The Consequences of Executive Turnover in Australian Hospitals

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Abstract

Background: The high rate of senior executive turnover in the healthcare industry is a major issue for health services planners in Australia and internationally. However, few studies have examined the causes and consequences of this phenomenon in depth.

Method: In the course of planning a research project examining nurse turnover at the clinical level within three Australian States/Territories, the researchers became aware of frequent executive turnover at all levels (State Department of Health, Area Health Service, hospital). It was found that there were 41 executives occupying 18 different positions over a period of approximately 2 years.

Discussion: Factors such as age, gender, education, lack of career advancement opportunities and remuneration have all been identified as important contributors to healthcare executive turnover. High turnover rates have been found to be associated with a number of negative consequences, including organisational instability, high financial costs, loss of human capital and adverse effects on staff morale and patient care. Whilst the use of 'acting' roles may assist in filling executive positions on a temporary basis, there are serious drawbacks associated with their extended use.

Conclusion: There are a number of steps which health services planners may take to attempt to minimise executive turnover such as providing staff members with appropriate challenges and opportunities for growth, and ensuring that a clear succession plan is in place.

Keywords

Executive turnover, healthcare executive

Introduction

In a climate where healthcare is often described as "dynamic", the frequent turnover of healthcare executives may threaten organisational stability and functioning. Whilst a number of studies have investigated staff nurse turnover (Lavoie-Tremblay et al., 2011, LeVasseur et al., 2009, O'Brien-Pallas et al., 2006, Takase, 2010), with the exception of recent publications by Havens et al. (2008), Jones et al. (2009) and Sredl & Peng (2010) and earlier work by the American Organisation for Nurse Executives (AONE) (American Organization of Nurse Executives, 2006, American Organization of Nurse Executives, 1994), few studies have explored the phenomenon of turnover of health care executives (including nurse executives) in depth (Johnstone, 2003). Instability which may result from executive turnover must be minimised. Reducing the incidence of turnover requires understanding the factors which contribute to such turnover, and instituting steps to minimise their impact. The present paper addresses this gap in the literature by using an example from the Australian public hospital context to identify the factors implicated in healthcare executive turnover. It also examines some of the consequences of this turnover, and suggests ways in which executive turnover may be minimised.

It should be noted that in the present context, the term *healthcare executive* encompasses senior roles (typically, but not exclusively, nursing roles) at State level, Area Health Service level (groups of hospitals under one administration) and organisational (hospital) level. For the purpose of this study, *turnover* is broadly defined as *any* job move. This may be due to staff members leaving the organisation (or profession), transferring to another role (either within the same organisation or to another organisation), or taking extended leave from the current position (such as annual leave, personal leave, or extended sick leave (Hayes et al., 2006).

Background

Australia has a competitive research grant scheme known as the ARC Linkage. This scheme, administered by the Australian Research Council (ARC), aims at supporting collaborative research and development projects between higher education institutions and industry partners. Proposals for funding must involve a partner organisation outside the higher education sector (Australian Research Council, 2009). The funding partner, ARC, and Chief Investigators are all required to sign contracts, accepting the conditions of the grant and detailing their obligations to each other.

The authors were awarded an ARC Linkage Grant in 2006 to undertake a study investigating the relationship between patient and nurse outcomes and staff nurse turnover. Three

Australian States acted as partner organisations, contributing both funding and in-kind support. The proposal for competitive funding was submitted on12/05/06; notification that the application was successful was received on 11/10/06; the date on which contracts were signed was 14/01/08; and the project commenced on 19/03/08 with the appointment of a project director.

Prior to the study commencing, a senior executive in each state was required to sign the contract agreeing to participate in the research. However, there is variability between States as to which executives have the authority to sign such contracts. For instance, in some States contracts can only be signed by the Director General of the State health authority, while in others the Chief Executive of the hospital or Area Health Service (several hospitals operated under one administration) is authorised to sign.

Table 1 provides an overview of the number of changes to senior healthcare executive positions leading up to the commencement of the data collection. As can be seen, there was a high rate of turnover at all levels (State Department of Health, Area Health Service, hospital). In examining these statistics, it should be noted that the average tenure and turnover of executives is not definitively known, as the figures used are based on the researchers' experience during the course of commencing this study, and may in fact *under*-represent executive turnover or be an artefact of the positions and time period.

