

4.3.1.1. Questions related to purpose as motivator for the system.

The clinicians' perspective is dominated by the centrality of the needs and care of the patient. They cite several factors to re-enforce this perspective: Measures and statistics should be used and adjusted to improve patient care rather than be kept only to track performance. Similarly, records on equipment utilisation should be aligned to patient needs, and determine the type of equipment allocation to suit hospital patient conditions for improved outcomes, rather than be arbitrarily allocated to hospitals by the province. They see their purpose not only to cure but have a broader perspective which includes prevention.

"We could do more prevention because it is cost effective" CL4

Exco are largely forced by HO to keep lots of statistics (apparently to improve patient care) without clear evidence of its use.

"We collect literally everything, but I am not sure it is being read" M4

"We are asked to do the same things for District and Province. They don't communicate with each other" M2

"The data (we provide) should speak to the plan but it is not" M4

"There is no relationship between the budgets you apply for and what you get" M1

Research should be done on health care trends in the community so the hospital can anticipate and prepare for the conditions prevalent in the community. This should extend to regular communication and interaction with the broader community as a form of serving the patient. In essence, everything the hospital does should work in synergy to improve patient care.

This is not to say that there have not been improvements in patient care, as they clearly recognise. However, for them there is much to be changed in attitude and practice to improve the situation further, and to harness procedures with the patient in mind.

In contrast, Exco give a lot of lip service to the importance of improving patient care, but provide little specifics on what should change in practice. Instead they take a pragmatic view on what can be achieved with available resources. They are well intentioned towards patient care, but feel they are hamstrung by the facts of the situation, resulting in relatively passive intentions with regards to this issue.

In the language of the eternal triangle, Clinicians perspective is driven by the values of patient care and what can still be achieved through change, while Exco is focussed on the facts of the matter and how to manage within that context.

4.3.1.2 Questions related to the influence of client or stakeholder as motivator for the system

External influences are diverting managers away from improving the internal decision making system. While managers acknowledged that patient care was the ultimate purpose of the hospital, their responses focussed principally on how to respond and manage the demands of the District Health Office (DHO) and Provincial Head Office (PHO).

"Should anything go wrong they immediately jump on us we do things because they want us to do it, but support and appreciation is not there" M2

"Our Principals are our clients. That is the worst. They don't provide enablers." M5

There is a high degree of frustration with this relationship which is not supportive, and instead undermines the efficiency of the hospital. Consequently, it consumes manager's attention, and diverts it away from everyday management of the hospital.

"The District comes to check, check, check. They give you instructions on what to do, knowing full well you don't have the staff to do it" M1.

Clinicians are also frustrated with the absence of real support from these external institutions. In this respect it partly unites managers and clinicians. However, the additional frustration for clinicians is that managers are outward facing towards these external influences, and should be more internally focussed on working together with them on this issue.

4.3.1.3. Questions related to internal communication and staff morale as a motivator for the system

Internal communications should assist improved co-ordination between departments and functions instead of the poor communication at present. Day-to-day administrative procedures should serve to improve teamwork, leading to better output, rather than be used as a tool for information.

Poor staff attitude and quality of work is recognised as one of the six priority items within the hospital. There is disagreement between managers and clinicians on the role of internal communication and staff morale relative to this issue. Managers continue to pay lip service to better communication and improving staff morale. Instead of using communication as a tool for improving the situation, they remain distanced from staff. There is no real engagement with staff from the management side. Clinicians, who interact daily with hospital staff see this as an opportunity. They see value in this as a key contributor to improving output. The researchers own interpretation is that managers are too occupied with providing and satisfying the needs of the external superiors at DHO and PHO.

"Our principles are our clients. That is the worst" M5.

Consequently, staff communication and morale has been relegated to 'maintenance' mode – keeping people reasonably happy, or at least not disgruntled. Several comments suggest this is a point of frustration for clinicians.

"HR don't want to help. They are un-co-operative" CL 2.

"*Managers should come down for regular visits, then things will improve*" CL1.

Furthermore, the Performance Management Development System exists only in name, and is not used as a tool for improvement. On a rating of 1 (worst) and 5 (best), not one single person was rated a 5, only 1 out of 610 people were rated 4; 1% were rated 2, and everyone else a 3. Yet, there is clear recognition that quality and attitude of staff needs to improve.

4.3.2 Theme of Control

A further set of questions defined this perspective: What resources are controlled by the decision maker? Who is the decision maker? What conditions which should be in place to ensure accountability?

4.3.2.1 Questions regarding resources

This is the area in which the brokenness of the intended human system as envisaged by the Health Policy Framework is most evident. Many controls and decisions have been wrested away from the hospital. Exco are theoretically in control of resources, but they have largely been reduced to administrators. The real decisions regarding budgets and equipment allocation is made by the PHO and HTS who make allocations to hospitals in an arbitrary fashion.

"We are given responsibilities but no power to execute" M2.

"*So much equipment is ordered that never arrives, sometimes for 3 years. HTS prioritise which hospitals needs equipment most"* M1.

While clinicians feel that their proximity to patient care gives them a better idea of how money should be allocated to equipment, they are given no decision-making power. They feel that Finance control everything and only work by the rule book and don't truly understand the clinical issues involved. Ideally clinicians would like to have some budget of their own.

"Everything is based on finance. They only look at costs. You ask for 10 items, you get 2" CL 2.

"If we leave it to non-clinicians alone to take care of procurement, recruitment, and everything, it's difficult for them to actually understand where we are coming from" CL 5.

Managers agree that decision making is largely vested in budget committees, where clinicians can propose but not decide.

"Clinicians have no power over resources. They play a passive role" M4

Managers also feel that the hospital would function much better if they had more direct control over resources. At the moment they are at the mercy of allocations from HO.

"There is no relationship between the budgets you apply for and what you get." M1

4.3.2.2 Questions regarding decision making and accountability

Clinicians express frustration with the fact that they are held accountable, but have no decision making power.

"It's impossible for me to deliver if an ECG machine takes 2 years to be delivered and I don't have control over that: CL 5

Clinicians decry the fact that they can never make real decisions to improve the equipment situation.

"I don't make the decisions to buy, I only request" CL1

Clinicians feel that managers should manage the difficult process of equipment allocations – after all that is their job. Part of the solution is greater transparency of the real situation.

"Even if you don't order something for a while, then you order something you are told there is no money. So where did the money go if I have not ordered anything for a while"? CL2

Managers have a similar dilemma as do clinicians. They also feel they are held accountable but have no control. In essence HO have wrested away control from hospital managers.

"We are given responsibilities but not the power to execute" M2.

4.3.3 Theme of knowledge

The questions which defines this perspective of the system were: What expertise is consulted? Who is involved as a professional? Who guarantees that the right expertise are consulted?

4.3.3.1 Questions regarding expert consultation

Managers largely judge the influence of expertise and knowledge on how it impacts on their ability to manage, and less so on the consequences it has on the hospital health system as a whole, nor the effect it has on their clinical counterparts. They recognise that broader knowledge and expertise within the hospital should be employed to make decisions and plans. This refers to Exco's own knowledge and expertise which they see as under-utilised, as well as to the knowledge and expertise of clinicians, which is also under-utilised, but probably less recognised as such by Exco. Two influences determine this under-utilisation. Firstly, they view the most important inhibitor to this as the fact that most of the decision making authority vests

outside the hospital with DHO and PHO. This ‘outward facing’ perspective towards external elements has such an overriding influence on them that they place little importance on the second influence, which is the potential to themselves draw more on clinicians’ knowledge and expertise. Their perspective on the system relates largely to their own value needs and much less to the value needs of clinicians whom they should manage and motivate.

Clinicians reflect on their view that institutionalised committees and statistics have taken the place of the kind of engagement knowledge and expertise which would better match the systems needs and make a difference to the outcomes.

“We are given equipment which we use once in a while but are short of equipment we need every day” CL 3.

Similar to their management counterparts, they also desire to be much more involved and be drawn into collaborative decision making with managers. This reflects their personal needs for more meaningful participation and recognition. In addition, and much more strongly so than managers, they decry the negative influence this has on the health system as a whole. They feel that planning and outcomes could be improved if clinicians were invited into more meaningful collaborative decision making.

“I don’t make the decision to buy, I only request” CL1.

“We don’t get informed about our (budgetary) limits, we don’t know what our limits are” CL2.

Both, managers and clinicians have the need for their expertise and knowledge to be better utilised. For managers, the focus is to become better managers. For clinicians, the perspective is a broader systemic issue with potential for improved health outcomes. This is not to say that managers do not care for the health outcomes. They clearly do. However, it is not uppermost in their minds.

4.3.3.2 Questions regarding professional involvement and responsibility for ensuring this

Much of this question was already answered indirectly in the previous question. There is recognition that there is a mismatch between on the ground requirements and remote decision making, because experts are not consulted. Sometimes EXCO do not consult clinicians. At the same time HO do not consult EXCO. In fact, many decisions are taken higher up the line and remotely from the hospital without any hospital involvement or consultation. This agenda is set and imposed by HO.

"We are given equipment which we use once in a while, but are short of equipment we need every day" CL3

Clinicians feel that Exco should do more 'walk-abouts' to truly understand the situation on the ground, while Exco feel that HO should visit the hospital more often – not to inspect but to understand.

4.3.4 Theme of legitimacy

Questions which defined this perspective were: What secures legitimacy of the hospital system? Who are the witnesses to those affected but not involved? What worldview determines improvement? Respondents did not have a lot to say about this, so their responses are captured together rather than separately for each of the above questions.

The Health Policy Framework (HPF) envisaged a close relationship between the hospital and the community. This policy sought to involve the community through various structures, including a hospital Board. Furthermore, its vision was to track community needs and that these needs would be addressed holistically through primary health care and education, so that the hospital would not only treat illness.

This Framework is not functioning well. Community structures are not in place, the hospital Board does not exist. Many patients bypass the clinics and come straight to the hospital. The hospital is so overwhelmed by the number of patients it serves, compared to its budget and human resource allocation. This means that wider community service elements are low on their list of priorities. The hospital also treats a number of patients who should by right be transferred to a level 2 hospital, but which cannot accommodate them.

Both managers and clinicians recognise this current state and need for change. Managers are so focussed on the 'facts' of managing what is already on their plate, that they only mention legitimacy issues in passing. There is again evidence that issues of a more holistic approach to health, including community involvement is higher on the clinician's priority than it is for managers. Nevertheless, even clinicians do not see it as a pressing issue.

"The same things are raised at Exco meeting after meeting but no progress is reported" M1.

Clinicians consider the lower level clinical staff at the hospital as a more urgent legitimacy issue. They extend their definition of legitimacy towards this group of staff

members because they are largely ‘victims’ of a system which is not working well. Many of them are over worked and demoralised.
“Allow peoples voices to be heard. The ground staff think they are not heard” CL 5.
Clinicians feel that Exco should take active steps to correct this situation, but Exco are less sympathetic to this and feel that staff should improve their attitudes.

4.4 Conclusion

The findings of the initial mapping of the system using a rich picture, and the responses from the CSH questions were similar, although the latter provided much greater depth in surfacing the real underlying issues.
The responses reveal rich information about the system evidenced by many verbatim quotes. Different perspectives of managers and clinicians on a number of issues are revealed. The responses are given in context of the system as a whole as well as given from the position of respondents as either managers or clinicians. A number of responses were quite emotive and point to deep seated motivations and values attached to these suggested potential points of conflict between the two groups.
The researcher was satisfied that the findings were sufficiently detailed to answer the aims of the research.
The chapter five compares responses of managers and clinicians more directly, discusses the finding to several systems models and links them back to the aim of the research study.

