HOSPITAL ORGANIZATIONAL STRUCTURES, CULTURE, CHANGE AND EFFECTIVENESS

The Case of Hamad Medical Corporation in Qatar

A dissertation submitted for the degree of Doctorate in Philosophy.

by

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ABSTRACT

This thesis presents health care organizations as heterogenic and highly complex in nature with particular normative structures underpinning their formal rational structures. It seeks to explore the evolution of organization structure as applied to a medical corporation in Qatar and to examine the nature of organizational culture and multiprofessional cohesiveness. In doing so it assesses a range of models on organizational design and change.

The three hospitals that compose the corporation are investigated through triangulated interpretative qualitative and quantitative methodologies and the application of the Competing Values Framework. The comprehensive approach of the investigation resulted in a series of conclusions on the evolution of hospital organizational structures, the link between life cycle and structure, forms of organizing health services, characertistics of professional structures, the nature and success of change management strategies, coordination mechanisms, organizational and professional cultures, and health service, organizational and team effectiveness assessment.

Findings demonstrated that autonomous and sometimes conflicting professions worked in harmony and cohesiveness as a consequence of shared core values and the human relations focus of health organizations. In examining organizational design it showed that coordination mechanisms were preferred to integration mechanisms with the former playing an important role in conflict resolution and human relations. Finally, findings indicated that when organizational design has shortcomings, the organization substitutes through other mechanisms.

DEDICATION

To my father.

TABLE OF CONTENTS

Acknowledgements 12
Abbreviations 13
List of Illustrations 14
List of Tables 15

CHAPTER 1 INTRODUCTION

1.1 *Introduction* 18
1.2 *Relevance of research into organizational structure, change, culture and effectiveness* 18
1.3 *Outline of the thesis* 20
1.4 *Research Methods and Concepts* 21

PART I LITERATURE REVIEW

CHAPTER 2 THEORIES OF ORGANIZATION, ORGANIZATIONAL STRUCTURE AND CHANGE

2.1 *Introduction* 22
2.2 *Theories of organization* 22
2.2.1 Introduction 22
2.2.2 Classification of theories of organization 23
2.2.3 Conclusion on theories of organization 26
2.3 *Designing hospital structures* 27
2.3.1 Introduction 27
2.3.2 Hospital characteristics 27
2.3.3 The problem of coordination 28
2.3.4 Models of medical staff organization 30
2.3.5 The NHS reorganizations and the rise of the clinical directorate within the divisional structure 34
2.3.6 Comparison of different organizational structure models 38
2.3.7 Conclusion on designing hospitals 41
2.4 *Organizational change* 42
2.4.1 Introduction 42
2.4.2 Difficulties of managing change 42
2.4.3 Theoretical foundations 44
2.4.4 Models of change 46

2.4.5 Structural change; radical transformational or incremental? 51
2.4.6 Conclusion on organizational change 54
2.5 *Conclusion* 55

CHAPTER 3 THEORIES OF ORGANIZATIONAL AND TEAM EFFECTIVENESS

3.1 *Introduction* 56
3.2 *Organizational effectiveness* 56
3.2.1 Introduction 56
3.2.2 Organizational assessment perspective 56
3.2.3 Approaches to measuring organizational effectiveness 59
3.2.3.1 *The Competing Values Approach* 62
3.2.4 Effectiveness in public sector (non-profit) and health sector 65
3.2.4.1 *Evaluating Health Services Effectiveness* 67
3.2.4.2 *Studies on Organizational Effectiveness in Health Services* 69
3.2.5 Conclusion on Organizational Effectiveness 71
3.3 *Team effectiveness* 72
3.3.1 Introduction 72
3.3.2 Team design, functioning and effectiveness 72
3.3.3 Conclusion on team effectiveness 75
3.4 *Conclusion* 76

CHAPTER 4 ORGANIZATIONAL CULTURE

4.1 *Introduction* 77
4.2 *Approaches to studying culture* 77
4.3 *Organizational culture and effectiveness* 81
4.3.1 Conclusion on organizational culture and effectiveness 85
4.4 *Culture and theories of profession* 86
4.4.1 Review of studies on professionalization 86
4.4.2 Interprofessional relations amongst health professionals 87
4.4.2.1 *The determination of professional boundaries* 89
4.4.3 Interprofessional relations in the NHS 90
4.4.3.1 *Doctors* 90
4.4.3.2 *Nurses* 90

4.4.3.3 *Health Administrators* 91
4.4.4 Conclusion on culture and theories of profession 93
4.5 *National culture* 94
4.5.1 Culture of Arab Management 95
4.5.2 Conclusion on national culture 98
4.6 *Conclusion* 98

PART II: METHODOLOGICAL REVIEW

CHAPTER 5 RESEARCH PHILOSOPHY AND METHODOLOGY

5.1 *Introduction* 100
5.2 *Research philosophy* 100
5.2.1 Theory development and the interpretative paradigm 100
5.2.2 Theory development 103
5.2.3 Combining research methods 107
5.2.4 Conclusion on research philosophy 108
5.3 *Quantitative methods* 108
5.3.1 Introduction 108
5.3.2 Questionnaire of culture, structure and organizational effectiveness 108
5.3.2.1 *Case and sampling* 109
5.3.2.2 *Analysis methodology and presentation of findings* 110
5.3.2.3 *Descriptive statistics and preliminary findings* 111
5.3.3 Questionnaire on team structure, functioning and effectiveness 114
5.3.3.1 *Case and sampling* 115
5.3.3.2 *Analysis methodology and presentation of findings* 115
5.3.3.3 *Descriptive statistics and preliminary findings* 116
5.3.4 Conclusion on quantitative methods 120
5.4 *Qualitative methodologies* 120
5.4.1 Introduction 120
5.4.2 Interviews on structure, change and culture 120
5.4.2.1 *Methodology and analysis* 121
5.4.3 Documents analysis 122
5.4.4 Conclusion on quantitative methods 122
5.5 *Conclusions and preliminary findings* 122

PART III: FINDINGS ANALYSIS

CHAPTER 6: EVOLUTION AND CHANGE MANAGEMENT OF HAMAD MEDICAL CORPORATION (HMC) ORGANIZATIONAL STRUCTURE

6.1 *Introduction* 124
6.2 *Historical development of health services in Qatar* 124
6.3 *Evolution of organization structure of Hamad Medical Corporation* 126
6.3.1 Introduction 126
6.3.2 Formation and structuring of HMC 126
6.3.2.1 *From start-up to growth* 126
6.3.2.2 *Governance and leadership from 1979 to 1989* 130
6.3.3 1990 devolution trial at the WH 132
6.3.4 Organization structure from 1990 to 1996 136
6.3.5 1997 restructuring 140
6.3.5.1 *The 1997 major restructuring attempt* 140
6.3.5.2 *The reliance on committees* 146
6.3.6 1998/99 structure; restructuring hospital management 148
6.3.7 Evolution of HMC organizational structure 153
6.3.8 Analysis of evolution of organizational structure 156
6.3.9 Conclusion on the evolution of organization structure 158
6.4 *Change management* 158
6.4.1 Introduction 158
6.4.2 Patterns of structural change at HMC 158
6.4.3 Understanding radical change attempts failure 160
6.4.3.1 *Organizational change environment* 160
6.4.3.2 *Structural change management* 164
6.4.4 Analysis of change management and restructuring attempts 173
6.4.5 Conclusion on change management 175
6.5 *Conclusion* 176

CHAPTER 7 ORGANIZATIONAL DESIGN: STRUCTURE AND PROCESS

7.1	*Introduction*	177
7.2	*Organizational structure*	177
7.2.1	Introduction	177
7.2.2	Corporate structure	177
7.2.2.1	*Strengths and weaknesses*	178
7.2.2.2	*Governance and leadership*	183
7.2.2.3	*Conclusion on corporate structure*	184
7.2.3	Professional structures	186
7.2.3.1	*Medical organizational structure*	187
7.2.3.2	*Nursing organizational structure*	190
7.2.3.3	*Administrative organizational structure*	195
7.2.3.4	*Professional boundaries*	199
7.2.3.5	*Conclusion on professional structures*	204
7.2.4	Hospital structure	206
7.2.4.1	*Hospital-corporate power conflict*	206
7.2.4.2	*Power conflicts for hospital leadership*	209
7.2.4.3	*Conclusion on hospital structure*	210
7.2.5	Departmental structure	210
7.2.5.1	*Improving departmental structure*	212
7.2.5.2	*Conclusion on departmental structure*	215
7.2.6	Analysis of organizational structure	216
7.2.7	Conclusion on organizational structure	218
7.3	*Organization and organizational processes*	219
7.3.1	Introduction	219
7.3.2	Centralization	219
7.3.3	Information and communication	223
7.3.4	Planning	228
7.3.5	Coordination	231
7.3.6	Work process/procedures	238
7.3.7	Analysis of organization and organizational processes	242
7.3.8	Conclusion on organization and organizational processes	244
7.4	*Conclusion*	244

CHAPTER 8 ORGANIZATIONAL CULTURE

8.1	*Introduction*	244
8.2	*Organizational culture*	244
8.2.1	Introduction	245
8.2.2	Strength of core values	246
8.2.2.1	*Understanding the stakeholders*	248
8.2.2.2	*Understanding core values*	248
8.2.2.3	*Commitment to existing culture*	252
8.2.3	Analysis of organizational culture	256
8.2.4	Conclusion on organizational culture	258
8.3	*Professional culture*	258
8.3.1	Introduction	258
8.3.2	Interprofessional relations	259
8.3.2.1	*Medical relations*	259
8.3.2.1.1	Analysis of medical relations	262
8.3.2.2	*Nursing relations*	263
8.3.2.2.1	Analysis of nursing relations	267
8.3.2.3	*Administrative relations*	268
8.3.2.3.1	Analysis of administrative relations	272
8.3.3	Analysis of professional culture	274
8.3.4	Conclusion on professional culture	275
8.4	*Influence of national culture*	275
8.4.1	Introduction	275
8.4.2	Arab management culture at HMC	275
8.4.3	Conclusion on national culture	277
8.5	*Conclusion*	277

CHAPTER 9 ORGANIZATIONAL AND TEAM EFFECTIVENESS

9.1	*Introduction*	279
9.2	*Assessing organizational effectiveness*	279
9.2.1	Introduction	279
9.2.2	Competing Values framework	279
9.2.3	Internal organizational assessment efforts	284

9.2.4 Effectiveness of public health services 285
9.2.5 Analysis of findings 286
9.2.4 Conclusion on organizational effectiveness 289
9.3 *Evaluation of team effectiveness* 290
9.3.1 Introduction 290
9.3.2 Team functioning 290
9.3.3 Team performance 294
9.3.4 Team effectiveness 295
9.3.5 Team functioning, performance and effectiveness 301
9.3.6 Analysis of findings 302
9.3.7 Conclusion on team effectiveness 303
9.4 *Conclusion* 303

CHAPTER 10 CONCLUSION

10.1 *Findings and conclusions of study* 306
10.2 *First proposition* 315
10.3 *Second proposition* 316
10.4 *Third proposition* 317
10.5 *Limitations and future research* 318

