ARKADIUSZ PIETRAS

5 *Dual Social Roles of Clinical Directors – International Perspective and Example of Lublin District Hospital*

Opiekun naukowy: dr Izabela Koładkiewicz

Arkadiusz Pietras – student MSc International Business and Management – specjalność Strategic Management Akademii Leona Koźmińskiego, absolwent University of Bedfordshire na kierunku BA (hons) Business Studies, w 2011 r. otrzymał wyróżnienie dyrektora departamentu rozwoju muzeum Łazienki Królewskie.

1. Introduction

The analysis of trends in medical care had shown a paradox that due to more specialised and scientific medical training as well as development of new extremely expensive, but life-saving, medical procedures and technology resulted in problems for most developed countries in founding their health care systems. Thus, as a method of cost reductions, additional duties have been put on doctors occupying senior positions within hospital structures which in nature are more connected with management and leadership rather than medicine can cause internal conflicts for those doctors in the senior roles.

The purpose of this paper is to establish if the trend of growing importance of the managerial role that has been mentioned in literature, which relates to the dual social role of doctors within healthcare structures and is common to the health sector all around the world, has been introduced to the Polish healthcare system. It is important to notice the fact that in developed countries such as Denmark, England and US, after the necessary reforms of health system, more senior doctors have decided to undertake the role of manager and dedicate not only on patient treatments but also with business side of running a hospital (Kirkpatric et al. 2009). In case of Poland, despite the fact that several reforms have already been implemented the managerial aspect of doctors being involved in management and consequences of such involvement remains largely untouched. Therefore, growth in importance of managerial role of doctors from Lublin District Hospital (LDH) is the main hypothesis of this dissertation.

In order to test this hypothesis a research in the Lublin District Hospital which would include interviews and discussion with heads of department have been conducted. Due to explanatory nature of the subject of this paper a qualitative approach had to be implemented which forces specific research methods.

2. Literature review

2.1. Social dual role of clinical directors

Important aspect that need to be discussed before explanation of duality of social roles of hospital departments heads can start is clarification of what social role or hybrid management is and why gaining full understanding of that phenomenon is crucial for performing assign role. The social role is defined by Goffman in *The Goffman reader* (1997) as "the position, the incumbent finds that he must take on the whole array of action encompassed by the corresponding role, role implies a social determinism and a doctrine about socialisation. (...) Role, then, is the basic unit of socialisation." Further important aspect connected

with performance of the social role is role embracement which is "to disappear completely into virtual self-available in the situation, to be fully seen in terms of the image (...). To embrace a role is to be embraced by it" (Goffman 1997). Role embracement is particularly important especially in context of roles conflict where person in able to embrace one of the roles that is performing but is not able to incorporate another. Example of such roles conflict can be seen on example of heads of hospital department presented by Ervin (2009). In his work he presents a problem that concerns head of hospital department that are being faced by organisational change. Those people were excellent in role of medical expert but for them roles of doctors and managers were conflicting and therefore they were not able to perform their duties well.

2.2. Hybrid management implementation

To begin with, an example of UK's National Health System (NHS) will be presented to show how dual or hybrid roles have been implemented into senior doctors. It will be followed by presentation of Kaiser Permanente program which has been developed in US and also involves implementation of second role to senior doctors. Finally, as a last example a successful scheme from Danish health care system will be presented.

In the UK, the Griffiths Report published in 1983 is a landmark in engaging doctors into management and leadership roles. Before that publication there were no clear division of roles within hospital with doctors enjoying much of the freedom from politicians and managers who's role was limited to providing facilities and equipment for medical staff so they can carry on with their duties. With the financial problems of the 1980's in the UK the report has initiate a process of reform of the NHS which included introduction of professional management into hospitals as a form of ensuring effective leadership and clear responsibilities for decision making process. The report also included the need for medical professionals to incorporate leadership and managerial roles to be able to cooperate and support general managers. (Griffiths 1983). As an outcome of that report, most NHS hospitals begun a process of introduction of role of clinical director who as a head of department would combine management, leader and reduced clinical roles. The clinical director, together with business director and nurse manager would create a team called triumvirate which should be responsible for department operations and also serve advisory role to the hospital board and the CEO (Ham and Dickinson 2008). In order to be able to achieve such power structure a big cultural change needed to be implemented. That is why a professional bureaucracy have been introduced into hospitals. The

professional bureaucracy unlike machine bureaucracy can be characterise by inverted power structure which puts front line staff (Minzberg 1979), doctors in case of hospital structure, in a position where they can have a control over the content of work as they obtained specialised training and knowledge. There are, however few consequences of such power structure connected with control over workers and with leadership skills of professionals being in charge of departments (Ham and Dickinson 2008). Control in such type of bureaucracy can be achieved by horizontal process in which professionals through themselves and collegial influences should be able to achieve coordination of work, the development of so called professional networks in organisations is also an important aspect of control in professional bureaucracy. There are also three implications for leaders in that bureaucracy. First of all, professionals, doctors in that case, need to play a key role in formal and informal roles of leaders. Secondly, professional bureaucracies are characterised by dispersed or disturbed leadership which means that in medical care organisation there is a need for many focused leaders with medical background at different hierarchy levels. Lastly, NHS research (Hamilton et al. 2008) shows that collaborative approach to leadership is vital to show importance of team working but at the board level also to be able to coordinate major change programs that might be required. In practice, however; the implementation of such bureaucracy and management system shows that it brings different results into performance of hospitals in UK. The main reason for that is the fact that within one hospital many sub-cultures can be found which might not cooperate with each other and with clinical directors. Moreover, the study by McKee et al. (1999) shows that clinical directors display different types of construction and conduction of their directorship. The most commonly found type has been classified as traditionalist which can be characterised by focus on operational issues and limited on innovation and change which is not desired and can be the source of problems in hospital performance. The other styles which has been identified as a source of success in establishing professional bureaucracy in hospitals are described as „managerialist", which is defined by business-like approach to directorship and power-sharing, which involves working across hierarchy levels and bringing co-workers into efficient teams. In addition, the other source of problems with mentioned system implementation can be the fact that most senior doctors had little training in management and leadership in their universities and also that hospitals are not providing any additional incentives for those senior doctors who would like to get involved into directorial positions.