Table 1: **Incidence of executive turnover across the three states/territories of the study.**

	State/Territory 1	**State/Territory 2**	**State/Territory 3**
State Health Department Executive	7	7	5
Area/Hospital Executive	12	16	2
Hospitals in Study	7	3	1

The change in executives at the Health Department level over approximately 18 months is most striking as there is only one health department in each State, and therefore, only a limited number of departmental executives. In two States, the changes related to restructuring of portfolios following State elections and changes in government. In one State alone the researchers interacted with six individuals in the State's Chief Nurse position within a three year period. Three of these individuals were in an 'acting' capacity, arising from a need for temporary replacement following job transfers, resignations, extended leave, and secondment opportunities.

At an Area Health Service level, the researchers encountered 16 individuals within seven executive positions over a period of approximately 24 months. This equated to an average of 2.2 different persons in each role, with a new incumbent approximately every six weeks. Whilst changes in roles were frequent, the same executives were commonly encountered in several different acting roles over time, and, in some instances one individual was encountered in a specific role on more than one occasion. For example, Executive A's substantive position may have been Director of Nursing (DON) at a tertiary level metropolitan hospital. They may then have moved to an executive position at State/Territory level in an acting capacity to cover for Executive B, who was on leave. Executive C may then have moved to the DON role at the metropolitan hospital from a smaller district level hospital to cover for Executive A. During which time, Nurse Manager D may have been required to 'act-up' into the executive role. After Executive B returned, Executive A may have returned to his or her substantive position for a number of months, before successfully applying for an executive position interstate following Executive E's retirement. Of note was the number of executives (3) in acting positions in this example.

For the seven senior executive positions, the researchers liaised with 11 individual nursing executives with 54 per cent (n=6) acting in the particular role at the time of their interaction with the researchers.

Literature Review

Incidence of Executive Turnover

Much literature has been published overseas on the high turnover of Chief Executive Officers (CEO) particularly in large publically traded companies based in the US (Krug and Shill, 2008). Coyne and Coyne (2007) estimate that 50% of the largest American firms will have a new CEO within 4 years, whilst Britt (2003) notes that only 28% of CEOs stay in their job for over 5 years. Whilst less research has been done on CEO and senior executive turnover in Australia, a recent study by Favoro and colleagues found that 22% of CEOs in ASX200 companies[1] left their positions in 2008 (Favaro et al., 2010). Interestingly, the study noted that the rate of CEO turnover in Australia was significantly higher than in both the US and in Europe (Favaro et al., 2010, Stafford, 2009).

[1] The ASX 200 lists the top 200 stocks by weighted market capitalisation on the Australian Securities Exchange.

A similar pattern of high turnover exists for healthcare executives, such as healthcare CEOs and Chief Nursing Executives (CNEs).[2] In early research from the 1970-1980s, Freund (1987, 1985) reported that the average tenure of CNEs over a ten year period was 3.4 years, whilst in 1993, del Bueno found that turnover of nurse executives peaked after 3-4 yrs of employment (del Bueno, 1993). In more recent studies, Jones *et al.* (2008, Jones et al., 2009) found that although 43% of U.S. CNEs have occupied their current positions for five or more years, 62% of respondents anticipated changing jobs or retiring within the next five years. Similarly, the American Organization of Nurse Executives (AONE) found 35% of the respondents reported position changes averaging once every four years (American Organization of Nurse Executives, 2006, Sredl and Peng, 2010). Most concerning is the high incidence of involuntary or pressured turnover (Havens et al., 2008). Within the healthcare sector, between 25-50% of CEO and CNE resignations are reported to be involuntary (American Organization of Nurse Executives, 2006, Havens et al., 2008, Khaliq et al., 2006, Sredl and Peng, 2010). However, 'early retirement' can be a euphemism for involuntary resignations (Gregory-Smith et al., 2009, Wiersema, 2002), and some senior executives may be unwilling to disclose the nature of their termination to researchers. Therefore, the actual figure for enforced resignations is likely to be higher than reported. In the healthcare sector, involuntary turnover of CNEs is often associated with the arrival of a new CEO. In some cases, this turnover is a result of deteriorating relationships between the incumbent CEO and the current CNEs, or the new CEO may wish to appoint managers with whom they have a prior effective working relationship (Havens et al., 2008). However, this is not always the case. Rather, some CNEs reported surprise at their enforced departure, following perceptions of a good working relationship with the CEO (Freund, 1985) and/or positive performance reviews (Havens et al., 2008).