REFERENCES (PRIMARY SOURCES) 320

BIBLIOGRAPHY OF WORKS REFERRED TO OR CONSULTED 322

APPENDICES

Annex 1 Study Of The Different Schools Of Thought 342
Annex 2 Schools Of Theories Of Change 352
Annex 3 Early Organizational Effectiveness Studies 354
Annex 4 Gaertner And Ramnarayan's (1983) Characterisation Of Approaches 357
Annex 5 Review Of Studies On Professionalization 359
Annex 6 Hofstede's (1980) Classification Of Cultures By Dimension 365
Annex 7 Main Paradigms As Presented By Gioia And Pitre (1990) 366
Annex 8 List Of Questions In Comprehensive Questionnaire 367

Annex 9	Sample Of Comprehensive Questionnaire	370
Annex 10	Sampling Matrix For Comprehensive Questionnaire	390
Annex 11	Sample Of Committee/Team Questionnaire	391
Annex 12	Regrouped List Of Team Questionnaire Questions	398
Annex 13	Sampling Matrix For Team Questionnaire	401
Annex 14	Codes And Codes Description For Team Questionnaire	402
Annex 15	Interview Questions For Department Heads	404
Annex 16	Interview Questions For Executive And Corporate Staff	405
Annex 17	Interview Sampling Matrix	406
Annex 18	Analysis Guide By Profession	407
Annex 19	Analysis Guide By Hospital	416
Annex 20	HMC Analysis Guide	425
Annex 21	HMC Formal Organizational Structure, 1987	437
Annex 22	Proposed Organizational Structure For WH, 1990	439
Annex 23	HMC Formal Organizational Structure, 1992	441
Annex 24	HMC Formal Organizational Structure, 1994-1996	443
Annex 25	HMC Formal Organizational Structure, 1997	445
Annex 26	Restructuring Of Organizational Structures Attempts, HMC, 1997	447
Annex 27	HMC Formal Organizational Structure, 1999	451
Annex 28	List Of Corporate Structure Strenghts	453
Annex 29	List Of Corporate Structure Weaknesses	454
Annex 30	Weaknesses Of Departmental Structure	455
Annex 31	Methods Of Improving Departmental Structure	456
Annex 32	Cultural Characteristics By Hospital Tables	457
Annex 33	Cultural Characteristics By Profession Tables	458
Annex 34	Advices To Collegues Joining HMC For The First Time	460
Annex 35	Skills And Training By Profession Tables	461
Annex 36	Morale By Profession Tables	463

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ABREVIATIONS

HMC	Hamad Medical Corporation
WH	Women's Hospital
HGH	Hamad General Hospital
RH	Rumailah Hospital
CORP DEPTS	Corporate Departments at HMC
CV	Competing Values Framework
DEPT	Department
HEC	Hospital Executive Committee
DMT	Departmental Management Team
CMT	Clinical Management Team
ADMIN	Administration
PARAMED	Paramedical
WHO	World Health Organization
QP	Qatar Petroleum
NHS	British National Health Services
ASST.	Assistant
ADMIN DIR	Administrative Director
ADN	Assistant Director of Nursing
SADN	Senior Assistnant Director of Nursing
HN	Head Nurse

LIST OF ILLUSTRATIONS

FIGURES

Fig.3.1 `	Competing Values Framework Components	63
Fig.9.1	Competing Values By Hospital	281
Fig.9.2	Competing Values By Profession	283

CHARTS

Chart 6.1	Application Of Mintzberg's (1979) Components On 1987 HMC Organizational Structure	129
Chart 6.2	Application Of Mintzberg's (1979) Components On 1992 HMC Organizational Structure	138
Chart 6.3	Application Of Mintzberg's (1979) Components On 1994-1996 Hmc Organizational Structure	139
Chart 6.4	Application Of Mintzberg's (1979) Components On 1997 HMC Organizational Structure	142
Chart 6.5	HGH Administrative Organizational Structure, 1998	150
Chart 6.6	RH Administrative Organizational Structure, 1998	151
Chart 6.7	WH Administrative Organizational Structure, 1998	152
Chart 7.1	Standard Medical Department Structure	188
Chart 7.2	Nursing Department Organizational Structure	191
Chart 7.3	Administrative Organizational Structure	196

LIST OF TABLES

Table 2.1	Development Of Theories Of Organization	24
Table 2.2	Organizational Structure Models Compared On A Differentiation-Integration Continuum.	40
Table 4.1	Legge's (1995) Characterization Of Appoaches To Studying Culture	79
Table 5.1	Breakdown Of Comprehensive Questionnaire	109
Table 5.2	Respondent's Professions	111
Table 5.3	Respondent's Hospital	111
Table 5.4	Respondent's Years Of Service	112
Table 5.5	Respondent's Age	112
Table 5.6	Respondent's Gender	112
Table 5.7	Respondent's Qualifications	112
Table 5.8	Significant Relationships By Profession	113
Table 5.9	Significant Relationships By Hospital	114
Table 5.10	Respondent's Profession	116
Table 5.11	Respondent's Hospital	116
Table 5.12	Team Creator	117
Table 5.13	Respondent's Role	117
Table 5.14	Reason For Holding Meeting	118
Table 5.15	Team Composition By Hospital	118
Table 5.16	Significant Relationships For Team Questionnaire	119
Table 6.1	Evolution Of Hmc's Organizational Structure, 1979-1999	154
Table 6.2	HMC Employees' Awareness Of Changes	162
Table 6.3	Timely Implementation	163
Table 6.4	Planning Of Corporate Organizational Structure	165
Table 6.5	Evolution Of Corporate Organizational Structure	165
Table 6.6	Corporate Structure's Flexibility And Change	165
Table 6.7	Planning Of Departmental Organizational Structure	166
Table 6.8	Evolution Of Departmental Organizational Structure	167
Table 6.9	Department Structure's Flexibiility And Change	167
Table 6.10	Importance Of Continuity – Departmental Responses	167
Table 6.11	Importance Of Continuity – Corporate Responses	168
Table 7.1	Strength Of Corporate Structure	178
Table 7.2	Corporate Structure Weaknesses	179
Table 7.3	Swot Analysis Summary, 1997	181

Table 7.4	Improving Corporate Structure	182
Table 7.5	Medical Staff Involvement In Corporation's Management	201
Table 7.6	Medical Staff Involvement In Department's Management	202
Table 7.7	Nursing Staff Involvement In Corporation's Management	202
Table 7.8	Nursing Staff Involvement In Department's Management	202
Table 7.9	Administration Involvement In Clinical Matters	203
Table 7.10	Administration Involvement In Nursing Matters	203
Table 7.11	Department Structure Weaknesses	211
Table 7.12	Improving Departmental Structure	213
Table 7.13	Freedom To Structure Own Jobs, Departments	221
Table 7.14	Freedom To Structure Own Jobs, Corporations	221
Table 7.15	Information Conveying	224
Table 7.16	Needed Information Obtainable	225
Table 7.17	Departmental Information Travel	227
Table 7.18	Corporate Information Travel	227
Table 7.19	HMC Mission Statement	229
Table 7.20	HMC Objectives	229
Table 7.21	Departmental Objectives	230
Table 7.22	Reasons For Conflicts	232
Table 7.23	Minimizing Conflict	236
Table 7.24	Work Processes	239
Table 7.25	Smoothness Of Work	240
Table 7.26	Departmental Policies And Procedures	240
Table 7.27	Corporate Policies And Procedures	240
Table 8.1	Perceived Stakeholders For Hmc	246
Table 8.2	Stakeholders As Perceived By Administrative Staff	247
Table 8.3	Stakeholders As Perceived By Therapy Staff	247
Table 8.4	Stakeholders As Perceived By Medical Staff	247
Table 8.5	Descriptions That Were Found To Best Describe HMC	248
Table 8.6	Categories Of Advice Related To Culture	251
Table 8.7	Core Values Traced From Organizational Values	252
Table 8.8	Elements Considered Most Important For Success Of Health Services	253
Table 8.9	Corporate Productivity	254
Table 8.10	Departmental Productivity	255
Table 8.11	Medical-Medical Working Together	259
Table 8.12	Medical-Medical Relationships	259

Table 8.13	Medical-Nursing Working Together	260
Table 8.14	Medical-Nursing Relationships	261
Table 8.15	Medical-Administration Working Together	262
Table 8.16	Medical-Administration Relationships	262
Table 8.17	Nursing-Nursing Working Together	265
Table 8.18	Nursing-Nursing Relationships	265
Table 8.19	Nursing-Administration Working Together	266
Table 8.20	Nursing-Administration Relationships	267
Table 8.21	Administration-Administration Working Together	270
Table 8.22	Administration-Administration Relationships By Hospital	270
Table 8.23	Administration-Administration Relationships By Profession	271
Table 9.1	Team Functioning By Hospital	291
Table 9.2	Team Functioning By Profession	293
Table 9.3	Team Performance By Hospital	294
Table 9.4	Team Performance By Profession	295
Table 9.5	Team Effectiveness By Profession	296
Table 9.6	Team Effectiveness By Hospital	297
Table 9.7	How Management Can Improve The Committee	298
Table 9.8	How Chairperson Can Improve The Committee	300

CHAPTER 1 INTRODUCTION

1.1 *Introduction*

This study explores the characteristics and evolution of organization structure in a medical corporation composed of three hospitals by assessing a range of models of organizational design and change. It also examines the sociological context of health organization by exploring the nature of organizational culture and multiprofessional cohesiveness. Finally, it assesses organization effectiveness by assessing health service effectiveness, organizational effectiveness and team effectiveness.

A specific feature in this study lies in its theoretical and methodological eclecticism and its location. The study moves across schools of thought on organization in order to best understand the nature of the organizations under study. In order to achieve methodological eclecticism within the interpretative paradigm it uses a planned triangulation of qualitative and quantitative research methods. The selected perspectives and combination of structure, culture, change, and effectiveness studies to explore health settings result in worthwhile findings. Additionally, this study is the only one of its kind set in Qatar. It sheds light on how there are more similarities than differences across national boundaries.

1.2 *The relevance of research into organizational structure, change, culture and effectiveness in hospital settings*

The objectives of this study are to explore the evolution of organization structures as applied to a medical corporation in Qatar (by assessing a range of models of organizational design and change), to examine the nature of organizational culture and multi-professional cohesiveness, and to assess organizational effectiveness.

Three principal propositions will be addressed and tested:

1. Health professionals are inherently individualistic, specialist in character, enjoying autonomy yet when brought together in a hospital setting work within a generic and systematic framework.
2. An organization structure, which focuses on integration and coordination, will promote harmony and effectiveness in highly complex settings.

3. An effectively designed organization structure is one that is supported by proper processes and systems.

Research questions were broken down by section. Some questions asked by the researcher when exploring *culture* are:

1. What are the differences between the general characteristics and values of the different organizational members and the differences between general characteristics and values of organizational members and the organization itself?
2. Where there are differences, how are these handled by organizational members? Are there conflicts due to differences in values and culture?
3. In which ways, if any, does national culture affect organizational culture and structure?
4. In which ways, in any, does culture affect organizational effectiveness?