To continue further analysis of examples of health care systems that are implementing doctors involvement into managerial positions a case of the US, Kaiser-Permanente model of health care services delivery. The Kaiser-

Permanente program is an outcome of collaboration of two organisations, the non-for-profit Kaiser Foundation Health Plan and the Permanente Medical Groups. The origin of the program can be traced back to late 1930s when Henry J. Kaiser have been contracted by the US government for some construction work and discovered that his workers have not been covered by any health plan (Campen 2002). At present time Kaiser Permanente is the largest US non-for-profit integrated health care delivery system. This system is integrated as it combines not only 32 hospitals and physicians but also pharmacies as well as preventive care for more than 8.5 million members in 8 geographic regions (Della Penna et al. 2009). Such long cooperation between those two organisations have created a health delivery system and a corporate culture that is based on strong cooperation of highly specialised networks of doctors where peer responsibility for performance is strongly emphasise; therefore doctors are strongly encourage to commit to patient treatment and to involve their colleagues in reviews of treatment and their performance. In addition, the strong incentives, not only financial but also in chances for personal development have caused that many senior doctors decided to take leadership and management positions in medical groups which in fact are self-managed guilds that under contract of the health plan are responsible for preparation and implementation of medical care programs. Example of such cooperation have been presented in Della Penna et al. (2009) research paper in which authors present how innovative ideas can quickly be implemented into all Kaiser-Permanente hospitals regarding palliative patient care. Their research shows that due to a robust network of specialists and process of knowledge exchange between medical groups a complex but needed change could be implemented in a very efficient way that ultimately supports patients treatment.

Finally, example of the Danish model of implementing dual role on senior doctors will be presented. Similarly to beginning of the UK's NHS reform a process of implementation of management role into doctors have started in 1984 with publication by Interior Ministry of so called the white paper, which include recommendation of a need to introduce new models of hospital management. This have led to introduction of a management body called troika that includes joint management of a general manager, a doctor and a nurse at the hospital level and a doctor and nurse at clinical level (Kirkpatrick et al. 2009). Through the years that model have evolved with emphasise to pass most power to a single general manager possibly with medical background especially on medical levels. Such gradual evolution of the management system caused senior doctors to more willingly take part in management team and also caused medical association to include management subjects on to medical university programs to prepare

students for their future roles. In addition such large change in cultural paradigm in gradual implementation have been widely accepted by Danish doctors which is in contrast to UK's NHS where senior doctors struggled to accept managerial role. The table 1, presented below show differences in structure of management and doctors engagement in Denmark and England.

Table 1. Medicine and management: comparing Denmark and England

	Denmark	**England**
Structures		
Specialist general (or lay) managers	– Limited below hospital board level.	– General managers employed at all levels.
Medical-management roles (operational)	– Consultants act as „unitary" managers of most hospital clinics supported by nurses.	– Consultants acts as clinical directors, with management responsibilities shared with general managers.
Medical-managerial roles (executive/strategic)	– Senior consultants as members of the „Trojka" management team in all Danish hospitals and Directors in 10% of cases	– Medical Directors on all hospital trust boards in a mainly advisory capacity
Engagement		
Macro context (Peak associations)	– Medical Associations keen to assert their ownership of hospital management in competition with nurses. – Promotion of clinical leadership in undergraduate and (especially) postgraduate education.	– Professional associations initially hostile to general management and later ambivalent. – No significant changes to professional education, although recent moves in this direction.
Micro context (Doctors within organisations)	– Growing levels of commitment to management roles at board and (to a lesser extent) clinic levels	Generally weak commitment to management roles at all levels, although some exceptions

Source: Kirkpartic et al. (2009: 651).

3. Analysis of managerial role of doctors

In addition to what have been already discussed it would be useful to analyse managerial duties as heads of departments. McGuire et al. (2008) and Isosaari (2011) compares role of heads of department in NHS hospitals to line managers in other public services organisations. What authors are claiming in their work is the fact that in addition to typical roles of line managers which are connected

with control over day-to-day operations and costs of those operations, more often human resource management are also passed to line managers or in case of hospitals to heads of departments. The framework of line manager involvement in HR has been developed and consist of enablers of involvement, inhibitors of involvement, drivers of change within public sector companies and degree of change of HR processes and quality service. Enablers and inhibitors formulate most important part of that framework. Enablers consist of elements such as: close relationship with employees, greater degree of responsibility and task variation. Inhibitors of HR involvement of line managers are linked with: lack of training and support, additional workload, short-term goals more important than long-term and political pressure. Additionally, in professional bureaucracy, first line managers are at the core of the operations and they rather deal with individual subordinates rather than group of people. Thus they nature of the work is focused on short-time performance of the department.

