# Health care leadership in an age of change

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## Abstract

*This study examined the leadership practices of a sample of network and hospital administrators in metropolitan Victoria, Australia. It was undertaken in the mid-1990s when the State Liberal-National (Coalition) Government in Victoria established Melbourne's metropolitan health care networks. I argue that leadership, and the process of leading, contributes significantly to the success of the hospital in a time of turmoil and change. The sample was taken from the seven health care networks and consisted of 15 network and hospital administrators. Bolman and Deal's frames of leadership -structural, human resource, political and symbolic - were used as a framework to categorize the leadership practices of the administrators. The findings suggest a preference for the structural frame - an anticipated result, since the hospital environment is more conducive to a style of leadership that emphasizes rationality and objectivity. The human resource frame was the second preferred frame, followed by the political and symbolic. These findings suggest that network and hospital administrators focus more on intellectual than spiritual development, and perhaps this tendency needs to be addressed when educating present and future hospital leaders.*

## Challenges facing leadership in health care

Rapid changes have occurred in the delivery of health care in the last decade. Most of the developed countries have either planned or implemented major reforms. The impetus for these reforms has been financial, cultural and political - the main aims being controlling costs, enhancing access and maintaining the quality of health care. Policy makers in many countries are trying to balance the high-powered incentives associated with consumer choice, markets and competition with their commitment to public policies that secure universal access and clinical quality in health service delivery. The emphasis in health care is now on best practice approaches to management and work organizations in the drive for world-class performance. The best practice approaches to management also require effective leadership. 'Leadership' is a quality similar to 'integrity' and is inextricably linked to 'values'. Leadership is not about what is done but *why* something is done. Nader (1999) suggests a leader is only a leader when *leading* - carving a new path. In health care we need leaders who are carving a new path for the present and the future.

In Australia the forces that have driven health reform are similar to those affecting most developed countries. The current wave of health reforms started in the second half of the 1980s. During that period there was an increased demand for health services, and simultaneously, constraints on health budgets. The factors that have contributed, and continue to contribute to increased demand for health include the ageing population, enhanced consumer knowledge and expectations of health care, advances in technology, and higher expectations of the health outcomes. Forces that have driven health reform include the lack of investment capital for infrastructure development, increasing technical efficiency and improving quality (Bloom, 2000).

Australia spends approximately 8.6% of its GDP on health. Compared to other developed countries this is not excessive. Most health experts agree that the amount is both adequate and reasonable, and that the standard of care provided is impressively high. Yet behind the push for health reform in Australia there has been the fear of increasing costs and the resolve to preserve - and even enhance - equity and access to health care.

The public hospital system in Australia has been a target of health care rationing and restructuring. Since public hospitals are by far the largest consumer of resources, this should not be surprising. However, policy makers in Australia have adopted structures and processes for health reform that were developed for a market-driven private sector management. These policy initiatives included efforts to extend the application of management concepts and technologies into clinical domains, as well as the introduction of output-based funding mechanisms (Degeling, Sage, Kennedy, Perkins & Zhang, 1999).

In Victoria - the second most populous state in Australia, and where this study was undertaken - there has been a significant range of health reforms, many of which have dramatically affected the Victorian public hospital system. One of these reforms was the establishment of the metropolitan health care networks in 1995 and the opening up of all major hospital development to private sector financing and operation. The purpose of the metropolitan health care networks was to address the distribution of hospital services and to achieve further technical and clinical efficiency. The main goal of these networks was to ensure that high quality, efficient and accessible health care services continue to be available in metropolitan Melbourne. Seven health care networks were formed; five of these networks were geographically based, whereas the other two were specialist-focused.

Stoelwinder and Viney (2000:212) discuss how the health reforms in Victoria's hospital system reflect the 'inexorable march of managerial rationalism', and the way that managerial rationalism gives precedence to technical efficiency. They argue that recent health reforms have provided the rationale for hospital and government managers to gain control of the system. However, in a complex professional organization such as a hospital, there is a constant struggle for control between organized stakeholders - on one side the managerial group, and on the other the health care professionals. This struggle should not be surprising. Hospital managers value order, control and rationality whereas health care professionals will not knowingly embrace change defined by others.