CHAPTER 5: DISCUSSION

5.1 Introduction

The emphasis in this chapter is to interrogate the data to bring to the surface new understanding and perspective to the problems identified in the health system.

The content was analysed, compared with and interrogated against issues identified in Chapter 2, and finally interpreted and inferences made in order to answer the aims in Chapter 3 (Downe-Warmboldt, 1992).

In keeping with the systems thinking approach, the interpretations will be explained with reference to the system as a whole using systems models as well as in comparison between managers and clinicians. Each of their perspective of the system will be explained to clearly contrast their position relative to each other, thereby giving understanding to some of their differences, potential conflict areas, as well as potential solutions for a better working relationship and improved health outcomes.

A number of systems models will be used to aid analysis and understanding of the data as already indicated in chapter 3.

5.2 Contrasting perspectives of the system using Ulrich's eternal triangle

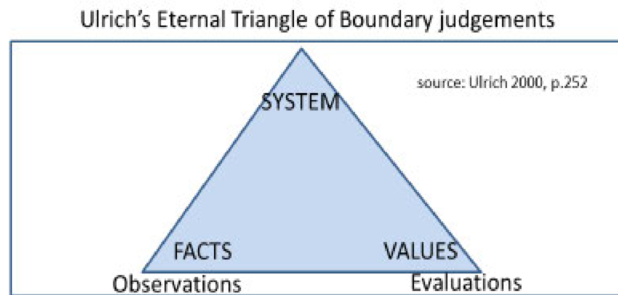
The analysis has brought new understanding from systems thinking, highlighted by managers and clinicians different perspectives of the system and what 'counts', as indicated in aim one and two. In effect, they reveal each group's reference points for concerns and what stand they take regarding the system. The respective positions they take, imply that they have boundary judgements in place to reach them (Ulrich, 2005).

With reference to controls within the system, rules and regulations have displaced the focus on managing the team and motivating people as previously found by a study of Von Holdt & Murphy, (2007). The human factor in this process has largely been removed. The system displays strong characteristics of reductionist behaviour akin to a Hard Systems approach. This approach assumes a static environment, compartmentalises work and limits innovation, and has difficulty in adapting well to changes in the external environment. It results in dehumanising employees and inhibits co-ordination (Morgan, 2006).

Both managers and clinicians recognise this as a mammoth frustration in doing their jobs properly. They are essentially caged in by their principles, yet are expected to deliver. Both are caught in the 'facts' mode, of Ulrich's eternal triangle. They both recognise that there needs to be change, and that this change needs to include greater involvement and decision-making powers at hospital level, as originally foreseen in the Health Policy Framework. However, the reductionist approach enforced by the DHO and PHO inhibits this. The only potential area where the internal decision-making system could improve is through greater transparency and communication from EXCO to clinicians. This would at least alleviate the situation for clinicians.

With reference to sources of knowledge within the system, both managers and clinicians are strongly influenced by values in regard to the influences of expertise and knowledge. They see the need for change in order to improve health outcomes. Manager's values are rooted in the belief that they themselves have these expertise, and can be the central drivers to making a real difference to health outcomes. Clinicians on the other hand question whether the practices they have observed from managers: i) are sufficient justification for managers to make decisions on their own, and ii) are themselves inclined towards a more holistic and collaborative use of the broader expertise and knowledge available in the hospital.

Figure 4: Ulrich's Eternal Triangle of Boundary Judgements with authors table showing the importance which respondents placed on the value drivers for the system.



Influencing Factors	Mainly Facts driven	Both Facts & Values	Mainly Values Driven
Patient Care as Motivator	Exco		Clinicians (focused on system needs)
DHO and PHO as Motivators	Exco (external focus)	Clinicians	
Staff Morale as Motivator		Exco	Clinicians
Sources of Control	Exco (external focus)	Clinicians (Internal & external focus)	
Sources of Knowledge and Expertise			Exco (focused on own needs) Clinicians (focused on own & system needs)
Legitimacy			Both Exco & Clinicians

Source: (Ulrich, 2000).

Note: Figure 4 shows the tendency for managers and clinicians to evaluate the system mainly from either a 'Facts' (pragmatic) or are 'Values' (possibilities) perspective. Exco have mainly a 'Facts' perspective of the system, while clinicians have more of a 'Values' perspective of the system. Note that size of the type face for the words EXCO and Clinicians, shows the degree of importance those factors play in their view of the system. e.g. for Exco DHO and PHO motivators are huge influencers; for clinicians the DHO and PHO are small influencers.

Reynolds (2007) gives three reasons for using CSH for making evaluations:

i) "The framework helps to make sense of the situation. It reveals important assumptions and relationships of the underlying entities being evaluated. These are often potential sources of underlying failures in performance."

While it is true that even the so called ‘facts’ of the system are based on value judgements, these represent mainly the “Is” perspective of the system. The above analysis reveals that Exco’s views of the system are rooted strongly in what the system IS, and not in what it can be. They are taken up with managing the day-to-day demands to stay afloat so to speak.

ii) “Value judgements are made transparent by surfacing and contrasting perspectives. CHS does not evaluate right or wrong. Rather it goes to the fundamentals of the systems goals and whether they serve the wellbeing of all participants in the system. It leads to reflection of and conversations around the influences of decisions.”

The goals of Exco are directed at keeping their external Principles satisfied. Their perspective is outward looking – literally looking over their shoulders all the time. This explains why they do not “see” the urgency for greater engagement with their clinical counterparts, nor with the staff as a whole within the hospital setting.

In addition, Exco are frustrated at fulfilling their mandate as managers. In the context of the Health Policy Framework, decisions need to be taken at hospital level. The authority to truly plan and decide on priorities for the hospital have been wrested from their control by their Principles. Not surprisingly, they see the restoration of their authority as a prior step before engaging more fully with the leadership and managerial aspects of running the hospital.

Clinicians on the other hand, see the need for other systemic issues to be addressed despite the less than ideal conditions. Their view is that greater engagement between managers and clinicians can help to aid decision making and wellbeing of the system, despite prevailing conditions.

iii) “CSH does not only evaluate possible improvements in the system, but also allows for evaluating whether the system is pursuing the right goals from the perspective of others (the affected but involved).”

There are three main “others” groups identified by respondents. Firstly, the broader community and community involvement as defined in the Health Policy Framework. It is clear that while Managers and Clinicians have some differences in their views about these groups, they both give them low priority. The energy of the system is directed at more pressing immediate issues. Secondly, the in- hospital patients as an “other” group. This is the area of greatest divergence between the views of managers and clinicians. Instead of having the freedom to pursue true patient care as the main goal, the reductionist structures and processes in the hospital have become dominant. Managers are trying to manage the system via these processes. Clinicians feel that managers can do something about changing this. The third “other” group is hospital staff. Managers are paying lip service to improving communication and building morale. Again, clinicians feel that managers are neglecting this group, and are instead serving other interest first, but that this can and should change, to improve the overall system. They believe that the human factors in the system should be given greater importance.

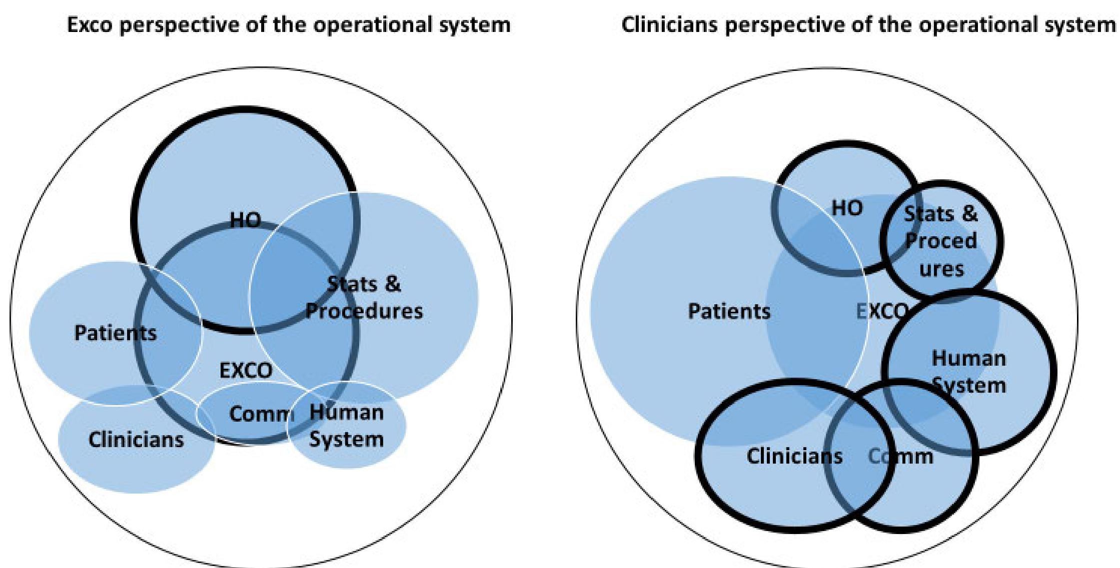
The systems thinking approach using Ulrich’s eternal triangle gives new understanding of what is important to each of the two groups concerned. Their specific views of the system influences their mindsets and working relationships as set out in aim number one and two. While there are hints about deeper motivators and potential sources of conflict, further analysis was needed to bring this to the fore more clearly.

5.3 Factors which might change the boundary judgement of the system

Boundary judgements are determined by a group’s own perceived facts and values of the system. However, the recognition by any one group that their own references and perspectives are limited and selective, and that another group within the same system might have different and equally valid alternative judgements, might lead to a broadening of their own facts and values (Ulrich, 2003). What might initially seem important to one group, may become less important, or their vision of the ideal might be tempered by the ideal vision of the other group. The purpose is not to arrive at a consensus, or to force a solution per se. However, the recognition of these differences

will in the least lead to greater understanding and transparency of why each group behaves as they do. This will provide a platform for engagement and possible improvement of the overall system. The model below seeks to highlight both those factors which are important to each group (size of circle), and those which they would ideally like to change (circle in bold). The diagram is based on the researcher's interpretation of the findings.

Figure 5. The system as interpreted from the perspective of managers and clinicians.



Source: Researchers interpretation of respondent's answers to interview questions.

Each internal circle represents a sub system of the whole hospital operational system. The importance of sub systems to each group of respondents is depicted by the size of the circle. The sub systems with bold outline are the ones which "ought" to change in each groups view.

This systems thinking model (systems within systems) brings to the fore the objectives of aim one to three even more clearly, but sheds further light on aim number three in that it gives a more graphic and stark perspectives of values and motivators, and how these influence decision making by each group.

5.3.1 Managers perspective of the system

For managers there are three over riding sub systems which determine success.

i) Exco themselves. They are central to the overall system and are doing quite a good job since they see their role to ensure all procedures and paper work is done properly. They manage compliance issues very well and are able 'to stay in the good books' of HO.

ii) Head Office. The system will improve when HO gives Exco more decision-making power. This limitation is seriously hampering the output of the hospital and is the single most importance source of frustrations for them. Managers do everything in their power, even to the extent of using personal relationships, to get responses from HO.

iii) Statistics and procedures. For managers these are a key indicator that the hospital is performing well. The hospital is measuring all the important statistics, with special emphasis on patient care and efficient outputs. Rules and procedures control everything and are themselves used as a form of operational management and a form of self-appraisal by Exco. Besides, the District and Province require them, and that should therefore be the focus of managing the system.