Another interesting aspect of hybrid or clinical management have been identified by Kippist and Fitzgerald (2009), and Mo (2008) who assessed the outcome of the reforms implementation mentioned in the previous part. What the authors have discovered during their research is a fact that hybrid managers can face a conflict in roles they need to perform. The main aspect of the managerial role of clinicians can be identified as focus on cost reduction as well as improvement on organisational efficiencies, which clearly can be in conflict with performing their clinical duties, not only on bases of time needed to perform those roles but also on decision taking regarding costly treatments. Furthermore, it has been identified by those authors that introduction of dual roles of head of departments and the powers that they have been handled to them can cause conflicts between the head and subordinates. Such effect is an outcome of the fact that doctors in hybrid position need to reduce their clinical duties and focus more on managerial ones which by their colleagues can be seen as a loss of the insider position. Moreover, Kippist and Fitzgerald (2009) have been able to identify barriers to the effective hybrid role implementation and those are: lack of management education, short time for clinicians to adapt to new role and most importantly lack of interest and incentives for taking managerial roles.

To sum up this part of the review, full clinical knowledge for doctors, nowadays, is a base line for further development as they want to progress in hospital hierarchy ranks they need to learn how complex health systems are operated and gain personal skills of being a leader.

4. Methodology

4.1. Identified research gaps and research questions

The research gaps that the author was able to identify are connected with adoption process of the dual role by senior doctors in Lublin district. Thus, to remind, the growth in importance of managerial role of doctors from Lublin District Hospital (LDH) is the main hypothesis of this paper. Therefore research questions were:

- Can doctors in LDH senior positions fell growth of importance of their management and leadership roles?
- How senior doctors in Lublin District Hospital (LDH) in managerial positions are dealing with duality of their roles?

4.2. Description of philosophy applied into research and intended research techniques

Taking under consideration the explanatory nature of the topic and research questions being ask in this paper, the interpretivism approach to research philosophy was used. It was due to the fact that research is focused on explanation of social roles as well as interactions and differences of heads of departments as social actors in a complex environment (Saunders et al. 2009). Such approach to research philosophy brought connections to certain research strategies and data collection techniques which would allow to observe above mention factors. For purpose of that research a single qualitative approach was used which will allow investigation into particular contemporary phenomenon within its real life context (Saunders et al. 2009). Due to the strict time limits the research would also had to fall into cross-sectional study, which would allow to observe certain phenomenon at a particular time rather than on wider time frame. As access to the Lublin district had been granted by the CEO of the hospital, the decision had been made to use non-standardised, semi-structure, face to face interviews with the CEO of the hospital as well as with heads of medical departments within that hospital as well as short period of observation to determine aspects that interviewees might not be aware. Questions used during the interviews have been adapted from the survey used by the NHS in report on doctors engaging in leadership by Ham and Dickinson (2008) (see appendixes) in order to widen the scope of research conducted by those authors by Polish health care system. The report includes results of interviews conducted in different European and Commonwealth countries, thus cooperation of answers from doctors form Lublin District Hospital (LDH) with those included in the report was possible, thus it

should be pointed out that those results can only be generalised for population of clinical directors who had participated in the study. In addition to those questions I was able to engage doctors into a discussion on matters like: conflict of roles, preparation process of becoming head of departments, problems in implementation of managerial roles, differences between being a leader and manager, and about management system that is currently used in the hospital.

4.3. Limitations

There are certain limitations of the study that should be considered. One of the most important is the fact that study have been based on a single case study, thus results and conclusions may not apply to other hospitals, for example of different ownership structure. Furthermore, as it has been pointed out the CEO and the medical director of the LDH and their opinions on the subjects could have altered the overall results of the study by providing additional information on management system structure. There are also constraints connected with short period of time in which the research have been conducted as in longer period similar study could be conducted on a wider scale of for example major hospitals in Lublin.

5. Presentation of research results

5.1. Results of the study

The CEO of the LDH had granted the access to the hospital and the study have been conducted between 28th of November 2011 and 16th of December 2011. In the first phase of the study the information about the study being conducted in the hospital have been presented to all head of departments and also dates of interviews had been agreed with those heads of departments who decided to take part in the study. In total the author had conducted interviews with 15 out of 19 heads of departments in the LDH. Unfortunately due to presented in previous chapter background information regarding re-organisation of the LDH both the CEO and medical director could not participate in the study. In the second phase of the study, heads of departments have been asked a series of questions as used by Ham and Dickinson (2008) in their study for the NHS as well as have been encouraged to take part in the short discussion on five board subjects mentioned in methodology chapter.

To begin with a small overview on participants will be presented. It can only contain limited amount of data as interviewers had been promised to have their identity keep as a secret, thus information that would allow further analysis have

to be limited to type of department and range of years that given respondent have occupied in a position of the head of department (see appendixes, table 2).

Generally in all hospitals there are two types of departments. Surgical departments can be defined as those where surgical procedures on different types of the body are performed, whereas diagnostic departments can defined as those where patients are treated on bases of their symptoms without need to perform surgeries. The range of time, on the other hand, that is spent by a doctor in a position of head of department in LDH depends on outcome of the selection process which is performed by commission created by the CEO for purpose of selecting a head of department. Typically, a head of department is selected for a five years term. Thus participants have been divide in categories of: less than five years, five to ten years, ten to fifteen years, and finally over fifteen years in a position of the head of the department. In the group of heads of department who decided to participate in the study there have been ten heads from surgical departments and five from diagnostic departments. Majority of participants serves in their position more than fifteen years or form ten to fifteen years, five participants form each group. Three of participating clinical directors serves from five to ten years and only two of them is in this position for less than five years.

To continue with presentation of the results based on discussions with clinical directors. The most important and interesting parts of the discussions have been but in a tables to allow quick comparisment of responses from participating directors. Each table represents a different subject (see appendixes, tables 3–7).