Managing change in health care provides a challenge to any health care leader if they are to embrace the essential principles of the contemporary world's best health care practice. Change processes that are top-down, negative, cost-cutting exercises, which pay lip service to employee participation, will not succeed, and will cause high levels of stress and low morale (Hindle & Natsagdorj, 2002). Health care leaders need to provide vision and long-term strategies for the organizations as a whole. Although these changes will cause unrest in the health care environment, this will be mitigated if health care leaders involve health care providers in the design of the change process - then joint ownership and opportunity should occur (Kilkeary, 1994; Carnegie, 1994). As Drucker (1992) says, there is enormous opportunity because change is opportunity. The changes themselves are not the concern, but all the different directions they take. In this situation, the effective executive, or the health care leader has to be able to recognise and run with opportunity, to learn and constantly refresh the knowledge base (Drucker, 1992).

Kotter (1992) asserts that leadership and management are now required in large measures due to the changing and turbulent environment. He states that the capacities for leadership and management depend on the strength of two variables present in the environment: the amount of change experienced or required, and the complexity of the work. When both variables are strong, high levels of leadership and management are required. When both variables are weak, relatively low levels of leadership and management are needed. Hospitals are now experiencing both variables at a high level. Traditionally, the hospital has often focused on management rather than leadership. For this reason, a study of the leadership practices of network and hospital administrators in a time of change was timely and potentially valuable.

## Purpose and significance of the study

The purpose of this study was to examine how network and hospital administrators in Victoria's metropolitan health care networks lead in a time of change. This aim was achieved by interviewing network and hospital administrators from the seven (later changed to six) metropolitan health care networks. There have been very few studies conducted on how network and hospital administrators lead in a time of change in Australia and overseas. Although the findings cannot be generalized to all network and hospital administrators, they contribute to a body of knowledge about leadership that can enhance the practice - and the practice of future hospital leaders. This has the potential to provide guidelines for the education and training of present and future network and hospital administrators.

# Method

This study used the qualitative approach and focused primarily on the leadership experiences of the network and hospital administrators. Bolman and Deal's frames of leadership (structural, human resource, political and symbolic) were used for data analysis. These frames were preferred over others as they provide a complete picture of an organization by recognizing its different dimensions or vantage points (Table 1). It was acknowledged that some of the data might not fit into these frames and new elements of leadership could emerge during the data analysis.

## Table 1: Overview of the four frame model

| | Frame | | | |
|---|---|---|---|---|
| | **Structural** | **Human resource** | **Political** | **Symbolic** |
| **Metaphor for organization** | Factory or machine | Family | Jungle | Carnival, temple, theatre |
| **Central concepts** | Rules, roles, goals, policies, technology, environment | Needs, skills, relationships | Power, conflict, competition, organizational politics | Culture, meaning, metaphor, ritual, ceremony, stories, heroes |
| **Image of leadership** | Social architecture | Empowerment | Advocacy | Inspiration |
| **Basic leadership challenge** | Attune structure, to task, technology, environment | Align organizational and human needs | Develop agenda and power base | Create faith, beauty, meaning |

*Source:* Bolman and Deal (1997:15)

### *Sample*

The sample was taken from the seven health care networks in metropolitan Victoria. A Board of Directors governs the networks and the chief executive officer from each board was invited to participate in the study. The chief executive officers, directors of nursing and the directors of medicine from a hospital (with 500 beds or more) within each network were also invited to participate in the study. The sample size consisted of 15 network and hospital administrators. All the chief executive officers (seven) of the metropolitan health care networks participated in the study. The request for interview was submitted in writing and assurances were given about anonymity and confidentiality.

## Table 2: Information on participants

| Chief Executive Officer | Director of Nursing | Director of Medicine | Network | Hospital | Gender |
|---|---|---|---|---|---|
| * | | | * | | Male |
| * | | | * | | Male |
| * | | | * | | Male |
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| | * | | * | | Female |
| | * | | | * | Female |
| | * | | | * | Female |
| | | * | | * | Male |
| | | * | | * | Male |
| | | * | | * | Male |
| **9** | **3** | **3** | **8** | **7** | **12 Male 3 Female** |

### *Data collection and analysis*

This study used a semi-structured interview method. The interviews were conducted in the participant's workplace and were audio-taped for transcription. The open-ended questions were developed from the literature on leadership and particular attention was given to the work of Kotter (1992) who clearly describes the differences between management and leadership. The open-ended questions were as follows:

- What are the changes that have had a significant impact on the hospital or the network?
- What do these changes mean to the people working in the hospital or the network?
- How is the direction established for the network or hospital to produce the changes that are needed or are occurring?
- How are people aligned to understand and believe in the established direction?
- How are people motivated and inspired to implement the established direction?
- How is it determined whether the changes required to achieve the desired direction have produced a successful outcome?