Some research questions used to explore the *evolution of organizational structure* and *organizational design* are:

5. What are the characteristics of the past structures and those of the developing one?
6. What characteristics are specific to hospital settings?
7. Does the present organizational structure contribute to individual/group/organizational effectiveness?
8. Which organizational design and configuration best fit the internal and external characteristics of the organization?
9. What constitutes an effectively designed organization?

Some research questions used to explore *change* are:

10. What are the mechanisms through which change has taken place in the organization?
11. How successful or unsuccessful have change processes been?
12. What are the building blocks for successful change management in health settings?

Some of the research questions used to explore *organizational and team effectiveness* are:

13. What are the different approaches to assessing organizational effectivenesss?
14. Which organizational assessment approaches are generally used in health settings?
15. How can effectiveness be measured and what does this measure say about the organization under study?

16. What are the types and structural/process characteristics of the developing teams?
17. How effective are these teams?
18. What elements contribute to team effectiveness?

1.3 *Outline of the thesis*

In addition to this chapter there are nine more chapters in this study. Chapters Two to Four, which constitute Part One, cover theoretical material. Part Two; Chapter Five describes the methodology used. Chapters Six through Nine, which constitute Part Three, describe and analyse the findings. Finally, chapter Ten concludes by summarizing and drawing the main findings together.

Chapter Two explores theories of organization, organizational structure and change. The first section of this chapter sets the ground and theoretical boundaries of this study. The second section explores hospital characteristics, the difficulties in achieving the proper balance between integration and differentiation and compares different models of medical structures from the US and British NHS experiences on a differentiation-integration continuum. The third section explores change management theory, approaches and models.

Chapter Three explores some of the theoretical material on organization and team effectiveness. The first section explores the different organizational assessments approaches and focuses on the Competing Values approach. It also explores the difficulties in assessing organizational effectiveness in public health services from the U.S and British NHS experiences. The second section explores literature on team types, designs and evaluation methods. It also discusses some factors that may affect group effectiveness.

Chapter Four explores organizational, professional and national culture. The first section explores definitions, perspectives of organizational culture. It also addresses cultural strength studies. The second section explores professional culture, the classification of health professions and interprofessional relations. The final section explores national culture by studying research on national culture and research on the attributes of Arab management culture.

Chapter Five describes the research philosophy and methodologies of this study. The first section discusses methodological eclecticism within the interpretative paradigm. The

second section describes the questionnaires, interviews and documents collection methodologies.

Chapter Six explores the evolution of hospital organizational structure and change management by exploring the development of Hamad Medical Corporation's (HMC) structure from 1979 to 1999. Chapter Seven explores findings on organizational design by studying organizational structure and processes. Chapter Eight explores HMC's organizational culture by studying the homogeneity of core values, professional culture and national culture. Chapter Nine explores overall organizational effectiveness using the Competing Values framework and team effectiveness by exploring team functioning and performance. Finally, Chapter Ten concludes the study by summarizing the main findings, addressing the original propositions, and putting recommendations for further studies on this subject.

1.4 *Research methods and concepts*

Rooted in interpretative theory building, this study is inductive in that the researcher becomes involved in the events studied by attempting to observe from the perspective of the organization member's experience of the area of study. It attempts to overcome some of the positivist critiques of case study methodologies by adopting suggested methods for developing testable hypotheses and theory from case study research. Finally, in order to achieve methodological eclecticism within the interpretative paradigm this research uses planned triangulation of qualitative and quantitative research methods.

Combinations of qualitative and quantitative methods are used for investigation. Two highly framed questionnaires were distributed. The first explored effectiveness, organization structure, change and culture and was distributed to 300 individuals of whom 171 responded. The second explored committees and teams effectiveness and was distributed to 100 organizational members of whom 70 responded. A total of 114 interviews were conducted which covered organizational structure, structural changes and interprofessional relations. Extensive documents collection was also undertaken. Questionnaires were analysed with the help of a statistical software, interviews were coded then quantified so as to identify the most common responses and relevant documents were summarized. Quotes from interviews and documents were used to illustrate and explain findings. There were very few variations between the qualitative and quantitative findings. Nonetheless, where there were contradictory findings, these were expressed and an explanation sought.

CHAPTER 2 THEORIES OF ORGANIZATION, ORGANIZATIONAL STRUCTURE AND CHANGE

2.1 *Introduction*

This chapter commences by introducing and comparing the various schools of thought in organization theory. By exploring different perspectives and theories, the first section sets the ground and boundaries of the study. The second section explores designing hospital structures by first identifying the specific hospital characteristics that influence organizational design, then discussing the difficulties of coordination. It thereafter reviews and compares different models of medical structures from the US and British NHS experiences. These two have been selected seeing that the Qatari system largely follows the structures prevelant in the U.S. and the British system has undergone similar changes to those undergone by the Qatari system.

The third section explores some theoretical material and research on change management and structural change. After identifying some of the difficulties of managing change and reviewing the theoretical foundations underpinning change management, some approaches to change and methods of intervention are analysed. Finally, the nature and methods of achieving structural change are studied.

2.2 *Theories of organization*

2.2.1 Introduction

There are many different classifications or groupings of organization theories, for, as theories emerged, some were accumulative and complementary, while others were contradictory and in disagreement with previous schools of thought (Bolman and Deal, 1984; Hatch, 1997). Ott and Sheritz's (1991) grouping of the different organization theories into eight schools has been selected for this study for its completeness and holistic approach to the development of different organization perspectives, an aspect found particularly important when studying the application of organization theory in health care settings.

2.2.2 Classification of theories of organization

Table 2.1 Development of Theories of Organization, outlines the major elements of each of the eight perspectives[1]. It presents each school's representative theorists, its view of organization, its research methods and results. There is no distinct end or beginning to one school; they all melt into each other, build on or deconstruct each other.

It is interesting to observe how the theorists' view of the organization has evolved throughout the various schools of thought. *The Classic School* viewed the organization as rational, mechanic and goal oriented. Two main streams of classical theories developed; a sociological (Marx, 1867; Weber, 1946; Durkheim, 1893) and a classical management (Taylor, 1916; Fayol, 1916, Barnard, 1938) theory stream. *The Neoclassic School*, by realizing that organizations are also social systems with non-rational elements, criticized the classic pioneers for their narrow vision and paved the ground for the Organizational Behaviour/Human Resources, 'Modern' Structural, and Systems/Contingency Schools.

Although the three schools view organizations as rational and utilitarian each had its distinct contribution to organization theory. The *Organizational Behaviour/Human Resources School* viewed the organization as being in co-dependent relation with employees. Common themes of the organizational behaviour theorists are motivation, group and individual relations, leadership, the person-organization interface, power and dependence and organizational change (Ott, 1989). *The 'Modern' Structural School* saw the organization as being in constant struggle between differentiation and integration whereby most organizational problems result from structural flaws and can be solved by changing the structure.

The Systems/Contingency and Population Ecology Schools of thought described organizations as complex organic systems that are in continuous interaction with their environments and to which contingent approaches were needed. The Population Ecology school of thought drew on Darwinian theories of evolution concerning themselves with the formation, adaptation, competition, selection and survival or death of organizations (Hannan and Freeman, 1977).

[1] See Annex 1 for a detailed study of the different perspectives.

Table 2.1 Development of theories of organization

School	Classical	Neoclassical	OB/Human Resources	'Modern' Structural	Systems/Contingency	Multiple Contingency/ Market Organization	Power and Politics	Culture/Symbolism
Representative Theorists	Marx (1867) Durkheim (1893) Taylor (1916) Fayol (1916) Weber (1946) Barnard (1938)	Simon (1946,1960) Parsons (1956) March&Simon(1957) Cyert & March (1963) Selznick (1948)	Munsterberg(1913,1922) Mayo Team (1933) Maslow (1943) McGregor (1957) McClelland (1966) Argyris (1970)	Burns & Stalker (1961) Blau & Scott (1962) Walker&Lorsch(1968) Thompson (1967) Mintzberg (1979) Jaques (1990)	Katz & Kahn (1966) Thompson (1967) Galbraith (1973b) Hannan&Freeman(1977)	Cyert & March (1963) Connolly,Conlon&Deutch (1980) Keeley (1983) Jensen & Meckling(1976) Day & Day (1977)	Baldridge (1971) Pfeffer (1978,1981) Kanter (1979) Allan&Porter(1983) Mintzberg (1983)	Weick (1979) Berger&Luckman(1967) Pondy & al. (1983) Schein (1985) Sergiovanni&Corbolly (1984) Sathe (1985) Kilmann & al. (1985)
View of Organization	Rational. Mechanic. Goal oriented.	Rational utilitarian. With non rational elements. Social System.	Rational utilitarian. In co-dependent relationship with employees.	Rational utilitarian. Struggles between differentiation and integration.	Rational utilitarian. Complex organic systems. Contingent approaches are needed.	Non rational. Legal entity. Market of coalitions with negotiated order.	Non rational. Political institution. Market of coalitions with negotiated order.	Non rational. Made up of human assumptions and values.
Methods	Observation. Historical Analysis. Intellectual/Personal Reflections.	Empirically derived observations.	Empirically derived observations. Normative/Prescriptive assumptions.	Empirically derived observations. Objective, quasi-experimental.	Quantitative analytical. Logical-positivist (cause-effect). Objective, quasi-esperimental.	Perceptual Studies. Qualitative Studies	Perceptual studies. Observation/participant observations. Qualitative Studies.	Perceptual studies. Observation/particip observations. Qualitative Studies.
Results	Theoretical frameworks. Management principles for practice.	Critiques of classicals. Human, political and social issues in organizations raised.	Humanistic/Optimistic organizational assumptions and theories.	Typologies. Theoretical frameworks around differentiation and Integration.	Systems theories. Contingency theories. Population ecology views. Comparative studies. Statistical analysis.	Normative perceptual analysis.	Normative theories of power and influence.	Narratives and case studies.

Adapted from: Ott and Shefritz (1991)

It was the *Multiple Constituencies/Market Organization School* that first described the organization as essentially non-rational; a view that was later adopted by the Power and Politics and the Culture/Symbolism Schools. This perspective described the organization as a legal entity, a market of coalitions with negotiated order.

The Power and Politics School further pursued this view by adding that the organization is mostly a political institution. They realised that power is a structural fact, that specialization and division of labour create small, interdependent units with varying degrees of importance in the organization (Pfeffer, 1981; Kanter, 1979; Mintzberg, 1983). Since organizational resources are limited, conflict is inevitable, making influence, power, and politics the means in competition to achieve dominance (Baldrige, 1971). Competing organizational coalitions form around professions with the competition not always revolving around organizational goals emphasizing the non-rational nature of organizations.

The last school, the *Culture/Symbolism School*, considered the organization as being made up of human assumptions and values. Researchers under the symbolic frame argued that realities are social constructs and hence, in organizations, meaning and thus realities are established by organizational members (Weick, 1979; Berger and Luckman, 1967; Pondy et al., 1983).