In the whole, managers adopted a very functionalist and process driven perspective of the system, with relatively low emphasis on the human aspect of the system.

Other factors also played a role, but they were less important to managers within the decision-making system.

iv) Managers view of clinicians. Exco believe they do involve clinicians at all levels of planning, making sure their views are heard at various planning committees. In their view this means clinicians are involved. However, ultimately the decisions are taken by Exco, and their decisions are good, because all necessary functions are represented on Exco.

v) Managers view of patients. The purpose of the hospital is to deliver quality care to patients, but the systems and particularly HO determine how this is done.

vi) Human systems including staff. Human systems are acknowledged but do not need urgent attention. There are some indications that improvements can be made in communication, but this is not a major issue.

vii) Community. This is not of major concern to Exco. They only have sufficient resources to cater for existing patients.

Managers feel that the overall system can dramatically improve, by reducing the influence of head office and the province, and giving more power to Exco. However, they would not change the importance of current statistics and procedures.

5.3.2 Clinicians perspective of the system

For clinicians, there are two overriding issues to the functioning of the system.

i) Clinicians see Exco as pivotal to the success of the hospital system. They don’t want to take any power away from them, but they do want Exco to approach the rest of the hospital sub systems differently. They recognise that managers are faced with serious limitations from HO, but they expect them to do better than what they are doing now. They expect Exco to better manage the influence of HO, since ultimately that is their role. They feel Exco are too administratively orientated instead of being management orientated. Clinicians want to see signals that managers are in control. Procedures and processes should not exclude good management principles and in fostering good human relationships E.g. feedback and tracking of orders, active management of the HST relationship.

ii) Clinicians see their patients as priority and see all other sub systems as enablers for achieving the best outcomes for their patients.

In addition, clinicians attribute greater importance than their management counterparts to the need for change of some factors within the system

iii) Some statistics need to be questioned, and others need to be re-designed to show more meaningful information to help plan for specific hospital needs rather than reveal averages. Furthermore, there should be greater emphasis on budgeting and planning for specific departmental needs, not for the hospital as whole.

iv) Clinicians should be more valued and be invited to be involved in the planning process. This does not mean that clinicians want to take power away from Exco. However, Exco can benefit from people in the organisation who have specialist knowledge on the ground. Specifically, there should be more transparency in the planning process, and clinicians should become meaningful partners in decision making

v) The human system needs management attention, specifically better communication, more face-to-face interaction and motivation of staff. Exco need to close the 'distance' between themselves and staff.

vi) More attention needs to be given to understanding community needs and building these into the planning processes. There should be an active Board. These elements of the overall system can have a positive effect on health outcomes and relationships with the community.

The comparative boundary judgements of Exco and clinicians reveals what they rely on to make decisions and determine behavior. It reveals that clinicians' vision of the future system is based on a broader number of factors compared to Exco. Exco's vision of change is largely two dimensional, rooted in HO behavior, and their own authority. This difference in perspective provides the basis for good dialogue between these two groups, both in terms of understanding each other's position, and in engaging on ways to improve communication, co-operation and potential altering of the importance of contributing factors to an improved system.

The analysis recognizes that each group has different perspectives and that their views are important to them. It gives understanding on behavioural influences and highlights areas for dialogue regarding how to handle these differences going forward.

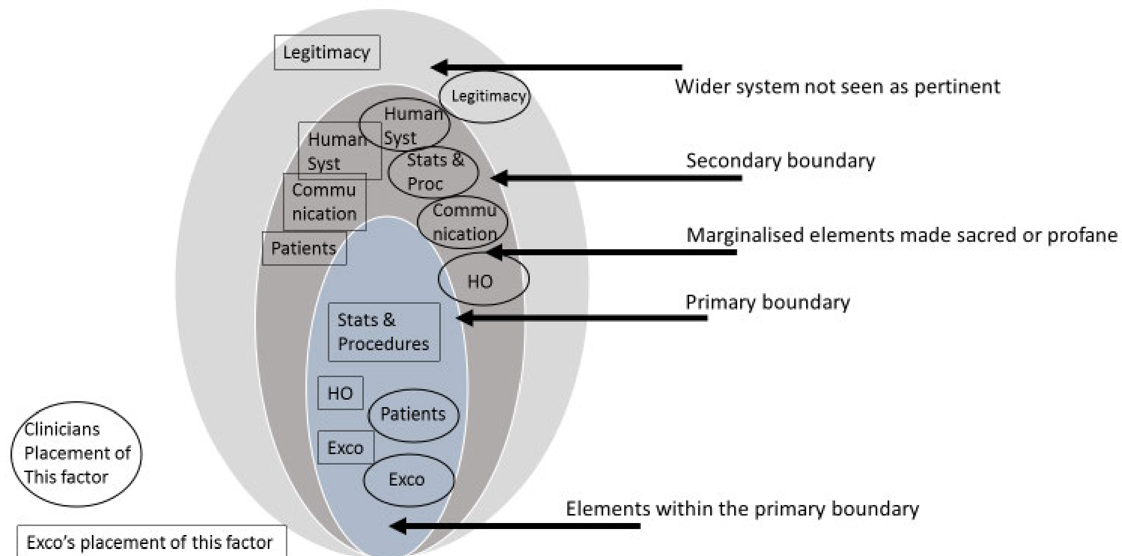
5.4. Factors which might cause conflict in the Exco/clinicians relationships

Boundary technique can help us understand issues regarding participation and relationships, particularly with regards to those unresolved differences which may lead to further problems within the human system. The critical approach in the technique leads to self-reflection and promotes awareness of those boundaries which are important or primary to one group but not to another, and leads to better understanding of what issues may become sources of conflict.

The adapted model below shows which elements of the system are judged to be either within the primary or secondary boundary by either Exco or clinicians. Midgley and Cordoba (2006) suggest that conflicts arise when issues which are of concern to some people, are placed within the marginalized area by the system instead of the primary boundary area. In practice, many issues may be placed in the marginalized boundary area. However, it is the manner in which they are treated within the system which causes potential conflict. Issues in marginal boundaries can either be 'made sacred',

meaning they are accepted and institutionalized as normal practice, even if they are not primary. However, when issues in the marginalized boundaries are also ‘profaned’ by one group, meaning they are devalued within the planning and decision-making system, they can cause conflict.

Figure 6. Primary and secondary boundaries. Adapted from Midgley 1992



Note: Placement of systems influencing factors either within the primary or secondary boundary has been done by the researcher based on subjective judgement. This judgement was based on the degree of importance either Exco or Clinicians gave to these factors in their interviews.

It is immediately evident in figure 6, that Exco have placed patient care in the marginalized boundary while clinicians have placed it in the primary boundary. They also place HO and statistics & procedures within the primary boundary, while clinicians place these in the secondary boundary. As potential sources of conflict, the question is whether they have been made sacred or profaned by any one group? Based on the known purpose and practice of the hospital, we can say that patient care, while not within the primary boundary for Exco, have nevertheless been made sacred. However, the factors that determine patient care differentiate more clearly between Exco and

clinicians. Exco uphold HO and stats/procedures as absolute primary boundary elements. On the other hand, clinicians have placed these in the secondary boundary area. It is true, that these elements have also been institutionalized within the system, but this has happened largely through imposition by Exco and HO. Clinicians are not comfortable with the importance given to these two factors and would much rather raise the importance of the Human Systems element including internal Communication and Staff Morale as a way towards patient care. Although the human systems and communication/staff morale area is placed in the secondary boundary area by both Exco and clinicians, the latter give it much greater importance, as well as desire the elements of these factors to change. This is the sharp edge of potential conflict and needs further investigation and engagement from both groups. We already know that Exco have a pragmatic "IS" perspective of these factors while clinicians are inclined towards giving vision and the "what could be" much greater weight in their perspectives. This analysis using Midgley's model speak pointedly about potential conflict areas as set out in aim number four. It is also clear that the sources of conflict are rooted in a better understanding of underlying values and motivators as mentioned in aim number three.

5.5 CSH results interpreted as a Kolbian Learning Cycle

The CSH technique shares some attributes with Kolb's learning cycle, but does not necessarily complete the learning cycle. There are nevertheless several lessons to be learnt and applied from this model to help clarify the role of CSH in learning. One such key learning is that learning is not a linear process but follows a continuous and iterative process, which CSH also encourages. The four modes of learning from Kolb, shown in figure 7, can be seen reflected in the CSH process and provide a reference point for how far CSH has and can contribute towards learning. The awareness of own boundary judgements, understanding of the positions people take within the system, identifying important factors, and defining primary and secondary boundaries, all assist in providing a platform for engagement, learning and potential improvement.

Figure 7. Kolbian Learning Cycle and modes of learning. Adapted from Luckett and Grossenbacher (2003)

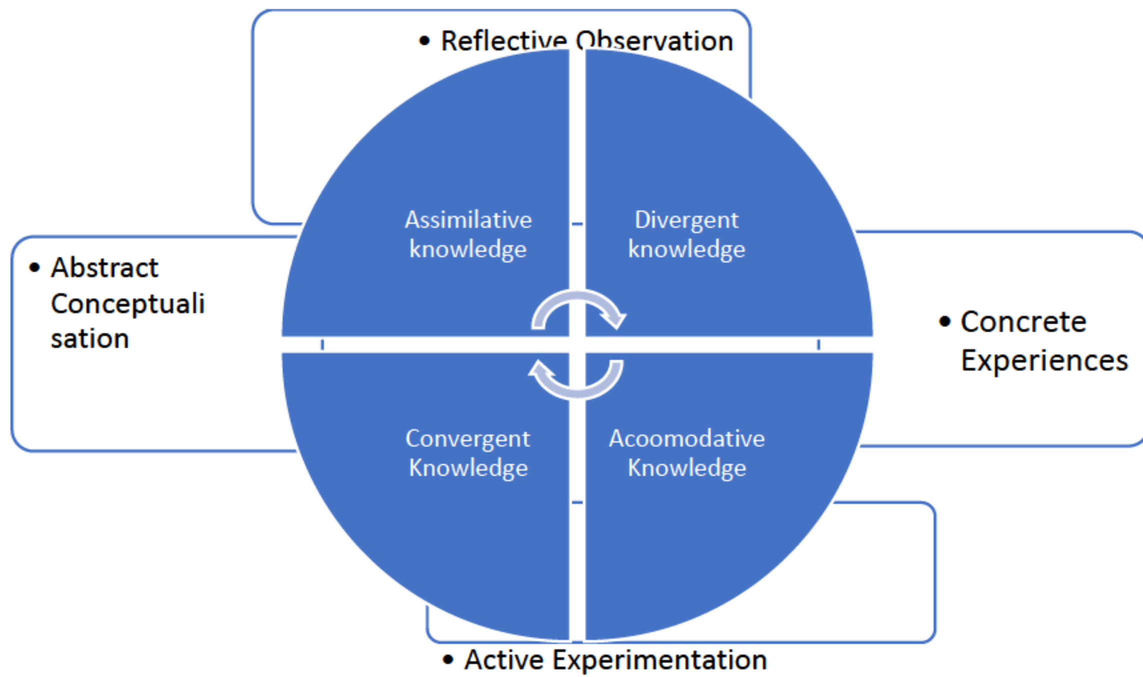


Table 2. Contrasting Phases of Kolb's Learning Cycle with CSH

Modes of learning	Kinds of knowledge	Appropriate activities	The CSH equivalent
Concrete experiences	Divergent knowledge	Observe and record observations	Different practices by different system actors under "IS". Self-awareness
Reflection of and observation of these experiences from different perspectives	Assimilative or theoretical knowledge	Assess and theorise what the observations mean	Reflect on the observations vs policy and vs the views of others
Create concepts that integrate their experiences into logical theories	Convergent knowledge	Decide what is important	Conceptualise abstract possibilities under "OUGHT". Decide what is important for different stakeholders
Use these theories to make decisions and solve problems	Accommodative knowledge	Implement decisions	With the benefit of a broader perspective of stakeholders, look for potential improvements to the system

The question to be asked of the hospital decision making system is whether people are really involved in the learning process or whether they are so overwhelmed by keeping up with daily pressing demands that no time is given to the bigger issue regarding systems learning. Secondly, is sufficient time allocated to engaging on these issues and joint problem-solving activities? This is a question to be asked for the 'in hospital' system as well as the broader DHS and how they approach problem solving. Potential conflict areas identified from marginalised and 'profaned' elements in the system could be addressed through a willingness of all to adopt a learning process through shared interpretations and iterative sense making.