Approximately 15 hours of audiotaped interviews were collected and transcribed in their entirety by a person other than the interviewer. A final draft of the interview transcript was supplied to the participant, to ensure that the contents of the transcript represented their views. The preliminary phase of the analysis consisted of reviewing the transcribed tapes. A separate file was created for each transcript, which was reviewed at least three times, and reference was made to the audiotape for clarification as required. The transcripts were then sent to the network and hospital administrators for verification or change. Many interviewees made changes and removed areas that they perceived to be contentious or unsuitable. A coding scheme, using the conceptual framework set forth for this study, was then implemented. The questions on change were coded according to the common themes that emerged and these were consistent with the literature.

## Results and discussion

### *Catalyst for change*

The administrators in this study identified most of the external and internal changes that impacted on the delivery of care in the hospital. These findings were consistent with the literature (Mistry, 1997; Ritchie, 1997; Courtney, 1997; Reamy, 1995; O'Grady, 1990; Navarro, 1995; Gaucher & Coffey, 1995). The changes included cost constraints, technology, consumer expectations, corporatization, restructuring and the ageing population.

Most of the administrators recognised that *cost constraints* were here to stay. They identified government policy, patient expectations, technology, length of stay, surgery and tax burden as the major thrusts for these cost constraints. An interesting finding related to the cost of the technology. Most of the participants identified that monetary cost outweighed the social, emotional and physical outcomes for patients. Yet who decides what the *technology* is to be used, or for whom? Is it appropriate that health care professionals decide where the money is to be spent? Do they support areas that benefit the consumers of health care? Do they support their own special interest groups or specialties?

*Consumer expectations* have also influenced the delivery of health care in the hospital. The focus in the past has not really been on the patient and this requires structural, political and cultural changes. The cultural changes will perhaps be the hardest to achieve, as patients often lose their identity once they are admitted to a hospital and are reluctant to challenge or question the health care professionals who are providing the care.

The changes that seemed to have the greatest impact on the clinical and non-clinical groups within the hospital were *corporatization and restructuring*. This is not surprising, considering the ethos of the hospital in the past. Hospitals were supposed to be concerned with caring for patients, not functioning as business entities. Many clinical people still view hospitals this way and cannot abide the shift to the corporate culture. Some of the clinically focused administrators had sympathy with this view. The corporate culture is here to stay, so perhaps a way of dealing with the issue is to educate undergraduate health care professionals in the areas of leadership and management.

The *ageing of the population* was another change identified by some participants, however this was not seen as a significant change. Perhaps this was due to the fact that demographic shifts and demographic factors relating to ageing have been around for some time and most were familiar with this change. Australia has a younger population compared to other developed countries and this could be another reason why it was not seen as a major change.

Most of the administrators were very knowledgeable about the changes. However others were not, and their lack of knowledge in this area was quite surprising. It is imperative that network and hospital administrators are aware of external and internal change and their impact on the hospital or health care system. If they are to lead the changes, rather than to control or manage them, they need to have this knowledge.

A change identified by a participant, and one that was not discussed in the literature, related to gender imbalance in the hospital. This participant argued that the gender imbalance in the hospital needed to change. Health care delivery has traditionally been a male-dominated occupational area, in terms of the clinician, but in terms of the vast majority of people involved with nursing care it has been dominated by females. The challenge to the network and hospital administrators is to encourage more males in nursing and to have more women represented at the executive levels. What this participant said about gender imbalance is reflected in this study, as only three out of the fifteen hospital administrators were female and they represented the nursing division.