6. Analysis

To reflect on previously presented research results the analysis should begin with the first area of discussion which was the conflict of roles (see appendixes, table 3), from the responses given by clinical directs of the LDH it can be generalised that they do fell a conflict between their managerial/leadership role and being a doctor. The most important part of that conflict for them have been aspect of being responsible for financial performance of their department as well as cost reduction and in the same time trying to provide their best services to as much patients as needed. Furthermore, heads of departments have also indicated that performing managerial duties have become very time consuming for them so there is not enough time for them to look after their patients. However, there have also been a few of clinical directors who claimed that they do not see or feel conflicts in those roles as they are only focused with wellbeing of the patients. Such differences can be outcome of differences between characteristics of surgical and diagnostics departments or it can be a result of managerial role rejection. Aspects

connected with embracement of social roles (Goffman 1997) have been discussed and such situation as presented above connected with conflict of roles and roles rejection is clearly connected with fact that heads of department have failed to embrace their role in such way to avoid the conflict. This may be an outcome of lack of training or competency model which have already been mentioned or a nationwide program, like those used in Denmark or Kaiser Permanente program in US, which engages doctors in leadership and managerial activities. This problem of conflict of roles for the LDH clinical directors may become a wider issue as all questioned directors indicated that they see a growing trend or more managerial duties being pasted to them. This trend has been confirmed as during the course of interviews one of the participant have been kind enough to present his current job description alongside ones provided for him in earlier stages of his employment as a head in one of the diagnostic department. The job description is clearly divided to so called management and economic duties which also involves some leadership aspects, and duties connected with patient treatment. What have been really interesting is the fact that number of economic duties at the time of the interview was almost twice as big, number wise, as those connected to patient care. In addition to that, comparing current and previous description, the participant have been able to point out at least two new duties being add to the management and economic part, whereas the patient care section have remained unchanged.

Moving further to analysis of second aspect of discussion which was preparation to becoming head of departments (see appendixes, tables 4). Most of heads of department took some training, if any, after they become selected for that position, others managed to do two specialisation and one of them was public health management, while others were just relying on their experience as being assistant to previous clinical director of their department. One of the most important outcome of discussion on that matter is the fact that to become a head of department, doctors do not have to take any courses, so their promotion is clearly based on their success on medical field rather than on knowledge form managerial or leadership subjects which could mean they would not be able to perform well on their positions. As it have been mentioned, such state of matters can be attributed to lack of pressure and synchronisation of demands toward doctors and their training from governing bodies which creates and implement healthcare policy development in Poland after 1999 (Watson 2006; 2011).

Continuing the discussion to the next point which is quite connected with previous two points and it is problems in implementation of managerial roles by clinical directors (see appendixes, tables 5). It is connected to two previous areas as conflict of roles and lack of training in management or leadership should

cause problems at the beginning of doctors carrier as head of department. During the discussion there were doctors who confirmed that have struggle at the beginning with proper financial control, reporting and usage of managerial tools, but surprisingly, there have also been a group of doctors who have indicated that they managed to start their careers without a problem despite not being involved with any additional courses. They also claim that what have helped them was the fact that they had been working with their predecessors as their assistants so they had enough time to learn who to the job by just observing. In such situation it may be an example of good leadership skills of previous head of a department, who was able to use one of the participative leadership styles, like for example, democratic (consultative or participative) or laissez-fair (Lewin et al. 1939). There is also a possibility that through using consultative and participative systems (Likert 1979) he or she was able to get doctors involved so they will be able to step up in the future and take managerial positions.

The next subject that have been discussed with clinical directors was difference between being a leader and manager (see appendixes, tables 6). Such subject have been put in the interviews to check if participants could differentiate between those two roles because as theory suggests they ought to be treated separately. As predicted there is a mixture of answers to that. What should be also pointed out hire is the fact that word "leadership" is difficult to translate to Polish language thus it is difficult to judge if participants had a same understanding for that area of discussion. There were only few participants who had been trained abroad and know exact meaning of that phrase. One of possible conclusion is that doctors who differentiate from being a manager and a leader are consciously able to implement one of the style or system that suits them best and as it have been mentioned also suits type of department they operate, whereas others try to perform what they think is right. What is more, it can be generalized that doctors with any kind of previous training are more likely to differentiate those two roles than those without training. What is also important and have been observed the prefer leadership style for surgical departments is close to autocratic or directive approach as they to prefer to perform most difficult operations on their own, while on diagnostic departments clinical directors presented styles connected with collaborative approach and evolved subordinates in diagnoses and treatment process.

The final part of discussions have been focused on management system currently being used at the LDH and if that system helps managerial role implementation to the clinical directors (see appendixes, tables 7). Looking at the responses given by participants of the study it seems that most of them agree that currently used management system of the hospital is a failure and also one of the

cause of high debt of the organisation. The most important aspect is the fact that there is a poor communication between administrative and clinical departments. Many heads of departments participating in the study pointed out that people working in the administrative departments are not connected with medicine in any way so they do not know the procedures and the real costs of those procedures. Second problem of the management system is the fact it is an example on pure bureaucracy, which structure is complicated and limits clinical director abilities to introduce necessary changes to run their departments in a more efficient way, thus not helping at all in implementing the managerial role. Thirdly, at the time the research have been conducted, there were no decisions support system in placed on none of management level which would allow gathered the results for departments and compare them with each other; however, some initial steps have been taken to introduce a similar model to tactic, operational and strategic model (Winter et al. 2001) which in a first stage of installation would support operational level of the organisation and allow heads of departments to compare their financial results for department operations. This is surly a positive move but to strengthen it the governing body of the LDH should consider implementation of some aspects of professional bureaucracy as described by Minzberg (1979) in which clinical directors would have more power over decision making regarding their department such as staffing for example.

To continue the discussion of the results of this study presented in the previous paragraphs the analysis of comparisment of approaches to leadership and management in healthcare services presented in work by Ham and Dickinson (2008) will take place in order to put results gained from discussions with clinical directors into perspective as how preparation and education can influence the ability of clinical directors to embrace the additional role.