The analysis of Kolb's learning throws light on the health of the system as mentioned in aim number one and links back to some of the latest leadership thinking from several reviews in Chapter 2.

5.5 A unifying theory on systems thinking

Cabrera, Cabrera & Powers, (2015) have provided a simple and yet powerful framework for understanding the value and application of systems analysis using the DSRP acronym.

D: Distinctions. Understanding of something depends on how we draw the boundaries of that thing. i.e. the things we include and exclude. The preceding analysis reveals the bias of managers and clinicians in terms of what is included and excluded in decision making. For each group certain factors drive decisions while others do not. The mere understanding of the others bias can form the platform for constructive engagement.

S: System. A system is a combination of both its parts as well as the whole. Managers and clinicians share the same understanding of the system as a whole, yet place different importance on different parts of that system.

R: Relationship. This reveals the effect which parts of the system have on each other, and how this introduces a dynamic of thoughts, feelings and motives. Both groups behavior is influenced by different relationships they have established between parts within the system, and this may lead to enhancement or conflict between these two groups.

P: Perspectives. The same system can be viewed from different perspectives. Managers and clinicians see the system differently and reflect a different focus depending on the perspective taken. They have different perspectives of what is important now and what their vision is of a future improved system.

This DSRP approach speaks to all four aim of this research and further confirms what has been learned from the other models.

5.6 Conclusion

The discussion has drawn from a number of well documented systems approaches and models to demonstrate how this research has answered both the research problem as well as its specific aims.

The findings were subjected to several systems thinking models. These consistently and progressively confirmed the application, interrogation and results of the data.

The chosen research paradigm of action research rooted in an in-depth qualitative approach and interpretative methodology, the systems thinking approach, and the specific CSH method, proved to be the right approach to take for this research study.

It has provided rich data and understanding to highly complex emotive issues which have a dramatic effect on how inter personal relationships affect overall health outcomes. The next chapter will explore how this provides new understanding and what recommendations might flow from these.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter will seek to link the findings with the research problem and aims. It will show how the research contributes to new knowledge and how the conclusions led to specific recommendations as per the "action research' paradigm. Recommendations will be made about taking the understanding from this research further.

6.2 Conclusion

The CSH approach succeeded in providing understanding of the whole by understanding its parts. (Jackson, 2011; Ulrich, 2001). It has gone beyond mere understanding of leadership and management decision making issues and revealed the broader systemic elements which form the basis of their decision making behavior. By seeing this bigger picture, we saw clearly the interrelationship of processes, human factors and decisions. One can conclude that the system approach has served to reveal new understanding of underlying motivators and values at the root of each group's attitude and decision making. Their different systems perspectives showed that neither had a complete picture of the system, and that therefore much is to be gained by more communication, consultation and joint decision making. While such a recommendation is not new in itself, the basis of the discussion is, because each group have a better understanding of how the other view the system and their own influence. This basis for improvement constitutes the significance of the study. It is relational in participants context and reveals the perspective of 'the other' within the big picture of the whole system, not individual issues. This provides the basis for a new approach.
A separate and unexpected conclusion came from the debilitating effect which the DOH and the HST (procurement department) had by imposing unwanted and unhelpful decisions on the hospital. This warrants separate and further research.

6.3 Implications of the research

The deeper underlying influences and motivators of the two groups of people have come to the fore and shown where potential conflicts might arise. Specifically, it revealed the strong leaning of managers towards placing importance on pragmatic process and control elements of the system, which were largely imposed on them by

the DOH. Clinicians on the other hand lent more strongly on ‘what can be’, especially in relation to the human elements of the system, including communication and motivating people. It is suggested that the two groups engage on issues of ‘sacred’ and ‘profaned’ primary and secondary boundary issues to ensure these issues do not further inhibit their joint leadership of the system.

Neither managers nor clinicians felt that their expertise and knowledge was fully utilized in the system. This potentially had serious consequences on performance, motivation and commitment, since in effect both groups do possess considerable expertise and knowledge. It forms a strong platform for further engagement and discussion, and specific elements for finding possible improvements and how the two groups can embark on a learning journey together towards greater co-operation and joint decision making.

It is also suggested that the DOH is engaged on issues of control and decision making and explore ways in which the known expertise of both these two hospital leadership groups can be better utilised to make good resource, equipment and planning decisions for the hospital, instead of unilateral imposition of these from a distance by the DOH.

6.4 Limitations of the study

This was a limited study with interviews of only 10 people at one single hospital. Larger sample would increase the veracity of the data and provide greater granularity of understanding.

If additional people had been interviewed from other functions, more sub systems and their importance would be revealed. e.g. Measurement & information manager; the public relations manager.

Interpretations were based on the researchers own views and judgement. While seeking to be fair and balanced, nevertheless as originator of the research, interviewer and interpreter of the data, some bias by the researcher has to be recognized. Greater experience of the CSH methodology would have assisted the researcher in unfolding more meaningful in-depth results.

The conclusions need to be verified through further research in other hospitals and by other researchers.

At times respondents were pressed for time or showed sign of fatigue from a long interview process. In some cases they combined their responses on some questions

which seemed too similar to them (e.g. questions 10a – 12b). In some cases, there was reluctance to say everything they may have wanted to say. Some reticence was detected on the part of the respondents due to the interviews being recorded.
The small sample size made it difficult to add more quotes without risking the identity of the respondents.
The full CSH approach suggests several interviewee interventions in order to fully reflect several levels of unfolding of boundary judgements. This study only covered the initial step of unfolding revealed by self-reflection of the "IS" and "OUGHT" questions by clinicians and managers.
It does not cover additional reflection in view of the self-reflection of the other group, which would more fully reveal each other's different perspectives of the system, and how they might adjust their boundaries or suggest improvements as a result of that new understanding.
In retrospect, the choice of a hospital where the CEO is a medical doctor, may have limited the differences in perspectives between managers and clinicians. A hospital study where the CEO is not a medical doctor may show differences between Exco and clinicians more starkly.

6.5 Recommendations to solve the research problem

The aim of this study was to understand the mindsets of managers and clinicians towards each other from a systems thinking perspective, and how deep motivators and values could enhance or inhibit their working relationship for potential improvements in the system.
The study succeeded in revealing a new perspective on these leadership issues, and provide the basis for fresh engagement with deeper understanding of the underlying decision making factors. A number of recommendations flow from this.

i) By adopting a systems thinking approach the underlying motivators for behavior have been revealed and both groups need to be willing to engage with each other at this level rather than on isolated and incidence driven decisions. There needs to be a willingness to engage on the dominant influences of structures, processes and statistics from a systems thinking perspective and how these might inhibit innovative participative decision making which also might impact on relationships, not just from a management solutions perspective.

ii) Recognise that each groups value positions is valid in context, and should be used synergistically rather than divide the two groups. There is a need for better understanding of how joint ownership and decision making, as well as mutual recognition of skills and expertise can contribute to improving motivation and efficiency. Critical to the renewal of hospitals will be for the organization to build on what they know about themselves, not the focus on detailed processes and procedures. (Ng, 2004 citing Lloyd & Maquire). This comes down to better leveraging the combined knowledge of both management and clinicians. However, this is not simply a recommendation about better management practice or sharing of information. Rather it is a recommendation to recognize the underlying values and motivators of each group brings to the system and that these are valuable in creating a much better overall system.

iii) Adopting a learning culture can be step towards creating a healthy organization. Hospitals contain a wealth of both explicit, intellectual as well as tacit knowledge. If this knowledge is shared and disseminated throughout the organization it has the potential for enhancing capabilities. Some managers think that knowledge has been communicated when information has been sent by email. However, tacit knowledge specifically is communicated through face-to-face contact and through the socialization process (Choi, Poon & Davies, 2008). The challenge is to create a framework to recognize the value of this knowledge, and incorporate into the processes of everyday operations, thereby resulting in better decision making and a transformed organization (Velasco, Eiros, Mayo & Roman, 2011). Knowledge transfer and learning is influenced by the relationships between employees, it is not an abstract non-emotional activity. There is a need to integrate knowledge in the organization by creating a culture of trust and participation and transparency in the context of providing participants with opportunities to grow and learn. Healthy organisations grow and learn together. (Schuyler et al., 2016, Luckett & Grossenbacher, 2003) This is much more likely to happen when someone sees themselves as part of a knowledge and learning community. That 'community ownership' is encouraged when people see themselves as part of the decision-making

process. The ‘reward’ of being involved in decision making becomes the motivator to share information and knowledge (Lucas, 2006).

iv) By recognising and debating sub systems within the bigger system which at times pull in different directions the organisations thinking can be challenged. These can lead to flexible creative alternative ways of working superseding the reductionist and heavily controlled and rules based procedural approach. There is a great need for management to create inter team dialogue, encouraged new thinking through collaboration, better comprehension and respect of each other, and the willingness to accept a questioning attitude by all concerned. Diversity of opinions should not be seen as negative, but rather an opportunity to bring a holistic picture to the situation and facilitate overall learning. Where potential conflict points exist, they should be called out and be addresses rather than be ignored. There should be recognition of different views on what is central and marginal to the system and what should be ‘sacred’ and what is ‘profaned’ Silent acceptance, or worse, acquiesce, will not help the organization to move forward in building knowledge and improve decision making, and achieve better outcomes. There needs to be greater understanding of each other’s perspective and a sense of shared purpose. Recognition of informal leadership roles as well as their formal roles. There needs to be recognition of the human sub system (staff motivation, communication, transparency) as a contributor to overall performance.

v) Engagement is needed on the external DOH and HTS (procurement) heavy handed influence on hospital leadership. There needs to be agreement on clarifying which administrative requirements are primary and secondary, and how overlaps and duplications can be reduced. Management style plays an important role in influencing people and creating the right environment for teams to achieve their goals. There is an opportunity to explore how Exco and clinicians can each be given greater joint decision-making powers without constant interference from the DOH. Clinicians may be seen to be mostly poorly prepared for management roles. The incorporation of clinicians in management roles will not solve all problems. However, there is a lot of evidence to suggest that nurturing a more productive co-decision making role between management and clinicians will

yield positive results. Mutual recognition of informal and formal leadership roles will go a long way to building trust. For managers to be effective leaders of change, they need to bring clinicians into the management process. Doherty (2013) refers to this as distributed leadership.

vi) The Health Policy Framework needs to be reviewed and possibly adjusted in the context of other overwhelming immediate needs.

6. 6 Recommendations for future studies

What are potential ways of moving forward? Some thoughts are provided for further engagement and dialogue.

Leaders must create the conditions under which open and honest dialogue can take place regarding the issues raised in this research. This study was limited in its scope and depth resulting in qualitative value judgements of respondents' responses, by the researcher. Further probing, understanding and interpretation is required to confirm which of the issues raised are truly important to the two groups and in a broader group of hospitals.