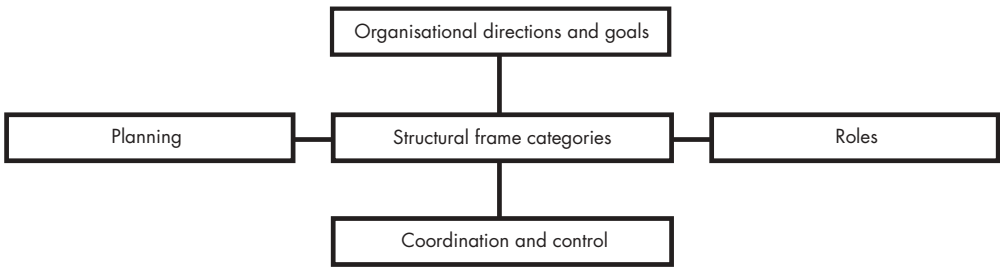
Another interesting finding was the attitude of the administrators toward the changes. Many did not question or challenge the changes. Change was seen as a norm within the hospital and most of the administrators were committed to change. Perhaps this finding is not surprising considering the political context at the time of the study. Some of the administrators were being paid arguably exorbitant salaries and this may have influenced their decisions. The attitude to the changes at other levels within the hospital (especially at the grassroots level) may not be as favourable.

These findings signify that health care administrators are now forced to deal with not only the exigencies of their own organizations, but also with a new social reality. The challenge is to lead the change, that is, to stimulate people to achieve goals. In this study it was evident that most of the administrators managed the change as they focused on getting people 'to do what needs to be done'.

### *Structural frame*

The findings related to the structural frame revealed that uncertainty and complexity were typical in the hospital. The categories that emerged from the data focused on the networks and hospital organisational direction and goals, the roles of the major players, and coordination and control issues, particularly the establishment of performance measures.

**Figure 1: Structural frame categories**




The *organizational direction and goals* of the networks and hospitals were mainly driven by the Metropolitan Health Planning Board (MHPB) recommendations. The focus was on accessibility, equity, quality and programs of care throughout the networks. As expected the networks were more focused on the MHPB recommendations whereas the hospitals were coming to terms with the massive changes, especially where there had been amalgamations. The hospitals were still focused on what was happening within their own organization and the concept of networking was quite alien to most of the people interviewed. In some cases the networks, especially the geographically based, wanted the hospitals to maintain their own uniqueness yet develop programs of care throughout the network.

The specialist network focused on the hospitals within the network as they were recognized worldwide and it would be foolish to even consider changing this. The findings also revealed that the network administrators' approaches to establishing the direction or goals were different. Some established elite teams whereas others tried to involve more people throughout all levels of the hospital. Another area of concern related to the vision of the hospital. Some of the administrators did not have a clear vision for their organization and in times of crisis and uncertainty this is paramount, as people need a vision that is persuasive and hopeful. This seems to be an area that needs addressing in the health care system. The literature touches on the issue and some of the critics argued that the hospital is about illness not health (Handy, 1992; Drucker, 1992).

Another interesting aspect of the findings was that many of the administrators felt the networks jurisdiction was limited. A chief executive officer (network) argued that 'we don't cover primary care, we don't cover a whole lot of residential aged care' and there is a boundary around the bit of health that they provide to a population of around 750,000 people. This participant suggested that half of the network has good access to health care whereas the other half has very poor access. These restricting boundaries do influence access and quality of care. Providing community-based care, from hospital to community, is one way of getting all the providers going in a coordinated way under the one umbrella. An alternative approach of integrating the services from hospital to community is essential if we are to provide a service that meets the needs of the patient and is financially viable. The hospital must move from the 'dumping out' mentality to the 'integrating care' approach as many of these patients, especially the chronic and mentally ill, either rebound into the hospital system or end up on our streets or in our prisons. This is not acceptable in a civilized society.

The realignment of *roles* focused on new duties and how the work was to be performed. The findings revealed that the administrators, doctors and nurses were the groups most affected by the role changes. Restructuring of work areas meant services were leaner and some jobs had disappeared altogether. The people who felt secure in their skills and abilities were less threatened by the changes.

Doctors were no longer perceived as 'gods' and they were now expected to work as a member of the multidisciplinary health care team and provide a service like every other profession within the team. They were not leaders by virtue of their title and status. Although this is supposedly happening it will require a massive culture shift within the hospital. Many of the other health care professionals still see the doctor as the leader and it will require education and training at all levels to change this perception.