Question one asked how personnel with medical background is involved into managerial and leadership structure. In case of Poland, participants of the study indicated that matters are quite similar as in countries where study have been conducted. The CEO position in publicly owned hospitals is performed only by professional managers without medical background thus they must rely on opinion on medical director who by law must derive from medical society. Such situation creates opportunity for doctors to take formal leadership and management position. Situation is quite different when it comes to academic and private hospitals. Respondents indicated that hospitals owned by medical universities are typically run by senior doctors, whereas in privately owned hospitals there have been a trend noticed for doctors to step up in to CEO position. Doctors in Poland have also opportunity to take positions of clinical directors as by law person on this position need to have medical education.

Continuing with analysis of answers to question 2 which asks if is it an explicit aim of health care policy to increase the involvement of doctors in management and leadership roles. To remind results of that question as there were a whole variety of answers; however most of them seems to indicate that there is no such explicit aim. Only counties like UK, Denmark and Germany, which in fact, history of health care reform is very similar, tries to implicitly implement doctors engagement into management and leadership structures into their healthcare policy development process. During interviews, respondents have indicated that to their best knowledge there is no such aim in Polish healthcare policy.

Questions 3 to 5 were looking at educational systems at medical universities to establish at what level and if any managerial knowledge is passed to students. It has been established that UK and Denmark are the most consistent countries to provide at least some leadership and management courses as early as on undergraduate level; however not in a formal way. Formal courses starts had been introduced both on postgraduate level and at the registration although in most of presented cases those courses are not obligatory. In Poland, as pointed out by participants of the study, their experience is that first contact, if any, with such courses took place years after registration where they have been preparing to take clinical director position and to their knowledge nothing had changed since they have graduated and registered as doctors.

When it comes to analysis of question 6 which aimed to establish whether training after registration is provided on national bases it can be seen that only Denmark, Germany and Australia are countries in which managerial or leadership training is provided on a national bases which, as it was mentioned, assures high level and quality as well as same or very similar content of those trainings, thus results of doctors participating can be easily compared. Heads of departments who participated in the study indicated that after registration training in subjects of management and leadership is left to the will of doctors. Those courses are being organised by local medical universities and the content is set by those universities vary across country. In addition to that participating doctors must pay from their personal funds.

The analysis of the last question, which asked if there is a national competency framework for management and leadership competencies present shows that UK and Denmark, but also Netherlands are countries in which such framework is present. This shows that healthcare policy developers in those countries are consequent in their approach to engage doctors in to management and leadership position by providing them with a guidelines to follow which combined with their previous training should make the step up and future work in such position much more easier for them. In Poland, on the other hand, joins the group of countries

where such framework is absent and heads of department or medical directors on hospital board need to rely on their own knowledge and experience

Comparing Poland to other countries a conclusion of certain consequences can be assumed when it comes to obligatory training of doctors from the early years of medical association. Example of Denmark shows that even without forcing undergraduate students into managerial and leadership courses and focusing on medical subject only they are able to coordinate education of students on further levels so they are prepared to take managerial and leadership duties later in their careers it also gives them opportunity to understand why those aspects are important for overall performance of the healthcare system. Referring again to results of Poland in presented tables an interesting aspect is the fact that the development of Polish healthcare reform after 1999 which falls into category of sociological institutionalism as it is largely being based of the UK's NHS model of healthcare when it comes to financing models and general governance and management models; however it completely does not follow the idea of compulsory training doctors in subjects like management and leadership or ideas of a national competency framework. Majority of training is left to will of doctors. Such situation is difficult to understand as later on, positions of medical director or head of department can only be performed by person with medical background who may be not prepared to do so.

7. Conclusions

Drawing conclusions from results and discussion on the presented state of the literature as well as from the study in previous chapter, there is enough information to answer research questions stated earlier in the text and confirm the hypothesis.

Moving forward to the first research question which asked if doctors in LDH senior positions fell growth of importance of their management and leadership roles. Quotes from the interviews points out that clinical directors in the LDH can especially feel importance of their managerial duties connected with administration of their departments. Those duties, as said by heads of departments, are more and more often connected with financial performance and implementation of cost saving activities as at present time hospital is heavily in debt and both the management of the hospital as well as governing body cannot afford for that debt to be increased any further. The problem is such situation is that most of the clinical directors, as people who have limited managerial knowledge in result of short or even non training, and little actual managerial power over their departments can only reduce costs by not exciding number of in-patients as

well as clinic patients which have been stated in the contract with the National Health Found (NFZ). This is due to the fact that treatments of patients over certain limit stared in this contract will not be paid for, and therefore will further increase debt of the LDH. What also have been pointed out by participants is the fact that despite the new managerial duties being put in their job description they still do not have control over basic aspects of the department operations like staffing or ordering. Therefore the outcome of the analysis of the current management system used in a hospital indicated that it is very bureaucratic and centralised. The main issue pointed out was the fact that people who deals with administrative aspects of hospital fails to communicate with clinical directors on what are the actual costs of procedures they perform or to come to decision on which procedures to perform the most to bring profits for the hospital.

The second research question asked how senior doctors in the LDH in managerial positions are dealing with duality of their roles. The answer to this question have been strongly influenced by the situation described when answering for the first research question as reasons mentioned above and also will to help people have cause a conflict between managerial role and doctors role for most of participants of this study. Furthermore, when combining answers of head of departments with type of department they represent it seems that heads of surgical departments finds it more difficult to combine those roles than heads of diagnostic departments as time needed to perform additional duties limits their opportunity to operate on more patients and increase revenues of department. Some other reasons are connected with mentioned financial constrains but examples of other European countries with long history of doctors engagement in management shows that there is a way to combine those two roles without causing a conflict. Examples of UK, and especial Denmark shows that for doctors to successfully embrace the managerial and leadership role education in those subjects needs to start being as early as possible. There also need to be a clear intent and will from people delivering the healthcare policy to change the law in that way that doctors who would be trained by medical universities or association could actually have power over most of aspects connected with their departments. Current situation in the LDH shows that despite healthcare reform of 1999 have been based on UK model of the NHS some aspects of the NHS reform involving doctors participation have been omitted when implemented in Poland. Thus it is possible that conflict of roles for heads of departments will grow as number of their managerial roles increases.