Table 2.1 also permits an exploration of the shift in research methods throughout the schools and the consequent shift in type of results obtained. The Classic School relied on observation, historical analysis and intellectual reflections. The results were theoretical frameworks, and general management principles. The Neoclassic School introduced empiricism into the observation and as a result were able to critique and point to weaknesses of the intellectually derived classical theories. The normative/prescriptive assumptions that underlined the empirical observations of the Organizational Behaviour/Human Resources School resulted in humanistic and optimistic organizational assumptions and theories.

The 'Modern' Structural School relied on empirical, objective, quasi-experimental methods. Its output is mostly typologies and theoretical frameworks around differentiation and integration. The Systems/Contingency School relied too on objective, quasi-experimental methods and quantitative analysis but they introduced a new concept, the logical-positivist approach, into organization research. The results of this school are mostly comparative and statistical studies as well as systems and contingency theories.

The Multiple Constituencies/Market Organization School and the Power and Politics School are similar in their research methods. They both relied on perceptual and qualitative studies, which resulted in normative theories and perceptual analysis. The Culture/Symbolism School also relied on perceptual and qualitative methods, however, because of its less normative approach and its belief that the organization is made up of human assumptions and values, the results of this group are mostly narratives and case studies.

2.2.3 Conclusion on theories of organization

Under the umbrella of the classical school's rational, mechanistic and goal-oriented view of the organization and the neoclassical school's critique of this narrow vision, this study draws on various perspectives. Studies from the organizational behaviour perspective are used to understand group and inter-group relations and approaches to organizational change. Approaches to change such as action research, Lewin's three-step model, phases of planned change, and models of change are explored in this study (Argyris, 1970; Burnes, 1992; Lewin, 1958; Bullock and Batten, 1985; Joss and Kogan, 1985).

The study of organizational structure is rooted in the 'modern' structural and systems, contingency and population ecology perspectives. The different organizational structures applied in hospital structures ranging from Burns and Stalker's (1961) theory of mechanistic and organic organizations, through Minztberg's (1979) models of organizations to the resurgence of the bureaucratic form (Weber, 1946; Jaques, 1990), are described. The struggle with differentiation and integration between organizational units and the acute problems of coordination in hospital settings is explored using modern structural theories and systems theories (Haimann and Scott, 1974; Thompson, 1967; Lawrence and Lorsch, 1967; Galbraith, 1973b). Theories from the population ecology perspectives are used to explore the evolutionary change of hospital structures (Hannan and Freeman, 1977; Van de Ven and Poole, 1992).

The study of organizational effectiveness using the application of the competing values model (Quinn and Rohrbaugh, 1981 and 1983; Cyert and March, 1963; Keeley, 1983) has its roots in the multiple constituencies' perspective. Power and politics theories are found to be important in furthering the understanding of hospital structure and culture. The peculiarities of health settings with their multiple professional cultures and structures

require the maintenance of a delicate balance of power between the different coalitions in hospital organizations (Georgopolous and Mann, 1962; Pfeffer, 1978).

Finally, the organizational culture and symbolic management perspectives have been used to study professional, organizational and national culture. Professional culture is explored through early studies on socialization of professions (Flexner, 1915; Carr-Saunders and Wilson, 1933; Millerson, 1964; Moore, 1970) and more recent health professions characterizations (Etzioni, 1969; Forsyth and Danisiewicz, 1985; Freidson, 1970a, 1970b). Organizational culture is explored through the differentationist perspectives (Schein, 1985; Gregory, 1983; Smirchich, 1983; Mogan et al., 1983; Anthony, 1994; Meek, 1988) as well as the integrationist perspectives (Hatch, 1997; Deal and Kennedy, 1982; Kotter and Heskett, 1992; Denison, 1990). Finally, national culture is explored in general (Hofstede, 1980) and more specifically through studies on Arab management culture (Hickson and Pugh, 1995; Al-Faleh, 1987; Attiya, 1992; Muna, 1980).

2.3 *Designing hospital structures*

2.3.1 Introduction

Having noted the different theories of organization, this section explores the designing of hospital structures. It commences by identifying the specific hospital characteristics that influence organizational design. It then explores the difficulties of coordination, achieving the proper balance between differentiation and integration, in hospital settings. Finally, different models of medical structure from the US and British NHS experiences that are found relevant to this study will be studied and compared.

2.3.2 Hospital characteristics

Before exploring the designing of hospital structures it is important to identify their specific characteristics and elements as these highly influence organizational design. Georgopolous and Mann (1962) identified seven characteristics of hospitals: (a) a reliance on extensive division of labour, (b) a high interdependence of services, (c) a human system which relies on formal procedures and policies and structures making it a highly formal, quasi bureaucratic organization, (d) a high degree of specialization and differentiation together with the need to coordinate skills and tasks make organizational

coordination important, (e) the normative structure formed by professional values that underpins the formal rational structure helps in integration and coordination of activities, (f) a structure with no single line of authority in which administrative authority follows a formal hierarchy and the medical staff are outside the administrative line of authority, and (g) the multiple lines of authority require the maintenance of a delicate balance of power in hospital organizations.

In another study, Goergopolous (1972) notes that the original main objective of a general hospital is to render personalized and professional treatment to patients, and the unpredictable and sometimes urgent nature of work has lead to a conflict between actions that are individualized and personalized and generally applied organizational rules and standards, a conflict between decisions based on expert knowledge and organizational authority, and a management by crisis situation.

Another contradiction in the health setting noticed by Georgopolous (1972) is the need for clarity of accountability and low tolerance for ambiguity/errors contrasted with the professional's preference for work autonomy. This creates a system where effectiveness depends upon the technical and social systems and where coordination of these two elements and the coexistence of multiple authority lines, is vital and difficult. Finally, he notes that it is important in this setting to have mutual understanding among the organization members about one another's roles, work problems, and needs.

2.3.3 The problem of coordination

Achieving effective coordination, the proper balance between differentiation and integration for harmonious functioning with minimum frictions, is particularly difficult because these two are generally viewed as different poles, and because of the high complexity of hospitals (Georgopolous and Mann, 1962; Haimann and Scott, 1974; Thompson, 1967; Lawrence and Lorsch, 1967a; Galbraith, 1973a). Various coordination mechanisms have been proposed by researchers on this subject and a contingent approach in selection of the appropriate mechanism for the particular organizational setting, system and environment has been recommended (Thompson, 1967; Lawrence and Lorsch, 1967b; Galbraith, 1973a).

March and Simon (1958a) noted that coordination may be achieved via programming of activities and continuous feedback. Litterer (1965) indicated that three coordination mechanisms were available for managers; using the organizational hierarchy, using the

organization's administrative systems and procedures, or relying on voluntary coordination activities by organizational members. Likert (1967) recommended the use of linking pins, people with membership in two groups in the organization.

Thompson (1967) noted that the mechanisms selected would have to depend on the type of task interdependence; whether tasks were pooled (independent but located in the same area), sequential (where they must be ordered in a particular sequence to produce the end result), or reciprocal (where tasks are cyclical and require feedback). He also recommends, for most cost effectiveness, to structure subunits so that activities within that subunit are as homogeneous as possible, thus avoiding costly and complicated interdepartmental coordination.

Lawrence and Lorsch (1967a) suggested a direct link between proper integration and effectiveness and recommended the use of task forces, teams, project offices and integrators to achieve coordination. Galbraith (1973b) considers organizations as information processing networks, where the critical tasks are information processing and decision-making. Thus, the main objective of the organization design is to ensure the efficient flow of information to decision-makers. Increased uncertainty results in an increased need for information by decision-makers and two scenarios are available to handle the increased amount of information need. First, decreasing the information needs of the organization via proper forward planning or decreasing the expected level of performance and making the organization output-oriented. Second, increasing the organization's information-processing capacity via improved vertical information systems or lateral relations between departments. Mechanisms for improving lateral relations noted are: promoting direct contact between managers, liaison roles, task forces, integrating roles, managerial roles, or matrix structure. Galbraith (1973a, 1977) in another study distinguished five approaches to coordination; hierarchy of authority, rules and regulations, planning and goal –setting, vertical information systems, and lateral relations.

Van de Ven et al. (1976) noted that coordination had to be achieved through impersonal activities (standardization efforts), personal activities, and group activities. Huse (1980) identified four mechanisms for coordination: programming, planning, customs and feedback. Mintzberg (1983) noted that mutual adjustment, direct supervision, standardization of work processes, standardization of outputs, and standardization of worker skills helped in coordination of activities. Other mentioned integrating mechanisms include collegial participatory decision-making structure, committees, quality circles and quality improvement teams (Long and Longest, 1996).

2.3.4 Models of medical staff organization

A brief review of the different models proposed by various researchers as being applicable to health settings is conducted. It is then followed by a discussion of studies specific to the British NHS organization structures that have been found quite analogous to those adapted in Qatar.

One of the earliest studies is that of Burns and Stalker (1961b), who distinguished between two types of organizational forms; mechanistic form and organic form. The mechanistic form is most suitable in organizations that are in stable environments and resembles the traditional bureaucratic form. As for the organic form, it may be found in unstable environments and its emphasis is on the application of specialized knowledge.

Scott (1987) identified three distinctive types of organizational forms that have evolved in health settings to support the autonomy of health professionals: the autonomous, heterogeneous and conjoint organization. In the autonomous professional organization there are clear and distinct separate lines of authority, control mechanisms and administrative structures for the professional staff and administrative staff. The heterogeneous professional organization is one in which the professional staff are subordinate to an administrative structure and are accountable to the organization. Finally, the conjoint professional organization is one in which the professional and administrative staffs are roughly equal in power and influence. Scott (1987) notes that matrix and parallel structures are variants of this form.

In another study Shortell (1982) describes the traditional functional organization with dual hierarchy which exists in many hospitals as incompletely designed, with the non-medical staff organized along functional lines and the medical staff around divisional lines. Nonetheless, he notes that because of the incomplete form of these divisions (no clinical or administrative support), the dual or even triad hierarchy of authority in hospitals that was first observed by Smith (1776) developed in order to balance the sharing of power.

Shortell (1982) then proposes three alternative models of medical staff organization that are comparable to Scott's (1987) organizational forms; the independent-corporate model, the divisional model, and the parallel model. In the independent-corporate model, the medical staffs are completely and legally independent of the functional organization with which they have a contractual relationship. Although the advantage of this model to the medical staff is considerable autonomy, there are difficulties in forming such a group.

Other disadvantages are the difficulties of coordination, and the reduction of the ability to respond to changes rapidly.

The divisional model is one in which the medical staffs are organized in medical divisions and the division heads have the functional support to conduct their tasks. The hospital becomes a totally integrated caring organization where vice-presidents for finance, planning etc... have staff duties and coordinate with the divisions' managers. Shortell (1982) equates this model to Scott's conjoint organizational form. Cross-divisional teams or committees for organizational wide issues can support this structure. The medical staff would enjoy more authority and control in the divisional model but have to learn new management skills. As for the hospital, it gains better control of resources, more integration, improved efficiency and flexibility but administration on the other hand loses control over hospital administration and nursing staff as it decentralizes power and authority to the division heads. This model is appreciated in large teaching hospitals where physician managers are strong and interdivisional communication and cooperation is fostered.