The administrators within the hospital were no longer certain whether they would have jobs or whether they had the skills to do the job because of massive cuts to corporate services. Restructuring had eliminated the traditional hierarchies of medicine, nursing and administration and now there was a much flatter structure. Many of the networks had established portfolios for their senior staff and in some cases they could be accountable for two or three disciplines.

The nurses' role has also changed and they are now expected to have a mix of clinical and management roles. In some hospitals they are on equal clinical partnerships with the doctors and the critics are watching very closely the dynamics of this new role. It is therefore essential that these nurses receive the ongoing education and training that is required to perform this role effectively.

Most network and hospital administrators saw *planning* as an issue, because it was difficult to get all people to move in the same direction. Issues such as timelines, amalgamations and different hospital cultures all complicated the development of the network and hospitals strategic plan. This finding was not surprising and perhaps the timelines from the Government were too unrealistic. The changes imposed were massive and they may have underestimated the impact on the players within the health care system.

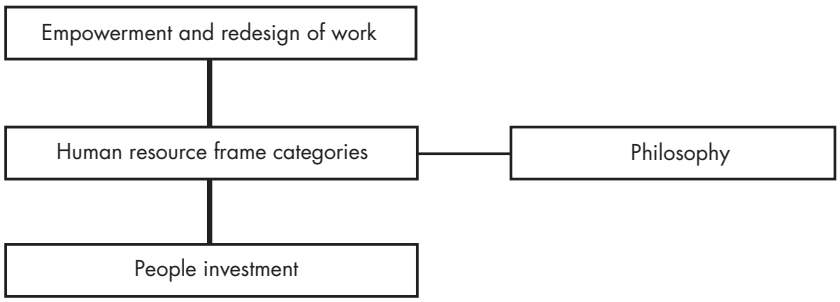
The findings related to *performance measures* suggest that the processes used to evaluate these measures were not consistent throughout the network and especially the hospitals. Other areas of concern were the information technology systems and the traditional and conservative practices that were influencing the quality of care provided to the patient. A director of medicine claimed that various departments within the hospital do their own patient surveys or quality audit programs and some have well documented quality-improvement programs whereas others have programs that are 'embryonic or non-existent'.

The structural findings suggest that the changes had caused people within the hospital to feel a loss of clarity and stability, confusion and chaos. When this occurs it is essential that the network and hospital administrators communicate, realign and renegotiate formal patterns and policies.

### *Human resource frame*

The findings revealed that the human resource frame of leadership was important to the network and hospital administrators and three major categories emerged: philosophy, people investment, empowerment and redesign of work (Figure 2).

**Figure 2: Human resource frame categories**




It was revealed that many of the networks and hospitals did not have a human resource *philosophy* that underpinned its direction. This was not surprising and was consistent with the literature. Some of the participants suggested that the way to get people involved in the organization was through the management style and management structure. Others claimed the philosophy must operate at all levels within the hospital, from top management to the grass roots or ward area. The value in networking was seen as an important philosophy. However, some of the network administrators felt the support was only rhetorical and jealousy, competition and unreasonable biases were still rampant. This is an important factor when considering the development of success criteria for the networks, although it is difficult to measure. There were other factors that contributed to the success of the philosophy and these included trust, honesty and effective leadership.

*People investment* was another category identified by the participants and included such things as job security, promotion, hiring, rewarding, training and education. The issue relating to job security was instability as people were no longer certain of a job in such a turbulent changing health care environment. Some of the participants claimed that people were very stressed and those who seemed to cope best were those who were quite confident about their skills and abilities.

The hiring and promoting of individuals within the hospital raised some interesting issues. The major concerns related to the hospital's rigid structure and the inequities between executive salaries. As most administrators could not reward their staff in financial terms some offered positive feedback on the work achieved. However, only the female administrators gave this feedback, a finding that concurs with the literature. Promoting from within the hospital elicited some interesting debate from the administrators about whether people in management positions need to have a background in health care. Some of the administrators saw the need whereas others did not. It was suggested that those without the health care background may prove to be the better managers, as they would not have any vested interest in their former discipline. The hospital's rigid structure and the inequities between executive salaries were other issues raised by the administrators. There was some discussion about the limitations placed on hospitals when advertising for people to work as clinical program directors. The hospital had to appoint from within and many people believed they were the leaders by virtue of their positions (professors and doctors) and were hired due to political reasons. These people were not necessarily the best persons for the job. However it was encouraging that this practice is slowly changing and the appropriate people are now being employed.

