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Healthcare executives as binding outsiders in fragmented and politicised organisations

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Abstract

Healthcare executives govern large, complex and often fragmented organisations in which the distance between policy and practices is often huge. An important effect is that — in some way — healthcare executives have become remote from their own organisations. They have to fulfil a dual role of maintaining a distance while at the same time continuing to be involved. In addition, they have to cope with the fragmented order of healthcare organisations in which departments and locations can be experienced as islands and where layers can turn out to be barriers. This study investigates the strategies that executives develop to deal with these complexities, while remaining detached outsiders. The empirical data are based on three ethnographic case studies in different sectors of Dutch healthcare. The study makes clear that distance and involvement are constantly constructed and reconstructed by context, structures and symbols and also by the various parties in daily operations; that executives make use of four specific methods to govern distance; and that executives play a special role because of their detached position. As processes of distance and involvement freeze, there is a special task for executives. In fragmented and politicised healthcare organisations, they can be of importance as 'binding outsiders'.

Healthcare executives: Remote and in control

Healthcare executives, who bear the ultimate responsibility within and for healthcare organisations, are expected to manage in a businesslike way 'at a distance'.[1–4]

At the same time, they are expected to show concern for the patients or clients of their hospital or nursing home, to know their staff, and to be well acquainted with the goings-on in their organisation.[5,6] This dual role of maintaining a distance while at the same time being involved has acquired a sharp focus in today's healthcare organisations.[7–13] In the Netherlands, like in many other European countries, changes in the healthcare system have led to a 'displacement of politics' from the national level to the local level of service delivery.[14,15] Supported by a policy of regulated competition, healthcare executives are held responsible for realising both good quality of care and efficient and

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effective services. As a result, the governance of healthcare shifts to the level of organisations and, in turn, fuels the strategic role of executives.

The complexity of running healthcare organisations is based first on the variety of medical and social work,[16] secondly on the fragmented way in which healthcare organisations are organised,[17,18] and thirdly on the autonomy of the professionals that creates a gap between policy and practice.[19] The specific characteristics of healthcare seem to be increasingly at odds with new developments in professional management methods,[20] as well as with the increase in scale of healthcare organisations. The specialisation of healthcare professionals and managers results in a distinction between 'organising care' and 'giving care'.[21] These developments, each in its own way, contribute to a certain remoteness — a distance — with which the executive has to cope. The question is how healthcare executives handle this. Accordingly, the main question of the present research was, 'How do healthcare executives manage at a distance in large healthcare organisations?'.

The objective of the research under discussion in this paper was to increase knowledge of the day-to-day tasks of healthcare executives by way of a twofold analysis: first, by observing and analysing what meaning is given to the concepts 'distance' and 'involvement' in healthcare organisations; and secondly, by studying how the dual role that arises from the 'double requirement' influences the work and behaviour of healthcare executives as well as their subordinate healthcare managers and caregivers. The goal was to make the tacit knowledge[22] of management of healthcare organisations both concrete and discussible. The resulting insight into the work of healthcare executives aims to contribute to the further development of the theory, as well as to practical improvement of healthcare management. In addition, it can serve to refine the image and rhetoric of the 'gap' between the executive layer and the frontline workforce.

Research design: 'From the inside out'

To find out how healthcare executives actually manage, the work of three healthcare executives is described 'from the inside out' by means of ethnographic research.[23–29] To broadly explore healthcare management, three organisations from different healthcare sectors were selected: a general hospital, an organisation for the care and support of mentally disabled people, and a nursing home/special care organisation. The choice was made not only to observe the work of three different healthcare executives, but also to study the findings and opinions of managers and employees from the various layers and locations within the same organisation. Using the concept of distance, the research focuses on the relationship between healthcare executives and frontline workers. It was deemed necessary to study this relationship from the various perspectives of executives, managers and staff. In each organisation, 25 interviews were done with employees through all layers of the organisation. At the time of the interviews, all three organisations had six organisational layers.

The data from these interviews were combined with document analysis and with data from the observations in the three different case studies.[30] The three executives were observed for six days picked from the diary of each executive. Days were selected when different meetings and a work visit or other meetings or points of contact with clients, managers or professionals were planned.

The meaning of distance and involvement

First a conceptual and theoretical frame was developed. Four kinds of distance were identified: physical distance, temporal distance, mental distance and social distance.

Physical distance describes the real and measurable space between two objects. Temporal distance refers to the time period between certain experiences. Mental distance means the degree of emotional involvement and refers to differences in mental frames and perspectives. Social distance refers to social stratification, to differences and distinctions between professional groups and persons.