The relationship between DOH and hospitals needs to be investigated further, and particularly the conditions which have led to the apparent authoritarian and reductionist approach to decision making. There is an opportunity to leverage the under-utilized skills and knowledge of leaders within hospitals to make better decisions regarding their specific needs. The CSH methodology could be extended to the value judgements between Exco and Head Office (or District), or Exco and HTS to further unveil boundary judgements within these groups.

While CSH does not depend on reaching consensus, this nevertheless remains an ideal. It is well worth defining what that ideal might be. Improvements could be 'tested' via a Soft Systems approach to identify whether there might be consensus on those sub systems which could affect overall health outcomes. The root definition approach (of the issue) in the Soft Systems Methodology is very useful in this context. It seeks to encompass all the stakeholders and issues to test whether the ideal does in fact incorporates some form of transformation. The CATWOE mnemonic ensures the root definition encompasses all required elements.

C (Customers) – patients requiring health care.

A (Actors) – principally Exco and Clinicians but also DHO and PHO, as well as other hospital staff.

T (Transformation) – improved effectiveness of health care
W (Worldview) – The fact that Actors can and are willing to bring about meaningful change through engagement and mutual ownership of issues.
O (Owners) – Health System Managers at Hospital, District and Provincial level.
E (Environmental Constraints) - Entrenched management practices; Issues of power and control; political influences.
The following root definition is therefore suggested as the 'ideal' desired transformation.

"**To get Exco and Clinicians to improve the effectiveness of patient care at Wentworth Hospital, by adopting joint ownership of planning, decision making, communication and staff morale, creating coordinated and co-operative practices within the operations of the hospital"**

The definition implies agreement from their Principles to adopt this approach, but the two key actors, Exco and Clinicians, should nevertheless start with what can be done immediately. The definition can be tested for validity by testing whether it contains transformation elements of:
P (What) – Adopt joint ownership
Q (How) – Co-ordinated and co-operative practice
R (Why) – To improve quality care
(Jackson, 2011).

6.7 Summary

The study has confirmed some of the issues and challenges between managers and clinicians raised in the literature review. In addition, it has provided more granular surfacing of the respective underlying value judgements of managers and clinicians which influence behavior and attitude. The systems thinking approach gave deeper appreciation of causality, specifically the perspectives each group takes on primary and marginalised issues, and how these impact on relationships. The biggest contribution of the study was a fresh understanding of how each group thought about the system, and how this could form the basis of discussing improvements.

This systems analysis revealed the mental models each group drew of the system. The distinction and relationship of various parts of the system provided a platform for dialogue and potential challenges of how the system should function. There is greater clarity on how Exco and clinicians viewed the system and what their vision was for

potential improvement. It has highlighted the larger value motivators behind shortcomings of processes and procedures, which lead to unintended consequences in messy situations, and therefore the importance of the human system as potential sources of conflict as well as opportunity for improvements through dialogue and mutual understanding.

It has also revealed that some of the shortcomings of managers have arisen due the imposition a typical hierarchical hard systems approach to decision making. There is an opportunity for the District and Provincial offices to play a more enabling role through allowing better utilization of expertise and knowledge at local hospital level, and allowing greater decision making within hospitals as intended in the Health Policy Framework.

Finally, the involvement of community structures in decision making is not working. This is because the immediacy of patient health problems was under estimated and demands priority. The study has also 'surfaced' another affected 'other' group who are hospital staff. This affected group can play a major role in improvement of the system if Exco accept and demonstrate their perceived value of this group to the system through greater engagement and interaction with them.

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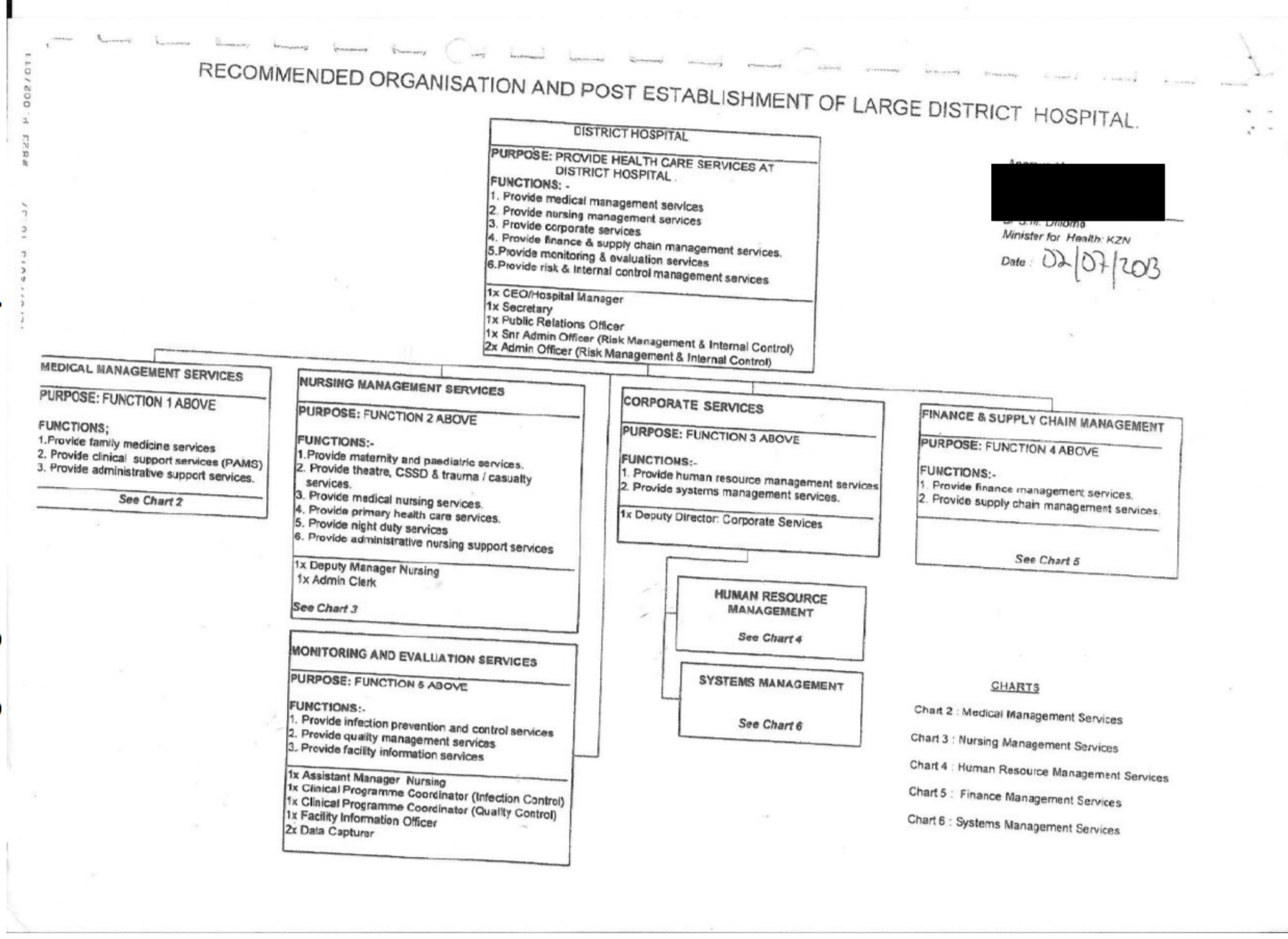
APPENDIX 1 Organogram for Wentworth Hospital



APPENDIX 2 Questions for Masters Dissertation for Mr RA Reimers

Project Title: To explore the Management and Leadership system amongst i) Clinicians and ii) Managers in a public health hospital, and how these are influenced by respective values and boundary judgements.

Questions for initial Mapping of issues:

The questions listed below are designed to map an initial view of the issues between Managers and Clinicians. Furthermore, this will act as a stimulus for more meaningful engagement in applying Ulrich's 12 questions in context. The same questions will be asked of both Managers and Clinicians

1. Initial introduction, explanation of the study, and obtaining the respondent's agreement to participate.
2. What are key issues in the Hospital Health system in providing quality care and reducing mortality rates?
3. What is your main role in delivering these results?
4. What is your main concern in fulfilling your role?
5. What is the role of Manages/ Clinicians?
6. Describe relationship with management/Clinicians and in which way they help or inhibit you fulfilling your role.

Ulrich's Original 12 Boundary questions of critical systems heuristics which reveal Boundary issues. (Ulrich 2001).

In the following questions I want to explore the planning and decision making system of this hospital, and in particular the involvement of Clinical staff – those directly involved in managing patient wellbeing, and Management – those involved in the overall management of the hospital.

I want you to answer these questions for yourself. There may be an official viewpoint, but I want you to answer this as far as you see it for yourself.

Sources of Motivation: I want to ask some questions regarding the motivation behind the hospital system – why it exists and for whom.

2a) What ought to be the purpose of the hospital – what ought to be the stakes involved or what should be the consequences?

2b) What is the purpose of the hospital? That is, are the stakes involved and what are the consequences?

1a) Who ought to be the client or stakeholder and whose interest should be served?

1b) Who is the client or stakeholder – that is whose interests are being served?

3a) What ought to be the measure of improvement – that is how should we determine whether and in what way the consequences taken together, constitute an improvement?
3b) What is the measure of improvement? That is, how do we determine whether and in what way the consequences, taken together, constitute an improvement?
When you now reflect on these motivational “ought” and “is” questions – are there any gaps between what ought to be and what is? What are the key problems? What is the consequence of this gap?
Do the way clinicians and managers work in the hospital inhibit or advance this purpose?
Sources of Control: I want to ask some questions regarding the power to control decisions in the hospital system.
5a) What resource ought to be controlled or be accounted for by the decision maker – that is, what stakes or conditions of success should those involved control and what should be outside their control?
5b) What resources are controlled or accounted for by the decision maker? That is, what stakes or conditions of success can those involved control or what conditions are outside their control?
4a) Who ought to be the decision maker (or holds the power) – that is who should be in a position to change the measure of improvement?
4b) Who is the decision maker (or holds the power)? That is, who is in a position to change the measure of improvement?
6a) From the point of view of those not involved (but affected) what conditions should be part of the environment to ensure accountability– that is what conditions should the decision maker control or not control?
6b) From the point of view of those not involved (but affected) what conditions are part of the environment to ensure accountability? That is, what conditions does the decision maker control or not control?
When you now reflect on these power to control related “ought” and “is” questions – are there any gaps between what ought to be and what is? What is the consequence of this gap?
What power or control is considered an issue or a problem?
Sources of Knowledge: I want to ask some questions regarding knowledge and expertise required for planning purposes in the hospital system – these are operational, administrative and management plans and decisions.