8. Appendixes

List of questions used in Ham and Dickinson (2008) study and applied for the purpose of this study:

1. How are physicians involved in management and leadership role in hospitals?
   a. Are hospital CEO usually from medical background
   b. Do hospitals have medical directors who sit on the board?
   c. Do physicians have leadership roles within hospitals?
2. Is it an explicit aim of health care policy to increase the involvement of doctors in management and leadership roles?
3. At the undergraduate level, what training and preparation do physicians receive for leadership roles? What is the content of this training? Who provides it? Is competence assessed and if so how?
4. At the postgraduate level, what training and preparation do physicians receive for leadership roles? What is the content of this training? Who provides it? Is competence assessed and if so how?
5. What training and development in leadership do physicians receive after registration? What is the content of this training? Who provides it? Is competence assessed and if so how?
6. After registration, is training provided on a national basis or is it left to individual hospitals and primary care organisations?
7. Does a national competency framework exist for medical management and leadership and competency?

Table 2. Presentation of respondents

Respondent 1 • Type of department: surgical • Years in position more than 15 years	**Respondent 6** • Type of department: diagnostic • Years in position: 10 to 15 years	**Respondent 11** • Type of department: surgical • Years in position: more than 15 years
Respondent 2 • Type of department: surgical • Years in position: less than 5 years	**Respondent 7** • Type of department: surgical • Years in position: more than 15 years	**Respondent 12** • Type of department: diagnostics • Years in position: 10 to 15 years
Respondent 3 • Type of department: surgical • Years in position: less than 5	**Respondent 8** • Type of department: surgical • Years in position: more than 15	**Respondent 13** • Type of department: surgical • Years in position: 5 to 10 years

Respondent 4 • Type of department: diagnostic • Years in position: 5 to 10 years	**Respondent 9** • Type of department: surgical • Years in position: 5 to 10 years	**Respondent 14** • Type of department: surgical • Years in position: more than 15
Respondent 5 • Type of department: surgical • Years in position: 5 to 10 years	**Respondent 10** • Type of department: diagnostic • Years in position: 5 to 10 years	**Respondent 15** • Type of department: diagnostic • Years in position 10 to 15 years

Table 3. Conflict of roles

Respondent 1	**Respondent 6**	**Respondent 11**
"Yes there is a strong conflict between managerial and doctor role especially when it comes to administrative duties connected with running the department."	*"Well of course I feel a conflict of those roles you have mentioned. First of all not only we have to cut costs where ever we can, as we are so much in debt, but what is more we can only cut cost by keeping in-patients in departments as short as it is possible, from which as a doctor I cannot be particularly happy."*	*"I do feel a conflict especially when it is connected with budgetary constraints and patient treatments."*
Respondent 2	**Respondent 7**	**Respondent 12**
"I can feel that conflict when it comes to financial issues and I have to stop submitting or operate new patients when we run out of contract with the NHF"	*"No, I do not see a conflict between doctors role and managerial role in my department. Personally I do not see how people could perform their jobs properly when they are conflicted inside themselves. Also in my opinion such conflict could indicate that person who feels that way should step down from their position as they probably do not understand that we are here primary for patients care and safety."*	*"I think such conflict may somehow depend on type of department, for me and my department I can see a conflict of those role as I cannot allow further growth of debt of the department by reducing costs for example by not purchasing new and cutting edge equipment."*

Respondent 3	**Respondent 8**	**Respondent 13**
"Well, yes, I think there is a conflict between those roles simply because as a manager we continue to receive new duties which keeps as away from being a doctors. This is particularly felt by doctors who "works with their hands" as in surgery or etc. where be keeping as away from the operating table means less money flow from the NFZ to the hospital and department. In addition administrative tasks focused on debt reduction seems to become more and more important and time consuming for us."	*"I do see a conflict between those roles as every day we have to limit our involvement in in-patient treatment to possibly cut the cost of such care. This due to the department being in debt, as most of departments are. When you become a doctor you would rather not be faced by such issues on a regular bases."*	*"There is a conflict as I find it difficult to control and reduce costs of running the department and in the same time perform necessary sometimes lifesaving treatments."*
Respondent 4	**Respondent 9**	**Respondent 14**
"There is a conflict when it comes to managing time between patient and administrative duties as well as when it comes to financing operations of our departments."	*Personally I fell a conflict between those two roles. When becoming a head of department you somehow suspend part of your doctors role in order to take on managerial problems like budgeting or financing the department etc., whereas you have been trained for many years to become a doctor and for heads of department treating patients should be a main concern."*	*"Personally I do not see a conflict between those roles. We all do what we have to do to save lives of our patients."*
Respondent 5	**Respondent 10**	**Respondent 15**
"I do not feel such conflict in my work."	*"In a sense there is a conflict as you need to give up time with patients to focus on duties connected with running the department; however I do not fell that is a major problem for me."*	*"I do personally feel a conflict between those roles as managerial role significantly reduces contact with patients and also makes you responsibly for plenty of things that are not connected with medicine but with finance most of the time"*