Shortell's (1982) final model is the parallel model in which the existing dual authority functional structure is left untouched and a separate permanent parallel medical staff organization whose function is to integrate, plan and solve problems is created. The parallel medical staff organization members have their operating responsibilities in the functional structure and spend some of their time working for the parallel organization, usually organized in committees. Its advantage is that it enables dealing with complex problems that the functional structure is incapable of solving and it provides the medical staff with an opportunity to share their input into management issues. As for the hospital, this structure enables it to involve physicians without greatly changing the existing structure. However, much training and support of parallel staff are needed and there is the possibility that the functional organizational members perceive the parallel organization as a threat, or that it starts overriding the bureaucratic structure.

Kimberly, Leatt and Shortell (1994) describe the different forms of hospital structures and note the presence of functional structures in small general hospitals, divisional structures in large teaching hospitals, and that, more frequently of late, matrix and program structures are being adopted as a way to improve lateral coordination and the information flow. They note that without formally adopting the matrix, most hospitals have the characteristics of matrix structures and may be considered as in the early stage of matrix structure. The fourth form they observed is the parallel structure.

Charns and Tweksbury (1993) identified nine forms of health service organizational designs and present them on a continuum moving from most differentiated (pure functional organization) to most integrated form (pure program organization):

- *Functional organization*, they note, was found in most hospitals until 1980s and can still be found in some organization. Its main advantages are economies of scale, and a strong focus on each function. Its main disadvantages are no integration, weak coordination and possible territorialism and fragmentation of care.

Parallel organizations:

- The first of these five parallel organizations is addition of a new function to the functional organization that retains its weaknesses and strengths.
- The second form is the direct contact, where integrative managers or program managers are given responsibility for specific programs that they accomplish through interpersonal skills and personal influence.
- The third form is the creation of limited lifetime task forces composed of medical staff and managers.
- The fourth form is having dedicated personnel in the organization by reorganizing departments into subunits.
- The fifth parallel organization is the creation of more permanent teams' led by one person or a nursing/medical/management trio. This form introduced dual authority and accountability to team members.

- The *matrix organizational* form with its dual functional and program dimensions, its dual responsibilities, dual authorities, dual reportability and dual career paths is liked by hospitals for its flexibility but it is difficult to achieve a true balance with the possibility of conflict due to its ambiguities.

- The final form, the *program organization*, is one in which each division is completely self-contained with only support services like finance and personnel provided centrally. This form has the advantages of being focused, integrated, and responsive to environment and consumers. However, because of the duplication of functional department's work, the loss of economies of scale, of organizational wide control on standards, and of power of all other professions other than medical staff, a modified program organization is preferred in hospitals.

With regards to matrix structures, true matrix is rare in hospitals; task forces and teams are more common and are sometimes wrongly called matrix structures. Dixon (1977) proposed the matrix structure as an alternative to the multi-disciplinary team adapted after the 1974 NHS restructuring, but admitted that considering the practical difficulties faced at implementing the multi-disciplinary team structure, it would not be simple to implement the more permanent and administratively difficult to manage structure.

Mintzberg (1979a) divided the organization into five parts; the strategic apex (those who set the strategic direction), the operating core (those who do the basic work), middle line (middle and lower managers), technostructure (those who are responsible for standardizing work processes-staff and not line responsibility) and the support staff (those who provide indirect services), and proposed based on various of their configurations five configuration that describe most organizations:

- *The Simple Structure* is seen in small organizations where the strategic apex is one person and the operating core is a small group. Such structures, if very small, may not even have a technostructure, middle line, or support staff.
- *The Machine Bureaucracy* is found mostly in manufacturing organizations, has similar characteristics to Weber's classical bureaucracy, and its main distinguishing character is significant and well developed technostructure and support staff.
- *The Professional Bureaucracy* is mostly found in hospitals and is characterized by an important operating core (professionals) with decentralized decision making to operating core staff, an underdeveloped technostructure, and in the case of large hospitals, highly developed support staff.
- *The Divisionalized Form* is one with independent units joined by a corporate administration and may be found in multiorganizational health systems and large state governments. In this form, the middle-line is large and well developed as divisional managers have substantial responsibility and authority.
- *The Adhocracy Form* is one that is complex, nonstandardized and fluid in which power is constantly shifting from one base to another. It has similarities with the matrix structure and project form.

Mintzberg (1995) also proposed that a number of 'contingency' or 'situational' factors such as age, size, technical system, environment and power structure influence organization's choice of design. Four of these contingency factors are relevant to our research. First, the proposal that *'the larger the organization, the more elaborate its structure; that is, the more specialized its jobs and units and the more developed its administrative*

components.' (Mintzberg, 1995, p.361). Second, the more dynamic and complex the environment, the more organic and decentralized the organizational structure. Third, the greater the external control of an organization the more centralized and formalized its structure. Finally, that fashion, rather than rationality, favours the structure of the day or culture, even when this one could be inappropriate.

Before moving to the British NHS structure, a note on the bureaucratic form of organization is important as hospital characteristics such as high formality, extensive division of labour and respect for lines of authority lend themselves to the bureaucratic form (Georgopolous and Mann, 1962). The most determined defender of the bureaucratic form of organization is Jaques (1990), who states that the bureaucratic structure has, despite its problems, persisted because it is the only appropriate structure especially in large organizations. In his view the problems with bureaucracy are due to misimplementation and not understanding the nature of hierarchy and layering and gives as example implementation in hospitals, which he notes *"function in spite of the system, only because of the enormous professional devotion of their staff."* (Jaques, 1990, p. 257). However, he believes that we should stop looking for other solutions such as group dynamics, which go against the accountability systems of organizations. He concluded by saying that,

> *"Managerial hierarchy or layering is the only effective organizational form for deploying people and tasks at complementary levels, where people can do the tasks assigned to them, where the people in any given layer can add value to the work of those in the layer below them, and finally, where this stratification of management strikes everyone as necessary and welcome"* (Jaques, 1990, p. 262).

2.3.5 The NHS reorganizations and the rise of the clinical directorate within the divisional structure

The British NHS has undergone many well-documented structural changes and restructuring attempts. Studying the evolution of hospital structures in the NHS has been found to be beneficial in understanding the evolution of hospital organization structure in Qatar.

Flynn (1992) describes the NHS structure in the period after 1948 as that of a tripartite functional structure of separate nursing, medical and administrative hierarchies forming a "loose federation" in which the medical staff were in contractual relationship with the NHS. Hospitals reported to Regional Hospital Boards and were managed by Hospital

Management Committees. The 1974 reorganization had as its objectives to improve coordination, unity, management and efficiency by introducing some 'scientific management' concepts (Flynn, 1992). Three 'tiers'; Regional Health Authorities, Regional Hospital Boards, and Area Health Authorities were created. A multidisciplinary 'Area Team of Officers' reported to a 'Regional Team of Officers' and functioned by a consensus management system. Packwood et al. (1992) note the presence of specialty divisions in the area's structure as early as then.

The 1983 Griffiths Report (Griffiths Report, 1983) observed that the NHS had no clear management structure and, drawing from private sector management concepts, introduced general management, accountability and scientific management methods. A hierarchical chain of command, and a high degree of centralization were achieved by appointing general managers at regional, district and unit levels and holding them accountable for performance and the creation of directorates of finance, personnel, etc... (Flynn, 1992; Harrison, 1988; Packwood et al., 1992) But the greatest contribution of the Griffiths Report to the NHS was the introduction of a management philosophy and concepts of performance and efficiency (Davidson, 1989).

Packwood et al. (1992) note that:

> *"The overall (result) was a structure that was familiar and flexible. But because it represented an amalgam of past purposes, some of which conflicted, some of which had become outdated, it was a structure that required strong leadership in the key roles to provide a sense of direction"* (Packwood et al., 1992, p. 69)

Overveit (1992) in a study of the different management structures in the NHS and their relationship with professional autonomy, found three broad types:

1. *Autonomous Professional Managerial Structures.* In this type, all professionals in an authority are organized under a profession-manager. In one variant of this type, the profession manager reported to the employing authority. In the second, the profession-manager reported to a general manager, who in turn reported to the employing authority. However, the profession-manager still had access to the employing authority.
2. *Autonomous Departments.* In this type of structure, practitioners were organized in divisions with varying degrees of autonomy. In one variant the head of the department was fully accountable to the general manager. In the second, the head of the department was accountable for defined services only and in the third, the

professional leader had a more co-ordinative role. This form was most common in the NHS after the unit management of 1982.

3. *Joint Management Structures:* in this type, a general manager and a professional superior jointly managed heads of departments. In one variant they reported to a professional manager for professional issues and to the general manager for managerial issues. In the second variant multi-disciplinary teams, under the guidance of a professional superior, managed the departments.

Packwood et al. (1992) described the traditional Unit/Division structure before the introduction of the Resource Management efforts as one in which individual consultants had case autonomy and where chairmen of clinical specialties were elected and became members of the Medical Executive Committee. Nurses and other professional groups had their own hierarchies and functional budgets, and communication was mostly through hierarchical chains of management or medical representatives.

The Resource Management Initiative (RMI) commenced in 1986 and had as its aim to maximize resource utilization by actively involving clinicians and managers in decisions on resource allocation and holding them accountable (Buxton et al., 1989). This initiative was supported by the reorganizations in the last years in the NHS and more recently the 1989 White Paper proposals that reiterated the importance of giving responsibility to the medical consultants, since they are the one who decide on the allocation of resources, in resource allocation decisions and management.

Packwood et al. (1992) note that as the RM initiative continued, *"it became apparent that one set of approaches to RM could be characterized as structure-led, changes in process being seen first to require appropriate organization structure if they were to bite"* (Packwood et al., 1992, p. 67) giving resource management the reputation of being synonymous with clinical directorates (Disken et al., 1990)

The clinical directorate structure with its focus on sub-unit multidisciplinary management and the processes and outputs of care, a structure imported from the John Hopkins Hospital in Baltimore, had been introduced in NHS hospitals by 1986 (Packwood et al. 1992). Different clinical models had been existing in the US for years, such as the John Hopkins Model (unity of command), Wodinsky's model (shared accountability) and Angermeier and Booth model (split accountability) (Brady and Carpenter, 1986).

In their evaluation of RM in six sites in 1990, (Packwood et al., 1992) found that hospitals adopted one of the two models; the clinical directorate or the clinical grouping structure. In the clinical directorate structure, the clinical director who is generally a consultant maintains his practice as clinician but is also responsible and accountable for the directorate's budget. The clinical director reports either to the unit management board or the unit general manager and is a member of the unit management board. The director is supported by either a nursing director and/or a business manager. Consultants maintain their practice autonomy but adhere to directorate's plans and budget. The complications of this form are the selection of the appropriate size of directorate and the need for training clinical directors in management skills. There are also the risks that the clinical director's role does not get fully developed in terms of decision making and authority and they stay purely 'diplomatic' or on the side, that the clinical directors become 'powerful baronies'.