Training and education were identified by some of the participants as an important aspect of people investment. However, considering the changes that are occurring in the delivery of health care and the need for retraining and education, the lack of response concerning this area was surprising. There was a focus on generic education, especially in the area of middle management. It was emphasized that health care administrators who have management training and technical training tend to be the best managers.

Another category identified by the participant for the human resource frame was *empowerment and the redesign of work*. The strategies used to empower the people were autonomy and participation. Most of the administrators

agreed that communication was an important component of their leadership style and they used various methods such as face-to face meetings, open forums, and group discussions. Some of the characteristics they espoused were openness, honesty, nurturing, coaching, inspiring and these were used to encourage people to be more autonomous and participative in the workplace. How to manage the changes so that people were involved was also a strategy used by the participants. The strategies included change workshops, open discussions and communication that was honest and positive. An interesting aspect of the administrators' approach to change was the idea that people had to be taught how to survive or adapt, because change was now an integral part of everyday hospital life.

Many of the administrators identified the need for teaming or teamwork in the delivery of health care within the hospital and the network. There has been a big shift since the introduction of casemix funding and program care to deliver health care within multidisciplinary teams. The difficulties encountered in achieving this included the power of the doctor and the fact that most health care professional have not been educated to work as members of multidisciplinary teams. If the concept of integrated care within communities is to work it is essential that the diverse health care professionals see the need to work as a team and put aside any power issues they may have.

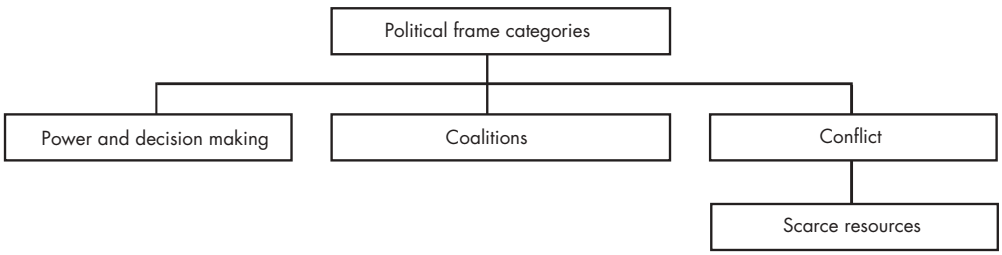
### *The political frame*

There were three categories identified by the participants that mirrored the political frame. These were power and decision-making, coalitions, and conflict, especially the competition for scare resources (Figure 3).

The groups involved in power conflicts were the doctors, nurses, unions and the Department of Human Services (DHS). The power conflicts between these groups are not new. Perhaps the groups that are being challenged the most are the unions and the doctors. Some of the network administrators were keen to see nursing and medical managers working as equal partners in the clinical settings and this has been established within some hospitals One hospital administrator was very scathing of the DHS and conceded there were moves, by some individuals within the Department, to close hospitals in the inner city area. This hospital administrator also claimed that DHS were providing incentive funding that promoted unnecessary surgery.

The union referred to the most was the Australian Nursing Federation. This is not unusual, considering nurses are the largest groups of employees in the hospital. As discussed previously, the issue of nurses as professional, versus vocational, workers is a real problem and one that plagues the nursing profession. Nurses want professional recognition yet, as a chief executive officer (network) alleged, the employing institutions, unions and the Government do not provide a framework for them to practice as true professionals. Other power struggles related to amalgamations of hospitals, and the staff that caused the most problem were non-clinical people, as most of health care professionals have worked across campuses. The power of medical doctors was questioned. They were now seen as employees, as opposed to independent consultants, and this had resulted in a general loss of power. The corporatizing of doctors has also occurred and they are now expected to be involved in management at all levels of care. Some of the participants acknowledged that there was not always shared decision making throughout the network and hospitals, however some also claimed that this processes was changing, and more people at all levels were becoming involved in the process.