Factors influencing turnover

Gender, age, and educational level have been identified as potential factors influencing executive turnover (Adams and Ferreira, 2009, Becker-Blease et al., 2010). The influence of *gender* on executive turnover is particularly relevant in healthcare, which is a female dominated profession. Recent Australian data has shown that males represent only around 9.4 per cent of registered and enrolled nurses (Australian Institute of Health and Welfare, 2010), whilst in the US, only 5.9% of registered nurses are males (Department of Health and Human Services: Office of Minority Health, 2009). Yet although there are significantly more

[2] It should be noted that some studies refer to Chief Nursing Executives (CNEs), whilst others refer to Chief Nursing Officers (CNOs). Despite similarities in these roles, the terminology used in the original studies has been maintained for greater clarity.

female registered nurses than male, evidence has been found to suggest a disparity in the presence of women in different healthcare executive level positions, particularly CEO positions. For instance, Borman and Biordi found that whilst 94% of CNEs were female, only 10% of hospital CEOs are women (Borman and Biordi, 1992). Additionally, Wilson and Stranahan (2000) found that female CEOs in large hospitals in the U.S. experienced higher turnover rates compared to male executives. One possible reason for this may be because female executives often have family commitments (such as caring for young children or elderly parents), and may find it difficult to balance a demanding career with personal commitments (Lavoie-Tremblay et al., 2010, McIntyre, 2010, Schluter et al., 2011). However, it is notable that other researchers have found that there are no significant differences in length of tenure or rate of turnover between male and female healthcare executives (Newhouse, 2007). Clearly, further research is needed to clarify the influence of gender on senior healthcare executive turnover.

Age is a second factor which has been identified as being an important contributor to executive turnover (Jones, 2008, Karlsson and Neilson, 2008). Age distribution of CEOs varies across countries and industries, with the average age typically between 50-55 years (Jones, 2008, Soh, 2007). Overseas evidence indicates that the mean retirement age for CEOs across all industries is 55 years (Gregory-Smith et al., 2009), which is a younger retirement age than that of the general workforce (where individuals typically cease work at 65 years of age). Whilst mean retirement age of CNEs has not been comprehensively studied, the average age of CNEs surveyed in the U.S. was 52 years, and 28% had plans to retire within five years (Jones et al., 2008, Jones et al., 2009). In Australia, the average age of 'Nurse Managers' (encompassing all levels of nursing executives) is 46 years (Australian Institute of Health and Welfare, 2009). Given that CNEs are generally experienced nurses at the pinnacle of their careers, it could be assumed that many of these Australian nurse executives are approaching retirement age, and may be considering leaving their positions.

The third factor influencing turnover is *education*. A variety of evidence has been found that suggests that educational background influences promotional prospects, particularly at an executive level (Sharabi, 2008). However, recent research by Bhagat and colleagues found that whilst education level plays an important part in the *hiring* of new CEOs, it does not play a significant role in CEO *retention* (poorly performing CEOs tend to be replaced regardless of their levels of qualifications) (Bhagat et al., 2010). In regards to healthcare executives, findings from the aged care sector have demonstrated that the educational background of DONs affects tenure (Decker and Castle, 2009). The researchers found that a higher educational background was associated with shorter length of time in the position, while lesser qualified executives were more likely to remain in their position longer. This may be

because individuals with higher educational qualifications have less difficulty in finding attractive alternative employment prospects than those with lesser qualifications. Further evidence on the importance of educational qualifications for healthcare executives comes from the 2005 Nursing Leaders Survey, which compared the qualifications of CEOs at highly performing hospitals with those of CEOs at median performing hospitals (Cejka Search, 2005). The researchers found that whilst 95% of CEOs at the top hospitals possessed a masters degree, only 81% of CEOs at median hospitals had a similar qualification. However, as the researchers note, the CEOs at the high performing hospitals also tended to have more operational experience, which may also explain their superior performance (Cejka Search, 2005).