Table 4. Preparation to becoming head of departments

Respondent 1	**Respondent 6**	**Respondent 11**
"Only experience as a doctor."	*"I must admit that in my line of work there is so little free time I could not managed to take any additional courses. I can only relay on my personal experience."*	*"I do not have other qualifications other than medical so I think I can say that experience comes with age and years on this position. It is mostly due to lack of time that you are facing when you managed to become a head of department. I also think those positions are given on bases of achievements on fields that we as doctors medical specialisations, rather than on how well we are prepared from managerial perspective. "*
Respondent 2	**Respondent 7**	**Respondent 12**
"Only knowledge and experienced gained through years of work"	*"In fact I have managed to finish two courses one is a postgraduate course on management in health care and I also have a specialisation in protection of public health."*	*"Yes, I have participated in postgraduate course in management."*
Respondent 3	**Respondent 8**	**Respondent 13**
"Yes, I took a two semesters course organised by medical university in Lublin but from what I know it is not obligatory for head of departments to take such classes."	*"I can only relay on my experience and observations as I do not have any additional training"*	*"Yes, I have participated in postgraduate courses when I become a head of this department. I have done those courses only for that purpose so if would not become head of department I do not think I would take this course."*
Respondent 4	**Respondent 9**	**Respondent 14**
"I do not have other education than medical, but typically to become a head of department you do not need have management education but some achievements on the medical ground".	*"I was preparing to my role by doing an additional specialisation from public health protection, and also take part in plenty of internships in US and Germany where I could observe and learn from western standards."*	*"At the beginning of my career I was relaying on my experience as an assistant to previous head of department. For surgical departments and for those doctors who works with their hand it is more important to get as much practice in difficult operations rather than sitting behind the desk and performing SWOT or other analysis."*

Respondent 5	**Respondent 10**	**Respondent 15**
"I can say that my previous position as a deputy of head of department prepared me to become one eventually."	*"Only knowledge based on observation of others and experience as a doctor"*	*"In my case I took a postgraduate course of management in health care services on our local medical university. From what I know it is not necessary to do so but at least it gives you some view on what you should do as a manager on hospital department."*

Table 5. Problems in implementation of managerial roles

Respondent 1	**Respondent 6**	**Respondent 11**
"Yes, at the beginning you need to get used to incorporating new duties which takes time"	*"I did not face any problems in implementing managerial role."*	*"It was hard for me to manage without adequate knowledge but thanks to possibility of consultations with other most experienced head of departments and managers."*
Respondent 2	**Respondent 7**	**Respondent 12**
"Not that I was aware of any."	*"No problems to report."*	*"It was hard at the beginning due to lack of experience in practical application of knowledge."*
Respondent 3	**Respondent 8**	**Respondent 13**
"For me it was difficult to learn and put in practice all those managerial tools that are there to be used."	*"I had no problems in implementing managerial role to my line of work."*	*"I think I had no problems in implementing this role."*
Respondent 4	**Respondent 9**	**Respondent 14**
"Personally I did struggle at the beginning of and I think it was a consequence of lack of managerial training."	*"With such preparation I was ready to become the head of this department and had no problem with replacement of my predecessor."*	*"I had no problems in implementing both roles."*
Respondent 5	**Respondent 10**	**Respondent 15**
"Did not have any problems with implementation of managerial work, it came naturally after being the deputy for many years."	*"No problems whatsoever."*	*"Thanks to that course I had participated in I was ready to perform my duties and had no problems in implementation of the second role."*

Table 6. Difference between being a leader and manager

Respondent 1	**Respondent 6**	**Respondent 11**
"Yes there is a difference. At the beginning of my career I preferred to do most of the thing myself as I did not known may team of subordinates, but with time it changed to delegating tasks and coordinating duties so leader role become more clear to me."	*"I do not treat those roles as separate, in fact I think they are connected with each other and in that way it has been placed in my job description."*	*"My opinion in that matter is so that for a purpose of better quality of what we do those roles need to be connected and performed together so I do not differentiate them."*
Respondent 2	**Respondent 7**	**Respondent 12**
"No, I do not see the difference between those roles. In fact I think that those roles should be combined."	*"I do see a difference in management and leadership and I am trying to implement some techniques for example in conflict handling."*	*"I do think those roles should be treated as separate in order to master them both."*
Respondent 3	**Respondent 8**	**Respondent 13**
"For me there is a difference in those two roles. At the beginning it is difficult to become a leader because you do not know who to trust and what habits or rituals dose staff have. In my department I have change some things around for better so they fit around our work as I have stepped up."	*"For me there is on difference in those roles as they need to be performed together in such position. You cannot be a head of department without being a leader in that department and without some leadership skills you would never become a head of department."*	*"I do not see differences in those role. In my opinion it is the same."*
Respondent 4	**Respondent 9**	**Respondent 14**
"I do not see a difference between being a leader and manager and think those roles should be conducted together."	*"For me those roles are separate and on my position you need to be good on both and it is not easy. On my internships I had an occasion to see why leadership is so important. Unfortunately most of remaining heads of departments do not have such experience and my omit this role."*	*"In case of surgical departments I think that managerial and leadership roles are connected very strongly as me as a manager/ leader need to take important decisions. Unfortunately I am not able to operate on every single patients thus I need to trust my judgment and designated my co-workers to operate."*

Respondent 5	**Respondent 10**	**Respondent 15**
"Yes I do treat those roles as separate."	*"I do not fell those roles are separate from each other."*	*"Personally I think you can be a good manager and poor leader so I think there is a difference in those roles and when I am performing my duties I try to treat those roles separately".*