8a) What expertise should be consulted – that is what should count as relevant knowledge?
8b) What expertise is consulted? That is, what counts as relevant knowledge?
7a) Who ought to be involved as a professional – that is, who or stakeholder) should be involved as an expert. e.g. to inform planning, decision making or systems designing?
7b) Who is involved as a professional? That is, who is involved as an expert or stakeholder, e.g. to inform planning, decision making or systems designing?
9a) What or who ought to be assumed to be the guarantor – that is what should be considered a source of guarantee that the right expertise is being consulted? (e.g. consensus amongst experts, stakeholder involvement, support of decision makers, external authority, policy, etc.)?
9b) What or who is assumed to be the guarantor? That is, what is considered a source of guarantee that the right expertise is being consulted? (e.g. consensus amongst experts, stakeholder involvement, support of decision-makers, external authority, policy, etc.)
When you now reflect on these knowledge and expertise related "ought" and "is" questions – are there any gaps between what ought to be and what is? What is the consequence of this gap? Does this lead to any problems or issues?
Sources of Legitimization: There are some people who are involved in the hospital decision making system, and then there are those who are affected but not involved. They are affected by the premise as well as the promise of those involved and in effect bear the consequence of the current system, whether just or unjust. I want to ask some questions about these affected people.
11a) What ought to secure legitimacy of the hospital system (emancipation) for those affected from the premises of the hospital and promises of those involved – that is, where should legitimacy lie?
11b) What (currently) secures the legitimacy of the hospital system (emancipation) for those affected from the premises and promises of those involved? That is, where does legitimacy lie?
10a) Who ought to be witness to the interests of those affected but not involved – that is who ought to be treated as legitimate stakeholder, and who argues the case of those stakeholders who cannot speak for themselves, including the handicapped, the unborn, and non-human nature?

10b) Who is witness to the interests of those affected but not involved? That is, who is treated as legitimate stakeholder, and who argues the case of those stakeholders who cannot speak for themselves, including the handicapped, the unborn, and non-human nature?
12b) What world view ought to be determining – that is, what different visions of improvement should be considered and somehow be reconciled?
12a) What world view is determining? That is, what different visions of improvement are considered and somehow reconciled?
When you now reflect on the legitimacy of the hospital decision making system for those affected mot not involved, in view of the "ought" and "is" questions – are there any gaps between what ought to be and what is? What is the consequence of this gap?
Imagine you could do away with the current system, and re-design the hospital decision making system from scratch, what would change?

APPENDIX 3. Summary of responses to "IS" and "OUGHT" questions

3.1 Summary of Clinicians responses to "IS" and "OUGHT" questions

3.1.1 What is the Purpose of the hospital?

"IS" There is general agreement on the current purpose of the hospital in providing quality health care within their defined community. Management set the Vision and Mission and everyone falls in line with that.

"OUGHT" The purpose should extend to beyond what happens in the hospital itself. There should be greater community involvement, e.g. in revitalising community gardens for HIV patients. While the hospital is doing well in curative work, they need to improve in prevention and general health promotion. The hospital could have a positive ripple effect on the socio-economic conditions of the community if more preventative health benefits were achieved, as well as save money for the hospital itself in the long run. "We could do more in prevention because it is cost effective" CL4. "We have lots of diabetics so we should do more preventative work in this area" CL5.

3.1.2 Who is the Client or Stakeholder?

"IS" The focus is the patient, and includes approximately 10% of patients who come from outside their defined community, because Wentworth is seen to be providing better services than other hospitals in the area. The community is relatively poor with many socio-economic problems, drug abuse and dysfunctional families. Their catchment area includes many factories, which means they serve a transient community. People come for treatment who don't live in the community, but work in the area.

While Wentworth is classified as a level 3 district hospital, it provides services well above its designation and facilities, e.g. an acute ward, frail care, etc., for which their staff are not trained, because the next level hospital cannot immediately take patients who should be transferred to them. This results in many patients staying in the hospital for longer than they should. "Sometimes patients stay a week before we can transfer them" CL5.

Because Wentworth also serve the community as a whole, they are expected to take care of people who the community cannot take care of. These may be people with social problems but who are not really physically sick.

Clinicians also serve EXCO as a client as well as the District Health Office (DHO) and Provincial Health Departments (PHD), who they try to keep happy.
"OUGHT" Clients should also include the relatives of our patients. Most complaints come from relatives. They become angry when they expect one thing but get something else. Nurses and doctors should interact with and speak to the relatives and explain things to them. There should be greater community engagement and feedback as part of the planning process.
The DHO is both client and partner and defines the catchment area for Wentworth and allocated budgets accordingly. Budget allocation should provide for additional patients and for additional services the hospital currently provides. The under allocation of budgets results in compromised patient care, which should not be the case.
The PHD is also both a client and a partner. However, they should play their latter role more effectively, especially in providing better understanding of the procurement processes and practical flexibility in this process, especially when it comes to essential equipment for patient care.

3.1.3 Staff Morale & Communication incl Measures of Success
"IS" Individual departments and several committees' record and review general health statistics on morbidity, mortality, length of stay etc. These self-assessments lead to quality improvement project plans. For example, length of stay has been reduced from an average of 10 days to 5 days, despite some patients staying for long periods due to the social role of the hospital.
In addition, the DOH and DPH do regular assessment according to National Core Standards (NCS)
"OUGHT" Several measures were identified which would improve health delivery and planning:

- Patients. Statistics should measure the type of patients we treat. This will reveal the level of complexity and diversity of treatment provided, and provide an improved tool for resource and equipment planning. It would also help to streamline the referral process to other hospitals, since everyone would be prepared for cases which are not treated at Wentworth.
- Equipment. Some equipment is hardly used, whilst the hospital is desperately short of other equipment, necessitating the sharing of equipment between departments and wards. Often this results in wasted time and delays in patient

treatment. A solution would be to measure equipment utilisation, to ensure better planning for the type of equipment needed.

- Trends in community health should be measured. There are lots of internal measures of what and who the hospital is treating. However, the hospital needs to better understand what is happening beyond the hospital: the real needs and perspectives of the community before they come to the hospital. Preventative statistics would help both in planning and long term cost reduction.
- Internal communication. Senior people (Both EXCO and Clinicians) generally know what is happening in the hospital. However, many staff, both doctors and nurses are not well informed. The hospital needs to improve its overall internal communication processes to all levels. Part of this includes the level of co-ordination between departments. Patients are told they will get an ultra sound, but don't realise that the ward to which they are sent don't even have an ultra sound machine. "Doctors should know this but due to work pressure, only about 50% of them attend the Friday (communication) meeting" CL2.
- Teamwork. This forms part of their performance agreements but there is no clear measure for this. "The majority would fail because we don't work as a team with our doctors and nurses. The hand over book is sometimes used and sometimes not, depending on whether the person handing over likes or does not like the person to whom they are handing over" CL2.
- People lower down have lots of problems with the administration (representatives of EXCO), who often give people a hard time instead of being helpful in solving problems. Eventually things are resolved through personal intervention of a more senior person "HR don't want to help. They are unco-operative" CL 2.

3.1.4 Control of Resources

"IS" Most of the control is vested in the procedures and rules, even when things don't make sense. Decisions are sometimes taken which cost money, but the system is not flexible. DOH and PDH design the system and don't make decisions outside the procedural parameters.

Within the hospital, Finance control everything, and they work strictly by the rule book, even though it is claimed they don't really understand clinical procedures, the

equipment involved nor the urgency of the need and why it is important. “Everything is based on finance. They only look at costs” CL 2.

Clinicians have control over the equipment and resources given to them, but they don’t control the allocations nor the time frame for delivery. “You ask for 10 items, you get 2” CL 2. Consequently, they feel that they cannot give the holistic care they wish to give to patients. In many instances they are asked to do more than they can do with the resources allocated to them. “It’s impossible for me to deliver if an ECG machine takes 2 years to be delivered and I don’t have control over that” CL5. Nevertheless there is also understanding that clinicians are not really trained in this area.

“OUGHT” Clinical managers feel they have a better idea of how money should be allocated for equipment. Ideally they would want some degree of budget of their own or at least be more involved in procurement decisions and priorities.

3.1.5 Decision maker over measures of improvement and accountability

“IS” Several committees are in operation, which work according to guidelines from DHO or PHD. The Cash Flow Meeting (CFM) features prominently in the ordering and allocation of equipment. While clinical managers are represented on this committee, they see their role as recommender not the decision maker. “I don’t make the decision to buy, I only request” CL1. Equipment is ordered for the institution as whole rather than by department, and the allocation decision is made by management. “They tell me we can afford it next month, or the month after that, or maybe next year” CL 1.

There is also a perception that management are willing to help but are hamstrung by the system. The procurement system is very arduous and is controlled ultimately by Health Technology Services (HTS), a central government procurement office. This department is seen as distant and uncooperative towards individual hospital needs. They seem to frequently buy equipment en masse and arbitrary allocate equipment not in line with the real needs of the hospital. Examples are given of receiving equipment which gathers dust in the cupboard, while urgent equipment needs are delayed for months or even years.

Managers are expected to manage this difficult process and fight on behalf of clinicians. However, the lack of transparency and feedback (communication issues mentioned in the initial mapping) from management raises suspicion whether they are doing the best they can. In the end managers are responsible for enabling clinical work, but there are inordinate delays in delivery of (even) urgent equipment. “Even if you don’t order

something for a while, then you order something you are told there is no money. So where did the money go if I have not ordered anything for a while"? CL2

Clinicians are not always present at the CFMtg, but due to work pressure and being under staffed, it is not always possible. They are then represented by the Medical Manager.

"OUGHT" In order to improve the system, clinicians should be given greater say in budgetary meetings, prioritisation, and allocations. "If we leave it to non-clinicians alone to take care of procurement, recruitment, and everything, it's difficult for them to actually understand where we are coming from" CL 5. Clinicians want their voice to be taken more seriously at the procurement committees, and have equal input compared to management. "Sometimes you sit in the meeting and you feel you are just there to make up the quorum" CL3.

There is nevertheless a recognition that in some respects clinicians are not well equipped for this role, and that some management training will help them.

It was felt that two elements could help the environment of accountability:

i) Greater transparency throughout the procurement process. This includes allocations and expenditure of money by department, as well as follow up and feedback on the status of items on order.

ii) The involvement of the end user in allocation of equipment. This applies to HTC who do the final purchase of the equipment, and should do so with greater understanding and feel for the need of individual hospitals. It also applies to EXCO or their representatives, who are at times remote from the coal face of direct patient care. "You can't hold me accountable if I don't get the equipment I require. Recently we had to make EXCO aware that they can't give us equipment they feel we need" CL5.

3.1.6 Relevant knowledge which is consulted

"IS" Ultimately the power of decision making lies elsewhere. Lots of statistics are gathered, presented to EXCO and ultimately to The Province. Planning is done nationally, and the allocations the hospital and departments get from them do not match the situation on the ground. There is a mismatch, particularly in terms of equipment, between what the clinical departments say they need, and what they are actually given. "We are given equipment which we use once in a while, but we are

short of equipment we need every day” CL 3. The consequence is comprised patient care and staff who are worn out trying to manage with inadequate equipment.
“OUGHT” Within the hospital itself, plans are developed within functional silos. E.g. the nursing silo, the clinical silo. Greater corroboration and co-ordination between functions is needed to present a holistic plan by department which includes all resource requirements within that department. The plan should also take into account the needs of lower management and staff, not only top management.

3.1.7 Professional Involvement and guarantee of the right expertise being used
“IS” In many ways Wentworth was thought to be much better than most hospitals in involving clinicians. Ultimately EXCO and the CEO specifically are responsible for ensuring that the right expertise is being used for planning purposes While the institution does indeed involve senior clinicians in strategic planning, most of the planning is done from the perspective of EXCO and the budget, not what is actually needed. The budget determines what is planned for, not the need on the ground. “We don’t get informed about our limits. “We don’t know what our limits are” CL 2. Hence the involvement of clinicians in planning is done with only half the available information.
“OUGHT” Some EXCO members (and their representatives) who are involved in planning and decision making need to close the gap in their knowledge and understanding of clinical issues. It seems that ‘walk-abouts’ by Exco are only conducted as formal engagements. There should be more informal engagements and interaction between Exco members (and their representatives) and clinical staff on the ground. This is something the CEO specifically and EXCO members need to change in the system. Management by committee is not sufficient on its own.