In organisational science, distance and involvement are discussed in terms of the relationship between 'leaders and followers',[31–40] whereas in the anthropological work of Edward T. Hall[41] and the sociological works of Anthony Giddens[42] and Georg Simmel,[43–46] the question of how distance and involvement work as a process is explored. The term 'distancing processes' does more justice to the dynamics of the practices described in this research. This study derived a set of potential methods to cope with distance from the perspective of administrative science.

The theoretical exploration formed the foundation for the empirical questions designed to discover the meaning given to the distance between executive and frontline workers in healthcare organisations and describe how 'managing at a distance' is applied in practice.

Three organisational stories

The results of the empirical study are described in this section as three narratives of different kinds of care organisations, focusing on the perceived 'distancing processes' and on the specific role of the executives.

Case study 1

The first case study took place in an organisation for the care and support of mentally disabled people. This organisation has 1,600 employees scattered across 120 locations. The structure of the organisation is based on the idea of organising on a human scale: it consists of small and specialised locations which provide tailor-made care.

It was expected that the scale and the various locations of this organisation would determine the distance perceived by staff. In fact, the opposite holds true — distance is perceived as the result of bureaucratic requirements, tensions caused by financial cutbacks, and management's lack of concern regarding clients and work processes. Furthermore, an explicit organisational vision intended to increase

cohesiveness has resulted in the opposite effect: employees perceive greater distance regarding the executive and the managers because they have been told to work in a different way, but feel that management fails to support them in their day-to-day problems. In addition, the organisational layers which were supposed to reduce distance have instead created distance between executives and employees and are perceived as 'barriers' instead of 'bridges'. Finally, what some employees consider as involvement of managers, others perceive as excessive interference or 'crowding'.[47]

The executive of this organisation has an educational background in care, and is additionally well educated in management. A few years ago he was chosen as the best national healthcare manager of the year. His professional and managerial career has taken place in this specific sector and largely in this specific organisation. The executive is strongly involved with the ideology of 'community-based care', which means supporting and empowering handicapped people to live as normal a life as possible. The executive has written several books and given numerous lectures about his vision on supportive care. He also meets with colleagues sharing the same vision, with whom he is politically active in fighting against care in big anonymous institutes, and striving for the human rights of handicapped people to participate in normal life. The executive exerts much effort in positioning his organisation and his vision strategically. He is acquainted with and well known by his personnel and makes structural monthly visits to various parts of the organisation. He wants to be in contact with the frontline staff and clients in order to fine-tune his vision. In the opinion of the professionals of the organisation, he is very approachable and well informed about what is happening inside the organisation through the operating management information systems and through the visits.

As witnessed during the observation, the executive often makes contact with clients working as employees in the organisation's restaurant or delivering mail. The executive also likes to use his visits to make contact with clients. However, interviews with the employees reveal some jealousy towards the attention he gives to clients. The employees express the feeling that there is too little attention for their daily work and the problems associated with community-based care. The professionals agree with the director's vision, but feel he does not really notice them in their daily practice.

Case study 2

In the second case study, the executive leads one of the largest general hospitals in the Netherlands, with five locations and 2,500 highly-educated employees. In this hospital, scale and distribution are also not the problem that creates distance. The staff involve the executive in primary processes, while at the same time keeping him at a distance. The gap between executive and employees seems to be due to ingrained conceptualisations and rhetoric of each group. The different parties seem to be caught in their own positions and there are conflicting interests that manifest themselves in a subtle game of approaching and distancing.

In addition, the hospital can be conceived of consisting of islands and kingdoms where proximity — for example between the wards of cardiology and respiratory problems, and between gynaecology and neonatology — sometimes paradoxically leads to distancing processes in which distance is created to protect budgets, the workforce, professional frames and discretionary space.[48]

The executive of this hospital has no medical background, he is not formally educated in the care sector, but is well versed in its practice. Previously he used to be the executive of an organisation for mentally handicapped people. The medical specialists appreciate the executive coming from the outside. Their professional autonomy is not threatened, and the executive happens to be a very interested outsider. The executive is very keen on the financial health of the organisation. However, he uses both the financial perspective and client perspective as directing forces. In all kinds of meetings he strongly promotes the slogan 'Patients First'. He does not have much connection with patients; rather, his behaviour is driven by an abstract notion of the patient. Most of his daily contacts are with the medical professionals. What fills his days is the difficult mission of keeping all the different kinds of medical specialists in line. He talks a lot with them about their visions and wishes. The executive encourages professionals to improve the quality of their work by starting quality projects, such as the American Institute for Healthcare Improvement's 'pursuing perfection' programme. He stimulates professionals to think about future developments and changes in the 'healthcare market'. He uses the outcome of the quality projects for public relations. As a result of this, professionals are proud to work in this organisation. Besides medical specialists, there are more — also highly educated — professionals in this hospital complex. The executive tries to visit the wards to drink coffee and to talk. All interviewed employees appreciate the executive greeting them and sometimes he even knows their name and what they are busy with. His personal attention motivates employees to improve their work. In their opinion the executive talks and 'walks' the values of the entire organisation.