Another factor which may have a role in executive turnover is *lack of opportunities* for advancement within the organisation. In their 2006 study of executives from over 80 different countries, Korn/Ferry found that the top reason for looking for an alternative position was lack of challenges or career growth (Korn/Ferry International, 2006, Marshall and Heffes, 2006). This factor was nominated by 33% of respondents. There is evidence to suggest that lack of advancement opportunities is an important contributing factor in healthcare executive turnover (Havens et al., 2008). In her early study of NSW nurse managers, Johnstone (2003) reported that promotion/career advancement was the factor most commonly cited by respondents to explain why they left their positions. Whilst many of the respondents moved to different positions either within the same organisation or geographic area, the probability of moving to a new role within the same organisation declined with each job change (Johnstone, 2003).This suggests that as a nurse executive proceeds higher up the management hierarchy, a point will eventually be reached where the desired promotion can only be achieved by moving *outside* the organisation. In this way, a desire for career advancement coupled with a lack of suitable opportunities within the organisation may contribute to nursing executive turnover.

The final factors to be considered when examining executive turnover are *remuneration and role responsibilities.* Research from the private sector has suggested that remuneration does not play a prominent role in voluntary turnover. For instance, Korn/Ferry International found that only 5% of executives cited inadequate remuneration as the primary reason for leaving their position (Korn/Ferry International, 2006). However, other studies have suggested that remuneration and benefits do have an important function in both executive turnover and executive performance. For instance, Balsam and colleagues found that executives who received equity compensation (in the form of stock or share options) were less likely to voluntarily leave their positions than executives who did not receive such options (Balsam and Miharjo, 2007).

In regards to the impact of remuneration on healthcare executive turnover, evidence suggests that healthcare executives may be paid more for jobs outside this industry, even though the span of control and level of responsibility is less in the alternative workplace (Workplace Relations and Management, 2008). In her review of the literature on CNO turnover, Batcheller found that one of the most commonly cited reasons for CNOs leaving their positions was increasing complexity of the role, with higher levels of responsibility, but no increase in monetary compensation (Batcheller, 2010). If healthcare executives feel that they are not receiving a wage which adequately reflects the complexity of the role and that they can receive a more generous wage in a job outside the healthcare sector, then it is not surprising that they may look for alternative employment in a different sector (Batcheller, 2010).

Consequences of Executive Turnover

The first consequence of executive turnover is the considerable *costs* associated with the resignation/dismissal of one executive and the hiring of a replacement. As Mendels notes, when a CEO leaves or is dismissed the company will usually pay him/her a generous severance package, as well as covering the costs of recruiting a new executive (Mendels, 2002). Thrall and Sinnott both estimate that the cost of replacing an executive equals around two and a half times the outgoing executive's annual salary (Sinnott, 2008, Thrall, 2008). Sinnott (2008) suggests that the cost of replacing a hospital CEO will typically be around US$500,000, whilst a more recent study by Sredl and Peng estimated that it costs an organisation around US$1.5 million to replace a CNE (Sredl and Peng, 2010). Given the large sums of money involved in recruiting new healthcare executives, frequent executive turnover may have a major impact on an organisation's financial situation.

Second, frequent executive turnover often has a *destabilising effect on organisations and staff* (Cummings and Estabrooks, 2003, Havens et al., 2008). As Cao and colleagues note, executive turnover is inevitably a disruptive event which leads to organizational instability, an increase in tensions, and deterioration of morale and productivity (Cao et al., 2006). This, in turn, may lead to increased dissatisfaction amongst employees and an increase in turnover of other staff, particularly if reorganisation is accompanied by layoffs or redundancies (Coyne and Coyne, 2007, Cummings and Estabrooks, 2003).

A number of researchers have examined the effects of executive turnover and resulting organisational instability in the healthcare sector (Khaliq et al., 2006, Wilson et al., 2000). For instance, in their study of healthcare systems in the United States, Wilson and colleagues identified a variety of functions which hospital CEOs typically perform, including planning for the future, capital and resources management, fundraising, marketing, and

making sure policy guidelines had been satisfied (Wilson et al., 2000).They noted that when a CEO leaves, these vital tasks are often either not completed, or are considerably delayed, which may have an adverse impact on the future of both the organisation and the employees (Cummings and Estabrooks, 2003, Khaliq et al., 2006, Wilson et al., 2000).