3.1.8 Sources of legitimacy, including representation of those affected but not involved
Note: There were no interviews of those affected. These are only the views of the limited number of Clinicians interviewed.
“IS” Legitimacy and representation is identified as three groups:

i) There is some direct community representation through individuals, community leaders, NGO’s political counsellors, religious leaders and social workers. They have access to the hospital through the PRO and ultimately to the CEO. Complaints by any of these are dealt with through a Complaints Committee and presented to the EXCO office. It appears that the community

has greater expectations from the hospital than what can be delivered. Although communication does take place via various media like radio and community newspapers, it appears that there is some disconnect between community expectations and true understanding of community needs.

ii) Staff, particularly lower end staff workers. While they work at the hospital, they are largely affected by decisions made by others. Many are burnt out, and morale is low. Absenteeism is quite high. Many come to work late, with no clear monitoring or consequences.

iii) In principle the hospital board represents the community. However, it seems this is not functional, or at best, passive.

"OUGHT" Community representation needs to take place through an active board. The hospital needs to engage more pro-actively with the community so they understand what is possible and what is not. There should be regular feedback to the community. Exco and management need to adopt a more open, transparent and engaging style – less distant. People at all levels should feel they have access and are heard by Exco. There needs to better engagement and communication with ordinary workers, not just top management. "Allow peoples voices to be heard. The ground staff think they are not heard" CL 5.

At times it feels that the clinicians group are the affected but not involved. This is of course not completely true. However, when it comes to relationship with HST, the District Office and the province, there is a big gap in positive engagement and understanding of needs.

3.2 Critical Self-evaluation amongst clinicians. Analysis of heir reflections of the "Ought" system vs the "Is" system

This analysis was done using the four themes suggested by Ulrich (Ulrich 2001; 2003; 2005)

3.2.1 Sources of motivation

While clinicians are mainly concerned with the immediate needs of their patients, they are also very aware of the initial causes of their patient's illnesses. They reflect on the wider community needs and trends in their lifestyle, and how earlier intervention in prevention and health promotion might assist in improving the overall health profile of the community, and simultaneously reduce the work load of treating ill patients. As part of that process they would like to introduce community measurements which will

detect early trends in health. They therefore recognise that the ‘community system’ outside the hospital, has a direct effect on the narrower ‘in hospital’ system

Head Office is seen as an important stakeholder in the overall health system, but one who is undermining rather than enhancing outcomes. Since poor availability and allocation of the right equipment is a frequent occurrence, they question whether current statistical measures within the hospital are the correct ones. Unlike their Exco counterparts they want to go to the root of the issue from within the hospital, not only fix the broken external HO system. They want to introduce new measures which have a chance of exposing some of the complex causes behind the surface statistics currently being measured. These include information on the type of patients being treated as a foundation for future planning and budget allocations. This reveals a broader systemic perspective of the health outcomes, and would greatly assist more accurate planning if these measures were introduced.

They face daily challenges in working under pressure with other people, and recognise that the human elements of better teamwork and communication would improve motivation and relational issues as a precursor to improved efficiency, while Exco do this in name only. At times Exco do not want to devote the necessary time to solve or help with staff issues and clinicians have to make extra efforts to resolve these. This human system is seen to directly affect the health outcomes system. It seems they have a better perspective of the soft human decision making systems in the hospital than their Management counterparts.

3.2.2 Sources of control

Clinicians work under difficult circumstances which require constant adaptability, yet they work within a system which is inflexible, further adding to the frustrations of their work. All planning and procurement decisions are controlled by rules and strict procedures. While HO ultimately controls these procedures it is managements role to make it work within the hospital, yet managers are at times perceived to look at issues only from their perspective. In the absence of management’s ability to solve these barriers, clinicians would like greater involvement in planning and decision making, particularly in the area of procurement. Too many decisions are currently based on ‘average’ allocations, and clinicians want to introduce greater departmental influences which better reflect differentiated needs in each department. This is not because they are looking for work. The motivation stem rather from the absence of clear signals that

management are in control. On the other hand, they also want to feel more valued as contributors in the planning activity and not be regarding only as implementers under the control of someone else. They certainly don't want to feel that management's involvement of clinicians in decision making is a pretence. It should be a real, active and meaningful partnership.

A possible improvement in the system could be affected if management introduced greater transparency into the budgetary, procurement and allocation procedures, as well as give more regular feedback on the status of orders for equipment. This would give clinicians a sense that management are indeed controlling the process well. Adding to this, improved skills and expert application of both hard and soft business principles by managers, would probably go a long way in resolving clinicians discomfort with the system.

3.2.3 Sources of knowledge

Managers cannot become clinicians and clinicians should not become pretend managers. Each should focus on their skills set. However, there should be a greater understanding and sharing of the full picture by both parties in order to develop mutual respect, better decision making, as well as improve efficiencies. The fact that clinicians should say "we don't get informed about our limits" CI 2, is indicative of some withholding of information by management which is not in the best interest of the hospital system.

The same principle applies to the hospitals relationship with HST. In the absence of HST taking necessary steps in improving relationships with Wentworth, the management should take active steps in inviting HST to visit and understand the frustrations and opportunities presented at the hospital. Exco should initiate this. In addition a clear and frequent communication should be established which ensures Management can give all concerned a regular update on the status and allocation of equipment.

3.2.4 Sources of legitimacy

Legitimacy seems to have two elements to it as viewed from the Clinicians point of view.

i) In line with their concerns for community evaluation and understanding, active communication and engagement needs to be established between

Wentworth and its community. The need for a well-functioning Board is very evident

ii) Lower level staff feel somewhat disconnected from the hospital decision making process. They should also be given a voice. There is a great need for both recognition of staff contributions under difficult circumstances, improve motivation, and set clear guidelines on expectations. At times management are not willing to devote time to staff issues.

3.3 Summary of managers (Exco) responses contrasting "IS" and "OUGHT"

3.3.1 Purpose

"IS" There is consensus on providing quality care to patients specifically, and also to the community as a whole. The focus is on secondary care i.e. those people who are already sick, simply because they do not have the resources to do more.

"OUGHT" There is a recognition that care is not always at the level of quality it should be. The environment and community determine that more should be done on preventative care. "We should be doing more preventative care but we are stuck where we are" M5.

3.3.2 Who is the client?

"IS" Three broad groups of clients are mentioned" Patients; Staff; District Health Office or Provincial Health Office. (DHO or HO). The focus is on patients who come to the hospital, while the rest of the community is mentioned only in passing. (Low levels of preventative care already mentioned). The CEO regularly does clinical shifts.

Staff as clients are mentioned several times. It is important for EXCO to keep them happy. However, as will be seen under the 'Measurement' section, this relationship is largely intentional but passive.

Respondents spent most of their time talking about the DHO and HO as clients. This was done with vehemence and frustration. These principals are occupying a great deal of their time and energy, and are seen as hindering rather than enhancing their work. "Should anything go wrong they immediately jump on us. We do things because they want us to do it, but support and appreciation is not there" M2 "Our principals are our clients. That is the worst. They don't provide enablers." M5

"OUGHT" Ideally they would like to spend more time with patients and also do more preventative work.

3.3.4 Measures of improvement

"IS" Measurements, statistics and data demand an inordinate amount of time and energy from the hospital as a whole. Most of this data is demanded by the DHO and HO, but seems to disappear into the system, with little response or feedback. There is a lot of duplication of statistics for seemingly unknown reasons. "We are asked to do the same things for District and Province. They don't communicate with each other" M2 Paper work has been multiplied and is now seen as unrealistic, diverting energy away from patients.

The district uses statistics as a form of remote management and control. Some paper work is deemed by managers to be useless, because HO don't really understand what happens on the ground, but is done because it is demanded. Instructions from HO rather than good reason is driving their behaviour.

"We collect literally everything, but I am not sure it is being read" M4.

The district comes to check on is, check, check, check. They give you instructions on what to do knowing full well you don't have the staff to do it" M1.

Despite all this data being sent to HO, managers still have to use their personal relationship with them to get things done, making phone calls to seniors in order to ask for actions to be taken.

Quality of staff is regarded to have declined, partly because of the poor training they receive but partly because of changing attitudes. People don't necessarily share the same vision of quality care. "Quality of people and their commitment is no longer the same. You know the young ones, all they are interested in is money"M5

Staff satisfaction surveys are conducted regularly, and feedback provided. Unfortunately, the staff survey is seen by management as a form of staff engagement in itself. There is little direct engagement with staff, or face-to-face interaction partly due to time constraints, but partly because management are somewhat remote from the people. The general staff feedback meeting was last done a year ago. Interaction with staff is largely done through email, internal circulars and memos.

Staff members are also monitored via the Performance Management Development System (PMDS). Roughly 610 hospital staff are rated on performance on a scale from 1(worst) to 5(best). No one was rated a 1; 1% were rated a 2 (under-performing); no one was rated at 5; 1 single person was rated at 4 (over performing); everyone else was rated at 3 (doing what they are supposed to do). This apparent result is despite the fact that management regard staff attitudes as an issue in the hospital and there

are many complaints from patients about staff attitude. Staff attitude is also one of the 6 priority items to be addressed in their plan. One wonders whether this element of the plan is only receiving lip service. There is no evidence that it is being addressed actively. Part of the reason why so few people are rated outside the norm of a 3, is because that requires further motivations and paper work to justify the rating. People are already sick and tired of all the paper work involved and therefore avoid at any cost, any additional work in this area.

"OUGHT" It was suggested that district should better understand the real issues at the hospital, or even be re-deployed into the hospital, since there is so much duplication between district and province.

Ideally data should be better o-ordinated and incorporated into the planning process. "The data should speak to the plan but it is not" M4.

There is also a recognition that communication with staff should improve, and that management should be more 'open' to them, give access to information, involve them in decision making and cascade feedback to all levels, although there does not seem to be a specific plan on how to do this.

3.3.5 Control of resources

"IS" The ultimate power to allocate resources is vested in the province (HO), even although this system of decision making and allocations is largely broken. Budgets are allocated to hospitals based on average figures, not taking into account specific needs of hospitals. Hence all the statistics supplied to HO are not used to plan budgets and resource allocation to specific hospital situations.

"There is no relationship between the budgets you apply for and what you get" M1.

"Lots of problems with that facility, especially getting responses from them. Turnaround time is a huge stumbling block" M4.

Within hospitals Exco act as the go-between clinician's needs and HO allocations. They co-ordinate and manage the process of best fitting the hospital needs to the budgets allocated externally. They see themselves as facilitating the needs of clinicians, but in reality the system has forced them to largely become administrators not managers, ensuring documents are in order, making sure the hospital is compliant with procurement procedures.

They think that clinicians have no decision making power over resources. Their power rests in the planning committees where they are asked to list and recommend their

requirements, but even that recommendation is in the absence of budgetary knowledge. It is not clear how final allocations are made when the hospital gets less from the Province than they asked for. It appears that the medical manager co-ordinates the requirements from all clinical managers, and makes some initial adjustments through consultation with them. However, there may be further cuts in allocations once a response is received from province, and that is done at Exco without the presence of clinical managers. Hence clinicians 'power' is vested in their representatives at Exco. Yet, not everyone on Exco seems to understand clinical things, even though they are vested with the power of decision making regarding equipment. "Clinicians have no power over resources. They play a passive role" M4.
"OUGHT" HO should give more decision making power to hospitals with regards to resources, especially equipment. That would save a lot of time and energy, and free the hospital to prioritise according to their real needs. The hospital would get lots more done and reduce frustrations. Budgets should be controlled by decision makers, but this is largely interpreted as meaning EXCO rather than clinicians.