## Figure 3: Political frame categories




The formation of new *coalitions* was the second category that emerged from the data. One of these was the new coalition between the doctors and the hospitals. As stated above, they are now an employee of the hospital and are paid for the work they do. Another trend in this new coalition is the corporatizing of the doctors they are now expected to be involved in management issues.

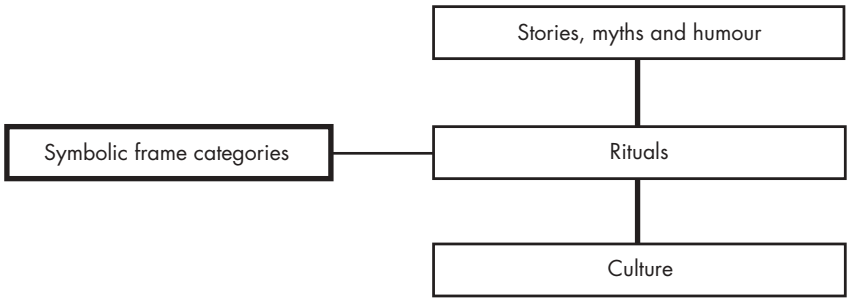
New coalitions were also being established with unions and the hospitals to ensure that the distribution of power was spread more evenly. Another significant new coalition was between the network and the hospitals. Most of the participants supported this coalition, although some conceded that the network concept had not been sold effectively to the hospitals and this could influence their success.

The third category that emerged from the data related to *conflict*. This finding was not surprising, considering the different partisan groups with the networks and hospitals, all competing for power and scarce resources. These groups all represent different values, traditions, beliefs and lifestyles. Many of these conflicts had been discussed in the structural and human resource frame and the conflicts relevant to the political frame were mainly related to *scarce resources*. Most participants claimed that the major factor that influenced the distribution of resources were the budget cuts. Many of the participants felt that there was inadequate allocation of resources by the State and Federal governments. However, most conceded that governments were now becoming more sophisticated in the allocation of resources and these were now based on output and to some degree outcomes. The vying for resources from the different partisan groups, the clinical role (patient care) versus managerial role (cost of care) and the view that 'everything' should be done for the patient were other areas of identified conflict. It is evident from this study that the golden eras in health care have now passed and the reality of cost constraints has taken hold. Stakeholders in the delivery of health care are now scurrying furiously to secure diminishing health care resources.

### *The symbolic frame*

In the *symbolic* frame there were three categories that emerged from the data. *Stories, myths and humour* compiled the first category (Figure 4).

**Figure 4: Symbolic frame categories**




*Stories* were one of the key mediums that the network and hospital administrators used for communication. Although they did not specifically refer to story telling it could be implied. The stories were told through different mediums and these included formal and informal meetings, face-to-face chats, presentations, seminars, newsletters and other forms of written communication. The stories communicated mostly the changes that were occurring throughout the network and the hospital. What this finding did not reveal was how the network and hospital administrators provided the drama, direction, cohesiveness, and clarity in their story telling. Perhaps the focus was more on detail and rationality rather than on personal artistry that highlighted human values and human spirit.

The *myths* reflected in the participants' response referred to the power of the medical profession; the subservient role of the nurse; the elitist perception of specialty units and their staff within the hospital and the community; the vision statements of hospitals and the goodwill of their workers. Many of the participants argued that some of these myths are stubbornly persistent, and have the potential to block adaptation to changing conditions in the delivery of health care. Perhaps the myths that provide the most challenge to the network and hospital administrator relate to the views about doctors, nurses, the vision of hospitals and the goodwill of health care workers.

Some of the participants used *humour* and *metaphor* when describing some of the situations within the network and the hospitals. They used humour in their language and one participant conceded that humour, honesty, and enthusiasm are essential components of job survival.

The second category was *ritual*. Many of the participants identified transition rituals that allowed the people to let go of the past, deal with the pain of the present, and then move into a meaningful future. Rituals that provided structure and meaning to the hospital in the past are now being challenged and a new order is emerging. Perhaps the rituals or procedures that are in urgent need of change, and were identified by some of the participants, relate to the clinical practices of the health care professionals. Many of these practices are not based on research and have the potential to harm the patients. These practices are deeply rooted in tradition and the culture of the hospital. In fact, many of the practices are unique to the hospital and the health care professionals learn very quickly that this is the way things are done.