Similarly, Havens and colleagues investigated the effect of CNO turnover on staff satisfaction by interviewing 21 US-based CNOs (Havens et al., 2008). The interviewees reported that turnover “creates staff unrest” (p. 521) and uncertainty, as well as a lack of consistent leadership. Additionally, respondents commented that high rates of senior executive turnover lead to fear and uncertainty in the ranks of other staff members. The other staff members may find it difficult to adapt to a new executive’s management style (particularly if this is very different from the former executive’s approach) and may also be concerned about the stability of their own positions (Havens et al., 2008). Importantly, the interviewees in Havens and co-workers’ study also reported negative impacts on the quality of patient care as a consequence of executive turnover. For instance, one respondent commented that when a senior executive leaves, “systems start to fall apart and care erodes” (p. 521).

Further, a study by Jones and colleagues (2009) found that 36% of Nurse Managers, clinicians and staff nurses felt that nursing had lost an important advocate with the departure of the CNO. Nonetheless, it is important to note that 41% of those surveyed *did not* perceive CNO resignation(s) to negatively impact on nursing care, staff satisfaction or productivity (Jones et al., 2009). Although this finding may initially seem surprising, it is important to note that both clinicians and frontline nursing staff tend to have minimal contact with CNOs. For instance, as Jones notes, most staff nurses (70%) do not report directly to the CNO, but instead report to a nurse manager or director. Similarly, clinicians may have little interaction with CNOs in the course of their clinical roles. As such, the resignation of the CNO may have only a limited impact on frontline nursing and medical staff (Jones et al., 2009). However, a more recent Australian study by Duffield and colleagues found evidence to suggest that clinical nurse leaders *do* have an important impact on staff retention and satisfaction (Duffield et al., 2011). More precisely, they found that wards in which the Nursing Unit Manager (NUM) was perceived to be a good leader, was visible, consulted with staff, provided praise and recognition for a job well done, and where flexible work schedules were available tended to be rated more positively by staff nurses than wards in which the NUM did not possess these leadership traits (Duffield et al., 2011). Clearly, further research is needed to better understand the impact of executive turnover on both nursing staff and patient outcomes.

A further consequence of executive turnover is *loss of human capital* (Rondeau et al., 2009). Human capital theory suggests that the skills, abilities and knowledge which individual employees possess make up an organisation's human capital, and contribute to the organisation's productivity (Rondeau et al., 2009). When an employee leaves the organisation, their individual human capital is lost. Senior executives typically have considerable experience in their field, so the amount of human capital which is lost following their departure is considerable (Lahaie, 2005). Additionally, the departure of the CEO is often followed by the departure of other key executives, leading to further human capital being lost. This loss is exacerbated by the fact that new appointees rarely liaise with their predecessor for background knowledge and advice (Friel and Duboff, 2009). Whilst these effects can be mitigated by promoting a replacement executive from within the same organisation, it is often the case that a suitable replacement executive cannot be found internally (Zhang and Rajagopalan, 2010).

A final consequence of executive turnover and the difficulty in finding a suitable replacement, is the use of *"acting" roles* or secondment opportunities to fill the position until a permanent appointment is made (Ballinger and Marcel, 2010). As a number of authors have noted, many firms do not have succession plans in place for when their executives depart (Financial Executive, 2010, Heidrick & Struggles and Rock Center for Corporate Governance Stanford University, 2010). Consequently, there is often a lengthy delay between the departure of the previous executive and the commencement of the replacement (Heidrick & Struggles and Rock Center for Corporate Governance Stanford University, 2010).

Inadequate succession planning and difficulties in finding a replacement CEO are also common in the healthcare sector (Thrall, 2008). For instance, in their study of US hospitals, Khaliq and colleagues (2006) found that there was often a delay between the previous CEO leaving and a replacement being appointed. Just over 40% of vacancies were filled in less than 3 months, whilst another 27% were filled in 3-6 months. However, 25% of hospitals took between 6 months and a year to replace their CEO, and another 5% took over a year (Khaliq et al., 2006). Additionally, due to a smaller talent pool, healthcare organisations are facing increasing difficulty in locating suitably qualified candidates. Thrall reports that the average time taken to recruit a new healthcare executive is around six months, and that in the last few years, the number of quality candidates applying for positions has halved (Thrall, 2008).

Appointing an employee in an "acting" capacity may be a useful short-term measure whilst the company looks for a permanent replacement executive (Ondercin, 2009, Quinton and Stern, 2010). As the current study found, the appointment of executives to "acting" positions is a common phenomenon in the Australian public hospital system. For example, within a two year period the researchers encountered 41 individuals working within 18 different nurse

executive positions across the three States/Territories. The surprising finding was that 19 of these 41 individuals (46.34%) were in an acting capacity.