Case study 3

In the nursing home/special care organisation of the final case study, comprising of six locations and 1,000 mostly low-educated employees, it seems as if time has stopped in spite of modernisation and increase in scale. The staff are mainly bound to their own location, yet the lack of contact between the different locations is not described in terms of distance. The various management layers in the organisation are not experienced as 'barriers'. Issues that arise on the frontline do reach the top layer of the organisation, but financial and policy issues are not discussed in all strata of the organisation. 'Organising care' is executed by executives, location managers and middle managers, but they interpret their work — and also talk — in terms of 'giving care'. The first layer of management, the team leaders, as was also the case in the two other organisations, are pulled between the separate forces of 'organising care' and 'giving care'. Do they have to be 'giving care' — hands on — or do

they have to 'organise care' — planning the workforce — from behind their desks? To stay close to direct care, despite an increase in scale, competition, rationalisation and registration, seems to be the main — management — task in this organisation.

The executive is a physician specialised in geriatric care and has spent his whole career in this organisation. Until a few years ago he still worked as a physician, and he loves to work with elderly people. He is very amiable, patient and attentive to everyone. One of his managers calls him 'our Guardian of Humanity'. Most of the caregivers in this organisation are not highly educated, they are not very reflective nor are they eager to learn. The executive does not visit wards, but his office is located centrally in the organisation and is used for all kinds of meetings. Through the day he meets managers, employees and clients in both formal and informal ways. The executive is well known by employees and he takes every chance — during holiday and other employee festivities — to climb the stage and participate in theatre or cabaret. This is highly appreciated by both staff and clients.

In almost every location of the organisation there is some building activity. These changes are driven by the image of the residents of the future, a new generation of clients with new desires. Yet the renovations take much time because there are many long-lasting discussions with employees and residents about, for example, floor coverings. The executive understands that change in his organisation takes time; he acts patiently and very respectfully to all parties, but when a decision is taken there is no delay. The chairman of the board of clients sings his praises: 'tell it to our director and everything will turn out right!'.

Summary

These three stories provide insight into the 'black box' of governing healthcare organisations. The perceived distances are locational and situational. The behaviour of the executives is adapted to the different kinds of organisations and the more or less contingent variables in the organisations. By analysing the case studies, however, it is possible to draw some wide-ranging conclusions regarding distance and the 'processes of distancing'.

Processes of distancing

The comparison of the case studies and theoretical reflections results in a multifaceted representation of the phenomenon of distancing and gives insight into the specific organisational processes of creating, reifying, overcoming or dealing with distance.

Shapes and sizes of distance

The theoretical characterisation of four different kinds of distance — physical distance, social distance, mental distance and temporal distance — has gained in significance in view of the empirical research. Although physical distance is often the most literal meaning that the respondents assign to the concept of distance, most respondents in this research

consider distance to refer to mental distance. Mental distance not only exists between executives and employees, but also between various departments and professional domains. An excessively radical application of rationality, objectivity and abstraction, arising from managing from a 'business' rather than from a 'relational' perspective, leads to a hardening of the mental distance between managers and caregivers causing them to drift apart. Mechanisms to bring mental frameworks closer to each other have developed less strongly than ways to overcome physical distance. Temporal distance is manifested in various ways in the case studies. Distance between management and frontline workers is experienced in terms of the speed — or lack thereof — of decision making. The different layers of management are then described as having a delaying effect. Managing then becomes finding an appropriate pace for decision making.

Physical, mental and temporal distance are always more or less intertwined with social distance, which is based on professional differences and the status value assigned to these. Social distance forms both an individual and a coordinating dimension in the characterisation of distance. Distance is primarily attributed by the respondents to the scope of the organisation, but is more likely to arise from the battle for scarce resources and it is the limited personal contact that causes distance and not the scale.

Distance and organisational structure

Distance is created and maintained by the structure of the organisation. The stratification of the organisation is intended to overcome the distance between executives and employees, but in practice we see that the layers also can produce distance.