*Culture* was the third category that emerged from the data. The hospital culture is complex, as the people who provide the services are unlikely to share experiences and beliefs. This complexity was seen in the participants response and most agreed that hospitals are experiencing massive cultural changes. Many changes focus on roles and power structures, especially the power of the doctor. These findings suggest that network and hospital administrators have to promote the concept of multidisciplinary health care teams, to ensure that the roles and power of the different health care disciplines are recognized, and given the status they deserve.

How the network and hospital administrators used Bolman and Deal's multiframes in their leadership practices is summarized in Table 3.

**Table 3: Multiframe leadership practices of network and hospital administrators**

| |
|---|
| **Structural Frame** |
| Achieving vision and goals of networks and hospitals |
| Providing high quality care and developing clinical units in hospitals |
| Aspiring to become world leaders in a range of integrated health care services to benchmark practices |
| Corporatizing the network, hospital and doctors and greater emphasis on financial accountability |
| Realigning of roles and responsibilities and establishment of multidisciplinary management and clinical teams |
| Integrating clinical and management roles in nursing |
| Developing information systems and outcome performance measures that reflected patient and community satisfaction |
| **Human Resource Frame** |
| Developing and implementing a human resource philosophy |
| Investing in people through job security, promotion, hiring, rewarding, training and education |
| Empowering people by promoting autonomy and participation |
| Redesigning work by developing multidisciplinary teams and program care |
| **Political Frame** |
| Establishing equal clinical partnerships between doctors and nurses |
| Sharing decision making throughout hospital and network |
| Forming new coalitions between doctors, hospitals and networks |
| Forming new coalitions with unions and hospitals |
| Vying for scarce resources |
| **Symbolic Frame** |
| Identifying myths |
| Identifying rituals |
| Instigating a new hospital or health care culture |

# Reflections

The frames of leadership most practised by the network and hospital administrators in this study were the structural and human resource frames. These findings suggest that network and hospital leaders focus on being the architects (structural frame) and the catalysts (human resource frame) and would not be expected, or perhaps

tolerated, to be advocates (political frame) or prophets (symbolic frame). If this were the case it would be essential that all present and future network and hospital administrators be adequately educated and trained to lead from the multiframe perspective, encompassing all aspects of effective leadership.

Another reason for these findings could relate to the complex professional nature of hospitals. There is a constant struggle for control between organized stakeholders - on one side the managerial group, and on the other the health care professionals who tend to have a 'tribal' nature. These influences make leadership more difficult in the hospital, especially from the political and symbolic perspective. We have seen a shift in the hospital to the development of multidisciplinary teams to provide care to the patient, yet this is only in the beginning stage, and there is much resistance from the medical profession. In this time of change, leaders within the hospital need to make sure that people from all the health care professional 'tribes' come together so that they know who they are, who they have just become, and who they still want to be. They could do this by adopting the multiframe perspective, ensuring that the political and symbolic leadership practices are embraced.

Another explanation may relate to the professional background of the network and hospital administrators. Seven of the administrators (47 per cent) had medical degrees and their gender was male. The medical education of these administrators would have mainly focused on the biomedical and physical sciences, to the detriment of the humanities and the social sciences, and their entry to medical school would depend on their high school matriculation score. In the last decade entrance to medical schools, especially in Australia, has changed. Prospective medical students are now required to be interviewed and do an aptitude test to determine whether they have the appropriate skills and personal qualities to study and practise medicine. Medical curriculums are also focusing more on the humanities and the social sciences plus written and verbal communication. The questions that need to be addressed are whether the professional background of the network and hospital administrators influences the way they lead, and should network and hospital administrators represent the diverse professional healthcare groups within the hospital?

Another factor that may have contributed to these findings related to the gender of the administrators - twelve (80 per cent) of the participants were male and three (20 per cent) were female. This gender imbalance within the networks and hospitals may affect the results for the literature does show that women in general tend to be more empathetic and have better communications skills (Rosener, 1990). Although these skills are essential to be an effective multiframe leader, they are more aligned with the symbolic frame and to a lesser extent the political frame. Would the results have been different if there were an equal number of males and females who participated in the study? Do networks and hospitals need to address this gender imbalance? Further research needs to be undertaken to provide answers to some of these questions.

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