The second form found was the clinical group structure, which is the transitional form between the traditional structure and the clinical directorate and has been equated to the matrix structure, where the clinical director has a coordinator role. Nursing and other support staff are accountable to their own hierarchies and medical consultants contribute to the unit general management via the medical advisory committees.

Packwood et al. (1992) note that the clinical directorate structure may be viewed as further strengthening of management and bureaucratisation by incorporating the clinicians into the management hierarchy or, on the other hand, as an increase of medical power. They also link the development of clinical directorate with the *"emergence of a new post-bureaucratic form of organization (Hoggett, 1991), characterized by decentralization, managerial devolution and professional incorporation in management."* (Packwood et al., 1992, p.75)

Disken et al. (1990) in their survey of clinical management structures in 13 acute units note that these structures were similar to those developed in the US. The units they surveyed varied in number and size of clinical directorates, with smaller units having up to six clinical directorates and larger units up to 16 with sub-directorates, and paramedical departments managed by consultants as well.

They identified three alternative models of the clinical directorates, and note that in general a top-down and bottom-up approach to management has resulted in successful clinical directorates. The first is the Consultant Manager as similar to the clinical

directorate model presented by Packwood et al. (1992). It is one that is highly decentralized with the business and nurse managers reporting to the consultant manager who has complete budget and service responsibility and accountability.

The second model is the consultant coordinator, similar to Packwood et al.'s (1992) clinical grouping model, in which the consultant acts as a coordinator of services and reports to the medical representative. The final model is the clinical general manager. Although clinical general managers may be responsible for operational management, the medical staff relate to management via their hierarchy and their elected representatives. This structure relies on teams and boards for lateral coordination between doctors and managers.

Disken and al., (1990) note that important prerequisites for successful clinical directorates are clear job descriptions, role allocations, and accountabilities for each of the Clinical Director, Nurse Manager and Finance/Business/Information manager. The latter could be part time or forgone in small directorates by having a Nurse Manager only. In addition training in management skills for the clinical directors is needed as well as an understanding by key players of each other's roles and responsibilities. They also note that resistance may come from other professions than the medical staff for it removes hierarchical career ladders for them and removes the control power of respective professional hierarchies, thus weakening their position as a profession.

2.3.6 Comparision of different organizational structure models

Table 2.2 Organizational Structure Models Compared on a Differentiation-Integration Continuum is a table that presents some the different organization structure models applied in health settings and discussed in this section on a differentiation-integration continuum with models in Grid I being the most differentiated and models in Grid IV the most integrated. The last three models on the table are NHS specific and represent the various forms of the divisionalized model (Grid III).

This table illustrates how the models in Grid I, such as the functional model, autonomous model, pure mechanic model, the independent corporation and the simple structure are those that most promote differentiation. Grid III models offer a balance between differentiation and integration but even within this level there are models that lean towards more or less integration. For example, the heterogeneous model, divisional model, some

forms of the parallel organization and some forms of clinical groupings lean more towards differentiation. The mixed organization with its teams and task forces, the joint management structures and consultant manager clinical directorate models incline towards integration. Grid V models such as the parallel model, modified program or program organization promote most integration with very little differentiation. The vast array of choices of models demonstrates how difficult it is to achieve the right balance between differentiation and integration in health settings.

Shortell and Kalzyuny (1983) note that there are two purposes for organizational design, the first to achieve effective coordination and integration of tasks, and the second, to design the organization in a manner that it may monitor and respond to its environment via appropriate communication, information and control mechanisms. Galbraith (1973b) in his information-processing model suggests that the main objective of organizational design is to ensure the efficient flow of information. They, like many other organizational structuring theorists, recommend a contingency approach to organizational design (Woodward, 1965; Thompson, 1967; Lawrence and Lorsch, 1967b; Burns and Stalker, 1961a; Mintzberg, 1979a)

Table 2.2 Organizational Structure Models Compared on a Differentiation-Integration Continuum

	Level of Integrat-ion	Burns&Scott (1961b)	Scott (1987)	Shortell (1982)	Kimberly, Leatt & Shortell (1983)	Charns & Tewksbury (1993)	Mintzberg (1979a)	Overtveit (1992)	Packwood et al. (1992)	Disken et al. (1990)
Differentiation	I	Mechanic Model	Autonomous Model	Independent Corporation	Functional Model	Functional Model	Simple Structure			
	II					Parallel Organization - add new function - direct contact - task forces	Machine Bureaucracy Professional Bureaucracy	Autonomous Professional Mgt Structure		
	III A		Heterogeneous Model	Divisional Model	Divisional Model	- dedicated personnel - teams	Divisionalized	Autonomous Departments	Clinical Grouping	Clinical General Manager
	B				Mixed Organization - task forces - teams					Consultant Coordinator
	C							Joint Mgt Structures	Clinical Directorate Structure	Consultant Manager
	IV	Organic Model	Conjoint Model - matrix		Matrix Model	Matrix	Adhocracy			
Integration	V		- parallel	Parallel Model	Parallel Model	Modified Program Program Organization				

2.3.7 Conclusion on designing hospital structures

The review of hospital characteristics suggested by Georgopolous and Mann (1962) paints a picture of a highly interdependent human system that relies on extensive division of labour and formal, quasi-bureaucratic organization to function. The high degree of specialization and differentiation and multiple lines of authority make coordination vital and difficult. These characteristics have resulted in a delicate balance of power, conflicts between expert knowledge and organizational authority, the contradictory need for work accountability and autonomy, and a need for mutual understanding and clarity of roles and functions (Georgopolous, 1972)

Achieving the proper balance between differentiation and integration is particularly difficult in complex hospital settings (Georgopolous and Mann, 1962; Haimann and Scott, 1974; Thompson, 1967; Lawrence and Lorsch, 1967a; Galbraith, 1973a) and a contingent approach to selecting the appropriate coordination mechanism has been proposed (Thompson, 1967; Lawrence and Lorsch, 1969, Galbraith, 1973b). An array of coordinating mechanisms have been proposed by researchers such as organization hierarchy (Thompson, 1967; Litterer, 1965; Galbraith, 1973a and 1977; Long and Longest, 1996), administrative activities such as standardization, planning, and rules and regulations (March and Simon, 1958; Galbraith, 1977; Van de Ven et al., 1976; Huse, 1980), improving lateral relations through liason roles, integrators, task forces, and group activities (Likert, 1967; Lawrence and Lorsch, 1969; Galbraith, 1973b and 1977; Van de Ven et al., 1976; Long and Longest, 1996), improving vertical information systems and feedback (Galbraith, 1973b and 1977; March and Simon, 1958; Huse, 1980) and finally voluntary personal coordinating activities (Litterer, 1965, Van de Ven et al., 1976).

The evolution of hospital structuring in the British NHS is reviewed in order to better understand the evolution of hospital structures in Qatar. The NHS structure evolved from a tripartite functional structure (Flynn, 1992) through a multi-disciplinary team based structure, and a highly centralized bureaucratic period (Flynn, 1992; Harrison, 1988; Packwood et al., 1992) to a clinical directorate structure encouraged by the Resource Management Initiative (Packwood et al., 1992; Disken et al., 1990). However, Packwood et al. (1992) noted that because of the successive structural changes the existing structure was composed mainly of an amalgamation of past restructuring initiatives and that it required strong leadership to provide a sense of direction.

Different models of medical structure from the US and British NHS experiences are explored and compared on a differentiation-integration continuum ranging from functional, mechanistic model to the parallel or program model. However, hospital characteristics such as high formality, extensive division of labour and respect for lines of authority have been found to lend themselves to the bureaucratic form (Georgopolous and Mann, 1967) more than organic, matrix and forms (Jaques, 1990; Mintzberg, 1979a, Dixon, 1977). The vast array of choices of models demonstrates how difficult it is to achieve the right balance between differentiation and integration in health settings.

Proponents of the contingency approach such as Shortell and Kalzyuny (1983) suggest two of the purposes of organizational design; to achieve effective coordination and integration of tasks, and to monitor and respond to the environment via appropriate communication, information and control mechanisms. Finally, Galbraith (1973b) suggests that the main objective of organizational design is to ensure the efficient flow of information.

2.4 *Organizational change*

2.4.1 Introduction

This section studies some theoretical material and research on change management and structural change. First, some of the identified difficulties of managing change are explored. Second, the theoretical foundations underpinning change management are discussed. Third, some approaches to change and methods of intervention are analysed and finally, the nature and methods of achieving structural change are explored.

2.4.2 Difficulties of managing change

Managing change is difficult and problematic (Howarth, 1988; Burnes, 1992; Greenwood and Hinings, 1996). Many examples of failed or disastrous change attempts have been documented in the academic empirical and theoretical literature on change (Burnes and Weekes, 1989; Cummings and Huse, 1989; Kanter, 1989a; Keller, 1982; Greenwood and Hinings, 1996).

Some of the difficulties identified are that; most organizations find transformational change difficult and are subject to inertia (Johnson, 1987; Pettigrew, 1985; Whipp and Clark, 1986), resistance may reverse changes as in the changes in the British NHS (Greenwood

and Hinings, 1996), and political obstacles as vested interests of powerful managers are threatened such as rewards, reputation and power that are closely tied to their policies and ideologies (Greenwood, Hinings, and Miller, 1997; Burns and Stalker, 1961a; Dalton, 1959; Halberstam, 1986; Pettigrew, 1973).

Empirical literature recognizes that organizations are not autonomous islands but are set within an institutional and technical context in which predominant modes of organizing are reinforced by normative pressure from outside the organizations (Granovetter, 1985) and that strong mimetic, normative and coercive processes are at work to shape and constrain organizations, most specially in uncertain or ambiguous environments (Greenwood and Hinings, 1996; Meyer and Rowan, 1977; Oliver, 1991; Child and Smith, 1987; Zucker, 1977). Change has been found to be risky, costly and disruptive enough to dramatically destabilize organizations (Greenwood and Hinings, 1996; Hannan and Freeman, 1984). As a result of this high probability of failure, large-scale changes only occur in response to crisis (Greenwood and Hinings, 1996). Considering all the above, merits of not changing (stability, developing a competitive advantage, routine functioning, aligned expectations and smooth coordination) have been pointed out by academic literature (Greenwood and Hinings, 1996).

Another reason why change is difficult to manage is the different types of change; radical vs. incremental, revolutionary vs. discontinues, and the vast array of change techniques. Yet, change is viewed as very normal and necessary; an urgent aspect of organizational life (Kanter, 1989; Peters, 1988; Senge, 1990; Tichy and Devanna, 1986). This has also been identified in the public sector where a growing recognition of the need for fundamental changes in the way public organizational organizations are structured and managed has been noted (Berzeley, 1992; Johnston, 1993; Osborne and Gaebler, 1992; Robertson and Seneviratne, 1995). In the case of health services, changes in the national healthcare and increased public expectations are changing the characters of hospitals. In the UK, this can be seen in the recent introduction of change efforts such as the introduction of general management (1983), the Resource Management Initiative (1986) and the internal market (1990) and TQM, BPR and benchmarking initiatives (Packwood et al., 1998).