Nonetheless, there are a number of drawbacks associated with the extended use of interim or temporary positions (Ballinger and Marcel, 2010). First, the departure of the incumbent executive and appointment of an employee into an "acting" role may lead to a domino effect of "acting positions" (Anonymous, 2006, Anonymous, 2007). For instance, if the incumbent healthcare CNE departs, another nurse executive may "act" in their position requiring the nursing unit manager (first-line nurse manager) to "act up" who in turn is replaced by a senior registered nurse on the ward, creating a vacancy on the clinical unit. These multiple acting appointments may lead to considerable instability within the organisation as the appointees attempt to master their new, acting role (Ondercin, 2009). More importantly, it is the clinical unit in this example which has lost a staff member (a nurse). The position is likely to be replaced by a nurse from the hospital pool or external agency. In either case the nurse is unlikely to be known to the staff on the clinical unit, and be less familiar with patients (Duffield et al., 2009). This phenomenon of high turnover and a reliance on casual or temporary staff is called "staff churn", and has been found to be associated with a number of negative staff and patient outcomes (Duffield et al., 2009). For instance, the presence of new staff who are unfamiliar with the ward and patients tends to increase the workload of the NUM and other employees, who may be required to assist in training and supervision. Working relationships may also be eroded, with turnover rates subsequently increasing (Duffield et al., 2009, Kalisch et al., 2008). Further, the lack of continuity of staffing may lead to a lack of continuity of patient care (Cabana and Jee, 2004, Duffield et al., 2009), which is concerning, as continuity of care has been found to be associated with increased patient satisfaction (Beattie et al., 2005) and decreased mortality (Estabrooks et al., 2005).

Conclusions

Given the high rates of health executive turnover and the negative consequences associated with such staff changes, it is vital that health service planners take active steps to reduce the number of senior executives departing their positions (Jones et al., 2009). There are a number of ways in which this may be done. First, executive roles are typically not "family friendly" (in terms of the hours worked, and the lack of part-time positions), which may make such positions untenable for individuals with family or caring commitments (Adams, 2009, Becker-Blease et al., 2010, Blanton, 2005). This is particularly important in the healthcare sector, which has a large percentage of female employees. One way of addressing this issue may be for organisations to consider part-time or job share executive roles, or allow for more flexible working hours (Guillaume and Pochic, 2009, Pitt-Catsouphes et al., 2004).

Such policies may allow executives to better achieve an appropriate balance between work and family, and help reduce turnover (Batcheller, 2010).

Second, as Korn/Ferry note, lack of opportunities for advancement is the most commonly cited reason for executives leaving their roles (Korn/Ferry International, 2006). Hence, another way in which healthcare organisations may be able to minimise executive turnover is by ensuring that their executives are provided with sufficient challenges and opportunities for career growth (Hausknecht et al., 2009). For instance, if a hospital is part of a larger health service grouping, it may be possible for executives at smaller hospitals to undertake a short-term secondment at the larger hospitals. This may assist them in furthering their professional development, and may provide them with new ideas which they can introduce at their hospital (Burley, 2004, Kedward and Jones, 2008).

Additionally, if a healthcare executive is in a role in an “acting” capacity, particularly for an extended period of time, it may be beneficial for the employer to allow the interim executive to assume most of the responsibilities of the role, rather than restricting them to a “caretaking” capacity. This will help to ensure that important works are not delayed, and may also enable the acting executive to clearly demonstrate their ability to do the job (Ballinger and Marcel, 2010). Healthcare organisations should also try to ensure that they can offer competitive remuneration packages for executives, in order to prevent them moving into other industries which provide better financial rewards for their work (Batcheller, 2010).

Finally, it is inevitable that even if these policies are put in place, there will still be some degree of healthcare executive turnover, particularly with many executives nearing retirement age (Citrin and Ogden, 2010). Additionally, once an executive has reached a high position in an organisation, there may be no further opportunities within the organisation, meaning that the executive is forced to consider leaving if they wish to progress in their career (Johnstone, 2003, Korn/Ferry International, 2006). Hence, it is important that health care organisations have clear succession plans in place to enable a smooth transition, and minimise disruption, should the incumbent executive depart (Coyne and Coyne, 2007).

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