Table 7. Management system and managerial role implementation

Respondent 1	**Respondent 6**	**Respondent 11**
"The current system dose completely not support role implementation nor makes it easier for doctors. We (heads of departments) have not much to say when it comes to hospital and our departments future.	*"The system is so complicated that it is only making things worse and limits our managerial opportunities."*	*"The existing system has a long history of failure but it managed to not been changed for many years. First of all there little if any economic data available for head of departments so we cannot compare our results with other departments in hospital and within other hospitals. The overall integration and communication among governing bodies is more than poor. What makes things worse some decision systems within hospitals are centralised whereas other are decentralise which makes no sense at all."*
Respondent 2	**Respondent 7**	**Respondent 12**
"I do not know if such system helps or not as I don't have experiences of working under different management system."	*"Is there any specific management system in this hospital? You tell me. All I know is that changes in strategies and future of hospital as well as on directorial positions are happening so quick and so often it is hard to keep up with them."*	*"The system does not help in managerial role implementation, simply because it is confusing and very up to bottomed, so it limits our possibilities to change or improve something within our departments."*

Respondent 3	**Respondent 8**	**Respondent 13**
"The current system is not helping as at all, even in our departments we have limited power to introduce things that we would like to introduce, not mentioned the whole hospital. In addition, I believe that there is not enough communication between administration departments and medical departments. Also level of medical competency of people working in those departments is low so they often do not understand what exactly are doing and what kind of costs are connected with it."	*"I think the management system dose helped me in implementing managerial role. I do not mind working in hierarchy and bureaucratic systems, they are less complicated for me then all those new ones you have mentioned."*	*"As for my department I fell that the CEO have not much to say or advise me when it comes to my daily operations so in that sense I fell that we are separate from the board of directors and other departments. On the other hand, there are some managerial and financial issues the CEO and the board can be influential"*
Respondent 4	**Respondent 9**	**Respondent 14**
"Management system is not helping. We are limited to only report what we have done in the department but have no power to implement any changes."	*"The management system is "so-so". On one hand it is quite clear who is responsible for what and control over operations is quite easy. On the other there is a minimal level of communication among governing bodies and we as head of departments have minimal impact on decisions regarding our departments and hospital issues."*	*"I am not an expert on management systems so for me there isn't any in this hospital."*
Respondent 5	**Respondent 10**	**Respondent 15**
"The current system limits our involvement in hospital management and also our power to change or improve our departments."	*"The current system does not help in role implementation as it tries limits managerial role."*	*"When it comes to our medical duties we are left alone and our departments are separate from one another, but when it comes to financial and operational performance the management system is very complicated and hierarchical, loads of red tape so this is difficult for head of department to take full control of their departments."*

Bibliography

Campen D. (2002) The Bleeding Edge of Decision Making in Managed Health Care – Kaiser-Permanente's Model for Formulary Development. *Value in Health*, Vol. 5, No. 5, pp. 383–389.

Della Pena R. et al. (2009) Rapid spread of complex change: a case study in inpatient palliative care. *BMC Health Services Research*, Vol. 9, pp. 245–254.

Griffiths R. (1983) *Griffiths Report: NHS Management Inquiry*. London: Department of Health and Social Security.

Ham C., Dickinson H. (2008) *Engaging doctors in leadership: What can we learn from international experience and research evidence*. NHS Institute for Innovation and Improvement.

Hamilton P. et al. (2008) *Engaging doctors: Can doctors influence organizational performance?* NHS Institute for Innovation and Improvement.

Isosaari U. (2011) Power in health care organisations: Contemplations from the first-line management perspective. *Journal of Health Organisational and Management*, Vol. 25, No. 4, pp. 385–399.

Kippist L., Anneke F. (2009) Organisational professional conflict and hybrid clinician managers: The effect of dual roles in Australian health care organisations. *Journal of Health and Management*, Vol. 23, No. 6, pp. 642–655.

Kirkpatric I. et al. (2009) Medicine and management in a comparative perspective: the case of Denmark and England. *Sociology of health and illness*, Vol. 31, No. 5, pp. 642–658.

Lemert C., Branman A. (eds.) (1997) *The Goffman Reader*. Oxford: Blackwell Publishing Ltd.

Lewin K. et al. (1939) Patterns of aggressive behaviour in experimentally created social climats. The Journal of Social Psychology, Vol. 10, pp. 271–299. In: Linstead S., Fulop L. & Lilley S. (2009) *Management & Organisation a Critical Text*. 2nd edition. Basingstoke: Palgrave Macmillan.

Likert R. (1967) *The Human Organisation: Its management and Value*. New York: McGraw-Hill.

McGuire D. et al. (2008) The role of line managers as human resource agents in fostering organisational change in public services. *Journal of Change Management*, Vol. 8, No. 1, pp. 73–84.

McKee L., Marnoch G., Dinnie N. (1999) Medical managers: puppetmasters or puppets? Sources of power and influence in clinical directorates. In: Ham C., Dickinson H. (2008) *Engaging doctors in leadership: What can we learn from international experience and research evidence*. NHS Institute for Innovation and Improvement.

Mintzberg H. (1979) *The Structuring of Organisations: a synthesis of the research*. Englewood Cliffs, NJ: Prentice Hall.

Mo T.O. (2008) Doctors as managers: moving towards general management? *Journal of Health Organisation and Management*, Vol. 22, No. 4, pp. 400–415.

Saunders, M., Lewis P., Thornhill A. (2009) *Research methods for business students.* 5th ed. Harlow: Pearson Education.

Watson P. (2006) Unequalizing citizenship: the politics of Poland's health care change. *Sociology*, Vol. 40, No. 6, pp. 1079–1096.

Watson P. (2010) Fighting for life: Health care and democracy in capitalistic Poland. *Critical Social Policy*, Vol. 31, No. 1, pp. 53–78.

Winter A.F. et al. (2001) Strategic information management plans: the bases for information management in hospitals. *International Journal of Medical Informatics*, Vol. 64, pp. 99–109.