In their daily work, managers and executives do not naturally come into contact with the actual provision of healthcare. Instead, they must make a considerable effort to organise such contact. Executives that have or gain personal 'floor experience' are seen as having greater involvement. On the other hand, the executive should not drop in too often or be too well informed. In such an event the staff will create distance. Due to competition for scarce resources, budgets cause both solidarity within each layer and conflict between layers, and thus cause distance between the layers of the organisation.

The translation of information from the frontline to the executive takes place through increasingly drastic abstractions from direct patient care. Information is passed from one tier to the next in increasingly truncated and summarised versions. This causes the layers to be experienced not only as links that pass on or translate information, but also as filters or buffers. Because intermediate strata identify themselves with the management, the information is transferred from 'top to bottom', but not 'translated'. Information that is too abstract when it reaches the staff causes a sense of distance from management.

The mental frameworks of 'organising care' and 'giving care' are not separated worlds, but are intertwined on all levels of the organisation. The separation of these mental frameworks does not take place on the

management level, but happens on the level where the greatest concern with the primary process is to be expected: the first executive layer in the organisation.

Constructivism

Distance and involvement are indeed produced in a continuous dynamic process. The constant search for a balance between distance and involvement is evident in all three organisations. The general consensus is that the executives are responsible for the increased distance. Managing is an ambiguous process, however, in which healthcare executives on the one hand steer free from direct involvement with the various implementation practices and frontline workers, and on the other hand seek various ways to make and maintain contact with those same workers.

In the struggle for discretionary space, professionals often use the relationship with patients as a weapon. However, healthcare executives also strengthen their relationship with the patient perspective in order to obtain legitimacy in the professional domain.

Distance and involvement are constantly constructed and reconstructed by context, structures and symbols, and also by the various parties in daily operations: it can be seen as a perpetual movement of inclusion and exclusion. However, a point of caution arises when distancing processes lose their process-like character: this can lead to gaps between specific groups within the organisation.

Managing distance

Based on the current research, managing healthcare organisations cannot be characterised as managing at a distance, but instead as managing distance. In the comparison of theoretical and empirical data, four different methods for managing distance were found: managing distance by means of extensions, connections, meeting places or boundaries.

Managing distance by means of extensions is aimed at dispatching people and information — into the organisation — in order to bring the different worlds that are separated by physical distance in contact with each other and to exert influence ‘at a distance’. Managing distance by means of connections mainly focuses on overcoming mental distances. Different mental frameworks are brought together by mediators that — provided they are familiar with both ‘worlds’ — can form a new entity that both parties can agree with and commit to. Managing distance by means of creating meeting places is important in dealing with all four types of distance; when individuals get to know each other they will be more open to each other’s ‘worlds’. Formal meetings create shared experiences, while informal meetings have a certain casualness or autonomy. Managing distance by means of boundaries creates mental and social frameworks. Inclusion and exclusion create a ‘clan’–like structure that sometimes has a physical — wards, locations or separate management building — form. Boundaries protect and create working space, but also exclude and screen off. They must be respected, yet remain permeable in order to make collaboration possible.

These management methods provide points of departure to manage distance in a manner that is balanced and tailored to the situation. The three organisations in the study show similarities, but also differences in the way in which managing distance is realised. In all three organisations, documents — budgets, policy statements and protocols — are sent out as extensions from the board. Sometimes the managers and even the executives are experienced as 'extensions'. In the geographically disparate organisation for caring for the disabled, distance is mostly managed by introducing and using meeting places. In the hospital, the border conflicts between the different worlds are a way of life, and 'connecting mediators', such as quality managers, play a translating and cohering role. The nursing home/special care organisation mainly works to increase connections, while at the same time maintaining boundaries between the different locations.

Strategic role of healthcare executives

As for the 'central actor' in this research — the healthcare executives — one can conclude that they behave as 'interested outsiders'. They make contact with different worlds in and around their organisation, but they resist getting too bound up with these worlds, in order to stay free to play the game of distancing and approaching. Healthcare executives are at the same time close and distant, involved and detached. Thanks to their familiarity *and* unfamiliarity, the healthcare executives are able to bring together and open up different worlds. In the more fragmented healthcare organisations (ie with scattered facilities), healthcare executives fulfil their dual role as 'binding outsiders'. Healthcare executives can reify their strategic role in the displacement of politics: as 'binding outsiders' they have the opportunity and the methods to keep policy and practice — or organising *and* giving care — together.

Lessons to learn

It seems necessary for managers, executives and researchers to give attention to the separation of the mental frameworks that take place on the first executive layer in organisations. This research aimed to describe the tacit knowledge of governing healthcare organisations, to make this knowledge more discursive. The methods to manage distance that came forward from this aim are still quite tentative and more research, reflection and discussion are needed to sharpen the scope and the methods.

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