3.3.6 Who are the decision makers?
"IS" In the first instance the decision maker is the province (HO). They decide on the budget allocation, which determines everything. However, it appears that frequently this decision making power goes one step further in that HST actually do allocations to hospitals according to their own judgement without consulting the hospitals. "So much equipment is ordered that never arrives, sometimes for 3 years. HTS prioritise which hospital needs equipment most" M1
Decisions taken within the hospital are taken as a team, meaning EXCO. "Exco weigh the need and the urgency" M4
While the concept of an extended management meeting exists, it is not working well, and appears to have no real influence. Even managers admit "We listen to their problems, we communicate and share" M2. There is little evidence of taking on board the issues which are raised. The perspective is 'this is what we do' without much being said about 'this is what we do about what they say'.
"OUGHT" Very little was said about how the system should change. There was a plea for being given more money and some recognition that people on the ground should decide what is most urgent and what is not.

3.3.7 Conditions and environment for accountability.

"IS" Very little was said about this. The problem is seen as an external one, where process rules everything and managers need to understand their role within that process. "We are given responsibilities, but not the power to execute" M2.

"OUGHT" There is a recognition that outcomes and efficiencies live side by side with care and welfare of your staff (one person only), and that EXCO should do more to balance these two elements. On the one hand EXCO must have an open door policy and truly listen. On the other hand they need to be clear on acceptable behaviour and discipline where necessary. There is a need for leadership in this area.

3.3.8 Relevant knowledge which is consulted

"IS" Exco feel they are well represented across several functional fields and therefore are well qualified to make necessary decisions? Nevertheless, in most cases this expertise is not sufficiently utilised by the province (HO), who simply force decisions upon them.

Clinicians are viewed not to have the necessary expertise to manage the procurement process, and should therefore be limited to make recommendations. Much expertise is required in the procurement process, which Exco feel they now possess. They are expert at completing all process requirement. This is their view, even though the overall delivery of the process is not working. The focus is the administering of the process rather than the outcomes. The perspective is that the reason that it is not working is not because they are not doing their jobs well, but because someone externally is imposing decisions upon them.

"OUGHT" All Exco members should have management training in addition to their basic qualification as well as understand clinical issues. Good managers need to lead but also to follow the lead of others. They should let other lead in planning if they are not the best person for it.

3.3.9 Professional involvement and guarantee of the right expertise being used.

"IS" It appears that Exco are not actively involved to ensure that all expertise is involved, since they already believe they represent a cross section of necessary expertise.

"OUGHT" Exco should involve more people, and be willing to draw additional expertise into decision making, especially those at the institution who have been there for a long time. In some instances expert clinical knowledge is worth bringing on board.

3.3.10 Sources of legitimacy, including representation of those affected but not involved

"IS" The hospital Board is selected by and represents the community, but is currently not functioning. Past experience has shown that board members often serve their own interests rather than that of the community.

Community 'war rooms' at which all stakeholders are represented are good forums to hear about community needs

The District office provides a voice to the wider population health needs

"OUGHT" District and HO should consult more with hospitals. Ideally the hospital should manage its own affairs, including procurement, as an independent entity.

The hospital needs an active Exco which is able to implement the decisions it takes. "The same things are raised at Exco meeting after meeting, but no progress is reported" M1

There should be greater flexibility to fix problems. Ideally Exco and clinicians should sit together to plan. Certainly, the communication between Exco and clinicians should improve. Procurement should be done in time to meet clinician's needs.

Both the staff and community need to improve their attitudes.

3.4 Critical self-evaluation amongst managers. Analysis of their reflection of the "OUGHT" system versus "IS" system.

3.4.1 Sources of motivation

There is general consensus amongst managers as well as clinicians that the purpose of the hospital is to provide quality care, firstly for existing patients, and to some degree to the extended community. Managers deal mainly with three stakeholders or clients. These are i) patients; ii) staff; and iii) Head Office (HO) in the form of the District Health Office (DHO) and Provincial Department of Health (PDH).

There is recognition that patient care is not always what it should be, but they perceive their statistics and health measures to be relatively good. Preventative care is mentioned in passing as are community needs, but of the three their overwhelming focus is the balancing of existing patient needs.

There is also some recognition that relationships and communication with staff needs to improve in general, but there is no clear articulation of what and how this needs to change. The ineffective Performance Management Development System which rates 99% of the hospital staff at ‘average’ is just one indicator of the passive approach taken towards motivating and developing staff. There is awareness of the issue, but no one on Exco is paying attention to fixing it. Lots of communication takes place electronically or remotely, with relatively little real face-to-face engagement.

Much time and energy is spent on keeping their HO stakeholder happy, so much so that day to day management and improvements of systems within the hospital receive less attention than they should. HO is spoken of vehemently with much frustration and some fear. Everything needs to be done to satisfy the demands of HO be it endless paper work, duplication of statistics, etc. in order to prevent any ‘judgements’ from above.

Managers perceive the external HO system to have an overwhelming effect on hospital outcomes.

3.4.2 Sources of control

Decision making power largely rests with the district and the province. They make decisions on budgets, equipment which does not speak directly to the needs of hospitals, and delivery times which poorly reflect the urgency of patient needs. Yet they demand the procurement processes be strictly adhered to. This has turned managers largely into administrators, who constantly jump at the urgent behest of HO. Managers have therefore been largely left to being the go-between clinicians and HO. Much of their role is vested in administering methods put in place by HO, and ensuring the hospital is compliant with procedures and documentation. Consequently, they have lost sight of their role as managers who need to spend time and effort improving the internal systems as much as they can. This is evident in the fact that there is little self-reflection on what could be improved. Instead their ‘self-reflection’ is focussed on what needs to change at HO. They want HO to give hospitals greater freedom to make decisions, especially regarding equipment. The discretionary budgetary authority for hospital managers at R5000 per items is very low.

Clinicians are given the power to recommend, not to decide, and since the hospital is performing relatively well, and managers are not so much concerned with improvements of the internal decision making systems, this is not taken as a pressing

issue. Thoughts about ‘end users’ making decisions about equipment is referenced as Exco, not clinicians. Similarly ‘team’ decisions are contextualised within Exco not the wider leadership team including clinicians.

There are some hints at the need to improve leadership overall. Management of staff as well as communication should improve, but these were not considered urgent.

Managers repeatedly reflect on how the HO decision making system should change, and how there is an imbalance of power between the HO and Exco. They regard internal hospital system to be largely intact and that Exco is doing a good job with that. They do not perceive internal decision making systems needing much change. There is recognition for the need of improvement, but the effect is not regarding large enough to warrant strong intervention.

3.4.3 Sources of knowledge

As can be expected, there was not much commentary about this theme. Self-reflection means that HO should give more decision making power to Exco. They see themselves as having the necessary cross section of expertise to make the right decisions for the hospital. They view themselves as experts in the processes laid down by HO, especially the procurement processes, but speak little about management expertise.

There were again some hints that maybe Exco’s self-appraisal of their abilities is somewhat lacking. There is a recognition by some that Exco members need training in management principles, and that some of them need a better understanding of clinical issues. These state that the principle of leading should also include the willingness to take on board the views of experts within the hospital who have specific expertise which Exco may not have (one person).

Exco’s limited view of the importance of internal decision making systems outside EXCO members become more evident under this section. They reflect largely on external, not internal issues, despite the fact that they are tasked with the role of ensuring internal systems. Exco’s view is that internal systems are well controlled – but this definition of internal systems is limited to procedures, statistics and paper work required by HO, not the relational and motivational systems of staff within the hospital

3.4.4 Sources of legitimacy

There is not much concern amongst managers about legitimacy issues. As already indicated their focus for change lies in how the relationship with HO should change. Community issues are low on their list of priorities. There is recognition that the hospital Board is not functioning, but at the same time there is reservation about whether this would change much about hospital output. There is recognition that staff relationships should improve, but this is not pressing.

There are some hints that Exco should be more inclusive in its planning, and that Exco should be more active in pursuing those decisions which it can influence within the hospital.

The ‘community system’ is even further out of sight for Exco than the internal human decision making system.

APPENDIX 4 Informed Consent Letter 3C

UNIVERSITY OF KWAZULU-NATAL
GRADUATE SCHOOL OF BUSINESS AND LEADERSHIP

Dear Respondent,

MCom Research Project
Researcher: Robert Reimers (0828281737)
Supervisor: Dr Stan Hardman (0825532176)
Research Office: Mariette Snyman (031-2608350)

I, **Robert August Reimers** am a MCom student, at the Graduate School of Business and Leadership, of the University of KwaZulu Natal. You are invited to participate in a research project entitled "To explore the Management and Leadership system amongst i) Clinicians and ii) Managers in a public health hospital, and how these are influenced by respective values and boundary judgements."

The aim of this study is: "To explore the Management and Leadership system amongst i) Clinicians and ii) Managers in a public health hospital, and how these are influenced by respective values and boundary judgements."

Through your participation I hope to understand **Management and leadership system in a public health hospital**. The results of the face-to-face interview is intended to contribute to a better understanding of the overall decision making system for the hospital

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey/focus group. Confidentiality and anonymity of records identifying you as a participant will be maintained by the Graduate School of Business and Leadership, UKZN.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

The face-to-face interview will take about **90** minutes to complete. I hope you will be willing to participate in very worthwhile research. At the end of the research project the results will be shared in a joint focus group of Managers and Clinicians who participated

Sincerely

Investigator's signature____
Date__________________

APPENDIX 5

UNIVERSITY OF KWAZULU-NATAL
GRADUATE SCHOOL OF BUSINESS AND LEADERSHIP

MBA Research Project
Researcher: rob Reimers (0828281737)
Supervisor: Dr stan Hardman (0825532176)
Research Office: Mariette Snyman (031-2608350)

CONSENT

I………………………………………………………………………… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.
I understand that I am at liberty to withdraw from the project at any time, should I so desire.
SIGNATURE OF PARTICIPANT DATE

…………………………………………………………………………………………………

I…………………………………………………………………………… (full name of participant) also give/do not consent to have the interview recorded.

SIGNATURE OF PARTICIPANT DATE

……………………………………………………………………………………………

APPENDIX 6

08 July 2016

Mr Robert August Reimers (721721021)
Graduate School of Business & Leadership
Westville Campus

Dear Mr Reimers,

Protocol reference number: HSS/0433/016M
Project title: To explore the Management and Leadership system amongst i) Clinicians and ii) Managers in a public health hospital, and how these are influenced by respective values and boundary judgements

Full Approval – Expedited Application

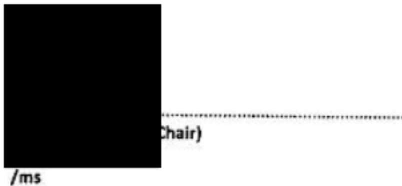
With regards to your response received on 01 July 2016 to our letter of 13 May 2016. The documents submitted have been accepted by the Humanities & Social Sciences Research Ethics Committee and **FULL APPROVAL** for the protocol has been granted.

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 discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.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cc Supervisor: Dr Stan Hardman
cc Academic Leader Research: Dr Muhammad Hoque
cc School Administrator: Ms Zarina Bullyraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
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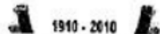

Founding Campuses: Edgewood · Howard College · Medical School · Pietermaritzburg · Westville

Appendix 7

an exploration of the management and leadership system in a public hospital in Durban

ORIGINALITY REPORT

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SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

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