However, considering the unique features of public organizations, change management in this sector has been found to be more difficult (Robertson and Seneviratne, 1995; Meyer, 1982, Rainey, 1983; Cummings and Huse, 1989) and even more so in the political nature of hospital settings (Packwood et al., 1998).

There are many internal and external levers for change which managers need to draw upon to accomplish successful changes (Common, Flynn and Mellon, 1993). Internal levers are those within management control emphasized by organizational development literature (Greiner and Schein, 1988). External levers include competition, restructuring, power shift in stakeholders, visibility pressures and pressures for better service design though TQM or performance measurement (Common, Flynn and Mellon, 1993).

Burnes (1992) notes that the management of change is one of the key issues that distinguish the successful from the less successful organizations and that;

> *"there is a general agreement that such changes do not fail because of faults in the technology or techniques employed per se, but because of companies' lack of ability in terms of planning and managing change, motivating and involving employees, and designing and implementing suitable job and work structures – all key aspects of any type of organizational change."* (Burnes, 1992, p.151).

Thus, although change is regarded as a normal aspect of organizational life, its difficulties and risks have been well documented, especially in the public health sector (Robertson and Seneviratne, 1995; Meyer, 1982; Rainey, 1983; Cummings and Huse, 1989; Packwood et al., 1998). Some of the obstacles identified are resistance, political obstacles, and costs (Greenwood, Hinings, and Miller, 1997; Burns and Stalker, 1961; Dalton, 1959; Halberstam, 1986; Pettigrew, 1973). In large scale radical changes the obstacles compound making the probability of failure higher (Greenwood and Hinings, 1996). Drawing on the right external and internal levers for change and properly planning and managing change were found to be important for the success of the organization (Common, Flynn and Mellon, 1993; Greiner and Schein, 1988).

2.4.3 Theoretical foundations

The theory of change management is drawn from concepts, metaphors and theories from a number of social sciences disciplines ranging from child development to evolutionary biology (Burnes, 1992; Van de Ven and Poole, 1995). Van de Van and Poole (1995) identified four basic schools of thoughts that are generally used in combination to explain observed change processes[2]. The life-cycle theory regards change as imminent and that organizations move towards a prefigured end state. The teleological perspective assumes organizations are purposeful and adaptative, taking action towards an envisioned end state. The dialectical theory perspective assumes organizations exist in a

[2] See Annex 2 for a more detailed description of the basic schools of thought.

pluralistic world where stability is a balance of power and change a shift strong enough to confront status quo. Finally, the evolutionary perspective explains change as a cumulative selection and retention process of organizational forms. This study draws on all four perspectives to explain structural change but more specifically on the life-cycle, dialectical and evolutionary perspectives.

Burnes (1992) considers that three schools of thought form the central planks of change management theory:

1. The Individual Perspective school

Two views dominate this perspective; the Behaviourists and the Gestalt-Field psychologists. The Behaviourist theory assumes behaviour is learned, individuals are passive recipients of external and objective data, and human actions are conditioned by their expected consequences (Burnes, 1992). Behaviour modification can be achieved through manipulation of reinforcement stimuli by rewarding desired behaviour. Gestalt-Field theorists assume that learning is a process of gaining or changing insights, outlooks, expectations or thought patterns and that behaviour arises from how the individual uses reason to interpret stimuli (Burnes, 1992).

2. The Group Dynamics school

The oldest of the schools, it emphasizes bringing about organizational change though teams and work groups (Schein, 1969; Burnes, 1992). Lewin (1958) reasoned that individual behaviour is a function of the group environment/field and that change efforts must focus on influencing and changing the group's norms, roles and values (French and Bell, 1984; Cummings and Huse, 1989; Smith et al., 1982; Burnes, 1992).

3. The Open Systems school

This school views organizations as a composite of interconnected sub-systems and that any change to one part of the system will have an impact on other parts of the system, affecting its overall performance (Scott, 1987; Burnes, 1992). Burnes (1992, p. 157) notes that, *"The objective of the Open System approach is to structure the functions of a business in such a manner that, through clearly defined lines of co-ordination and interdependence, the overall business objectives are collectively pursued. The emphasis is on achieving overall synergy, rather than on optimising the performance of any one individual part per se."* Miller (1967) identified four principal organizational sub-systems

as; the organizational goals and values sub-system, the technical sub-system, the psychosocial sub-system and the managerial sub-system.

This research adopts the view that a holistic perspective that utilizes approaches and techniques to change from the individual, group and systems perspectives would be more appropriate. This approach has attracted support from Burns and Stalker (1961a), Woodward (1965) and Lawrence and Lorsch (1967b) (Burnes, 1992). On the other hand, it has been critiqued by Bulter (1985) and Beach (1980) as being impractical and simplistic (Burnes, 1992).

2.4.4 Models of change

Burnes (1992) suggests that most approaches to change can be related to three basic models; action research, the three-step model, and phases of planned change that in turn arose from the work of Lewin (1958). The three models are:

1. Action Research Model

Developed by Lewin (1958) and later adopted by the Tavistock Institute in Britain, action research is based on the proposition that an effective approach to solving organizational problems must involve rational and systematic analysis of the issues in question (Burne, 1992, p. 161). Action research projects are generally composed of three groups: the organization, the subject, and the change agent. The three parties agree to come together as a group, under mutually acceptable and constructed terms of reference and carry out together data gathering, analysis and diagnosis (Burnes, 1992).

Some of the barriers of action research are the need to gain the commitment of both the organization and the subject of the change as well as the importance of the presence of a "felt-need" where realization that change is necessary is important for the success of the change (Burnes, 1992).

2. Three Step Model

Lewin (1958) put forth the view that successful projects should involve three steps; unfreezing (the present level), moving (to the new level), and refreezing (the new level). The unfreezing phase requires some form of confrontation meeting or re-education process for those involved. Bowers et al. (1975) suggested achieving this through team

building or other forms of management development activities, in which the problem to be solved is analysed and data presented to demonstrate the existence of a serious problem (Burnes, 1992).

The main objective of the refreezing phase is stabilizing the organization at a new state of equilibrium in order to safeguard from regression to the old ways of working (Burnes, 1992). It is achieved through the use of supporting mechanisms that positively reinforce the new ways of working; such as organization culture, norms, policies and practices (Cummings and Huse, 1989). The main barrier of this model is that the three steps towards change are somewhat broad and require further definition (Burnes, 1992).

3. Phases of Planned Change Model

Writers have developed Lewin's three-step model into a number of phases. After reviewing over 30 model of planned changed, Bullock and Batten (1985) developed an integrated, four phase model of planned change which describes planned change in terms of two major dimensions: change phases (distinct states an organization moves through as it undertakes planned change) and change processes (methods used to move an organization from one state to another) (Burnes, 1992).

The four change phases identified by Bullock and Batten (1985) are:

Exploration Phase: Change processes related to this phase include realization of the need for change, searching for outside assistance to assist with planning and implementing the change, and establishing a contract with the consultant which defines each party's responsibilities.

Planning Phase: Change processes related to this phase include information collection for proper problem diagnosis, establishing the change goals and designing the appropriate actions to achieve these goals, and getting key decision makers to approve and support the proposed changes.

Action Phase: Change processes of this phase include establishing appropriate arrangements to manage the change process and gain support for the actions to be taken, evaluating the implementation activities, and feeding back the results so that any necessary adjustments or refinements can be made.

Integration Phase: Change processes of this phase include reinforcing new behaviours through feedback and reward systems, gradually decreasing reliance on the consultant, diffusing the successful aspects of the change process throughout the organization, and finally, training managers and employees to monitor the changes constantly and seek to improve them.

Burnes (1992) notes the fundamental difference between the different approaches is the degree of positive involvement of those who are expected to change. The choice of approach reflects management's core values and beliefs and the dominant culture that exists in the organization. He also comments on the importance of achieving behavioural change:

> *"No matter which theory or level of focus (the individual, the group, or the organization) was adopted, the end result was the same: the need to change the way individuals and groups behave. This is a true for situations that involve changes in technology and structures as it is for those that solely involve changes in tasks. If the changes in structures and tasks are not accompanied by changes in behaviour, then the objectives of the change process are unlikely to be fully met"* (Burnes, 1992, p.167).

In reviewing quality management programs implementation Joss and Kogan (1995) found that a variety of change models have been applied to the NHS in the two commercial research sites observed. Four of the seven models that they have identified are relevant to this study[3]:

1. Top-down and bottom-up models of change

Top-down models assume that sound allocative decisions are best taken from the top (Hunter, 1983). Since policy-making and implementation are interactive processes, such approaches tend to inhibit rather than promote innovation at peripheries (Joss and Kogan, 1995). Bottom up models on the other hand aim at consensus through learning rather than compliance and control (Hunter, 1983; Joss and Kogan, 1995). The most effective sequence of introduction and implementation has been found to be those that are top-led and bottom fed where joint agendas are created with those on the operational levels (Joss and Kogan, 1995).

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[3] The other models identified are: normative and operational models of working, managerial and collaborative modes and policy and planning process (Joss and Kogan, 1995).

2. Backward mapping and forward mapping

Similar in concept to bottom-up and top down models backward mapping and forward mapping focuses on implementation. In forward mapping models, the traditional implementation process, policy-makers at the top of the organization set objectives and implementation is achieved through phased application of specific techniques (Joss and Kogan, 1995). On the other hand, backward mapping starts at the point of delivery and, similarly to top-led and bottom fed models (Hunter, 1983), a balance of backward and forward mapping activities (Elmore, 1982) can be achieved for better results (Joss and Kogan, 1995).

3. Normative re-education and coercive strategies

These are based on theories on ways in which individuals or groups can be persuaded to work. In contrast to coercive strategies, normative re-education approaches brought about by change agents assume that culture will move forward towards *"open learning and dynamic self correction"* and emphasizes the involvement of clients in the program of change (Chin and Binn, 1969; Joss and Kogan, 1995).

4. Rational organization and political bargaining

The organization's rational process and political bargaining cannot be separated when considering change programs (Joss and Kogan, 1995). According to Wolman (1984) implementation is primarily a rational process divided into the formulation and carrying out phases. The program formulated must be designed in a manner to analyse organizational capacity and problems, to accommodate for political problems, and to tackle unintended consequences of change in order to succeed (Joss and Kogan, 1995).

Authors agree that change interventions are generally structured, involving several distinct states and aiming at, directly or indirectly, improving performance (French et Bell, 1984; Bullock and Batten, 1985; Burnes, 1992). However, with the vast array of interventions and techniques available, choosing the appropriate response to the organization's particular situation is difficult and managers can be tempted to select the response which is easiest, nearest, or most successfully promoted even in presence of evidence pointing to their weakness or irrelevance (Simon, 1957; Burnes, 1992, Hinings and Greenwood, 1996).

Argyris (1970) points out that for interventions to be successful they must generate valid information, provide free informed choice for those involved, and create a commitment on the part of those involved to the choices made. Later Burke et al. (1981) added that successful interventions must also lead to cultural change (Burnes, 1992). This condition has been added based on the argument that organizational socio-structures are supported and legitimised by organizational culture (Allaire and Firsirotu, 1984; Burnes, 1991 and 1992; Handy, 1986).

French and Bell (1984) focused on the role of the change agent in structuring the intervention in order to ensure the success of the change intervention. French and Bell (1984) classified activities to be performed in interventions as; diagnostic activities, team-building activities, inter-group activities, survey feedback activities, education and training activities, techno-structural or structural activities, process consultation activities, Grid Organization activities, third party peacemaking activities, coaching and counselling activities, life-and career-planning activities, planning and goal-setting activities, and strategic management activities.

The works of Schmuck and Miles (1971) and Huse (1980) introduced the concept of level of involvement making it possible to link levels of involvement to the types of change involved (Burnes, 1992)[4]. Huse (1980) categorized change interventions along a continuum based on the "depth" of intervention, ranging from the "shallow level" to the "deepest level". Deep level intervention or change, he proposes, is one that is concerned and affects the work and personality of the employees and requires full involvement of the individual for it is to be accepted (Burnes, 1992, p.173).

This section outlined various models of change. Burnes (1992) identified three basic models; action research, Lewin's three-step model and phases of planned change. Most relevant to this research are Lewin's unfreezing, moving and refreezing phases and Bullock and Batten's (1985) four phases; exploration, planning, action and integration. Joss and Kogan's (1995) top-down and bottom-up models, backward and forward mapping, normative re-education and coercive strategies and political bargaining are also relevant to this research.

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[4] Schmuck and Miles (1971) produced a classification of methods and techniques under three headings; the diagnosed problem, the focus of attention and the mode of intervention.

All models and schools of thoughts emphasize the importance of achieving behavioural change but differ in the degree of involvement of those expected to change. Research has suggested that successful interventions are those containing free exchange of information, involvement and lead to cultural change (Argyris, 1970; Burke et al., 1981; Allaire and Firsirotu, 1984; Burnes, 1991 and 1992; Handy, 1986). The level of involvment has been linked to the type of change whereby the greater the depth of intervention, the greater the need for involvement of individuals (Schmuck and Miles, 1971; Huse, 1980).

2.4.5 Structural change; radical transformational or incremental?

Structural change has been highly in focus in the public sector as a means for improving public sector performance. Hinings and Greenwood (1988, p.47) question the appropriateness of such changes noting that when considering organizational design the priority to be placed respectively on structure, processes, people, attitudes, behaviour, and values and culture needs to be carefully considered.

Burnes (1992) notes that when looking at structural change, the more the structural change touches on individuals in the organization, requiring a change in their jobs, group or individual norms and behaviour the higher the level of involvement required and subsequently the appropriate change technique which provides for the required level of change should be selected.

The contingent link between structure and strategy has for years captured the interest of researchers. Chandler (1962) first argued that structure follows strategy and this was substantiated by researchers (Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 1981; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984). However, Bower (1970) proposed structure as a cause of strategy and this was examined by Grinyer and Yasai-Ardekani (1981), Hall and Saias (1980), Keats and Hitt (1988), Mintzberg (1979a), Pitts (1980), Rumelt (1974), and Williamson (1985). Minztberg (1995, p.183) found a stronger reciprocracy between strategy and structure, that neither takes precedence over the other, that *"each always precedes the other, and follows it, except when they move together, as the organizational jumps to a new position."*

Amburgey and Dacin (1994) in reviewing empirical research on this relationship found that the link between strategy and structure is based on efficiency and effectiveness and that the link between structure and strategy is based on the evolution of managerial cognition and skills. Their study supports the common conception of a contingency relationship

between strategy and structure. A change in strategy was found to increase the probability of a change in structure, with the change in structure taking place relatively soon. The opposite was also found, that a change in structure was found to increase the probability of a change in strategy, with the change of strategy taking place relatively soon. Their study also supported the hierarchical relationship between strategy and structure, where strategy was found to be a much more important determinant of structure than structure is of strategy and changes in structure were found to more commonly follow changes in strategy.

With regards to substantial changes like strategic, cultural, or structural changes authors argue and support a quantum view of change (Miller, 1986; Greenwood and Hinings, 1988; Amburgey, Kelly and Barnett, 1993; Hoskisson and Galbraith, 1985; Keck and Tushman, 1993; Amburgey and Dacin, 1994) where organizations make substantial changes only when it is absolutely necessary or extremely advantageous. Since such changes create disruption, organizations rapidly seek to cluster change element in order to achieve harmony and minimize disruption (Amburgy and Dacin, 1994).

Incremental change is piecemeal, uncoordinated in nature, and deals with smaller issues with the aim to fine tune an existing orientation based on current perspectives (Miller, Greenwood, and Hinings 1997; Burnes, 1992). Burnes (1992) views radical change as a coordinated sequence of incremental changes covering an extended time period and notes, *"it is the consistency and pattern which separates radical from incremental change rather than the differences in the actual tools and techniques"* (Burnes, 1992, p. 179).

Nutt and Backoff (1997) describe transformational change, as one which creates paradigmatic shift shaking underlying assumptions and perceptions, and which requires second order change processes. In reviewing the literature they found transformational change is generally achieved through three approaches; leadership, structure, and chaotic events. In the first, the leaders are the instruments of radical change and the ultimate direction is constructed as the leader progresses (Kouzes and Posner, 1987; Tichy and Devanna, 1986). The second relies on architecture to produce radical change and, to some extent; structure becomes a substitute for leadership where the transformational vision is more intentional than emergent (Galbraith et al., 1993; Nadler et al., 1992). The third approach views transformation as emergent, where order emerges from disequilibrium (Land and Jarman, 1992; Pringogine and Stengers, 1984; Wheatley, 1992).

When discussing the success of transformational changes Hinings and Greenwood (1988) stress the importance of the support of political leaders with a strong commitment to change while maintaining consultation and openness rather than tight management control. They also stress the importance of communication strategies, incentives, rewards and strategies for dealing with resistance to change.

Denis et al. (1996) stress the importance of strategic leadership in periods of change. However, in situations of ambiguity, such as in autonomous professional organizations, change requires collaborative leadership *"involving constellations of actors playing distinct but tightly-knit roles"* (Denis et al., p.695). However, this type of leadership is fragile and can easily be disintegrated by internal conflicts. As a result, transformational change was found to occur in cyclical patterns in which periods of change alternate with periods of political realignment (Denis et al., 1996).

Packwood et al.'s (1998) findings from a case-study of business processes re-engineering (BPR) application in a hospital suggest that it is difficult to attribute gains to BPR, *"despite the hard-nosed character of much of the rhetoric surrounding BPR, it seems that much of the gain is attitudinal; making staff more open to change and giving them some tools for its management"* (Packwood et al., 1998, p. 414). They also note that the matrix type of structure which revolves around the client challenges the traditional hospital structures and that successful BPR projects need to *"work with rather than seek to overturn the organizational status quo"* as well as seek the involvement and commitment of powerful interests (Packwood et al., 1998, p.414). Finally they note that radical change is difficult in public sector service organizations, and a more incremental approach needs to be adopted noting that, if *"BPR has to be applied incrementally and selectively it doesn't look very different from other quality initiatives such as TQM and benchmarking"* all of which have similar objectives and are perceived as radical within the highly professional hospital context (Packwood et al., 1998, p. 414).

In this section, it has been noted that research on structural change emphasizes the importance of a holistic perspective considering structure, processes, culture and behaviour; the need for more involvement at deep level structural change and the importance of strategies for dealing with resistance (Hinings and Greenwood, 1988; Burnes, 1992). A link between structure and strategy has been established whereby each precedes and follows the other except when they move together and the organization jumps to a new position (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976;

Grinyer and Yasai-Ardekani, 198; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984; Minztberg, 1995).

Transformational change was found to be achieved through leadership guidance, structural change, or chaotic events whereby order emerges from disequilibria (Nutt and Backoff, 1997). The cyclical pattern of transformation change and the importance of leadership in periods of change were stressed (Denis et al., 1996). Finally, based on the British NHS BPR experience, it was found that radical change is difficult in public services and incremental approaches more successful (Packwood et al., 1998).

2.4.6 Conclusion on change management

The difficulties and risks of change are compounded in the public sector and in large-scale radical changes (Robertson and Seneviratne, 1995; Meyer, 1982; Rainey, 1983; Cummings and Huse, 1989; Packwood et al., 1998, Greenwood and Hinings, 1988). Properly planning and managing change are important for the success of the change attempt. Change theory has developed from a number of social sciences disciplines and has different dominant schools of thought. The present research draws on all schools to explain structural change but more specifically on the life cycle, dialectical and evolutionary perspectives (Van de Ven and Poole, 1995). Additionally, this research adopts the view that a holistic perspective which approaches change from the individual, group and systems perspectives would be the more successful for change management (Miller, 1967; Burnes, 1992; Burke, 1980; Burns and Stalker, 1961; Wodward, 1965; Lawrence and Lorsch, 1967b).

Various models of change have been identified (Burnes, 1992; Lewin, 1958; Bullock and Batten, 1985). All models and schools of thought emphasize the importance of achieving behavioural change but they differ in the degree of involvement of those expected to change. The level of involvement has been linked to the type of change whereby the greater the depth of intervention, the greater the need for involvement of individuals (Huse, 1980; Schmuck and Miles, 1971).

Researchers on structural change emphasize the importance of a holistic perspective considering structure, culture and behaviour (Hinings and Greenwood, 1988; Burnes, 1992). The reciprocal link between structure and strategy has been explored (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 1981; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984; Minztberg, 1995). Radical

transformational change was found to be cyclical and achieved through leadership, structure or chaotic events (Nutt and Backoff, 1997; Denis et al., 1996). Finally, incremental approaches have been found to be more successful in the public health sector then radical change (Packwood et al., 1998).

2.5 Conclusion

The first section traced the evolution of theorists' view of the organization and research methods throughout the various schools of thought and introduces the theories and perspectives of this study. This study draws on various perspectives. Studies from the organizational behaviour perspective, 'modern' structural theories, systems, contingency and population ecology perspectives, multiple constituencies perspective, power and politics theories and the organizational culture and symbolic management perspectives are used to understand hospital organizational structure, change management, organizational and team effectiveness, and professional and organizational culture.

The second section explored designing hospital structure by first discussing hospital characteristics that influence organizational design. The difficulties in achieving the proper balance between integration and differentiation have been emphasised. Finally, different models of medical structures from the US and British NHS experiences have been explored and compared on a differentiation-integration continuum. The vast array of choices of models demonstrates how difficult, and contingent on organizational context, it is to achieve the right balance between differentiation and integration in health settings.

The third section explored change management theory by drawing on a variety of schools to explain structural change but more specifically on the life cycle, dialectical, and evolutionary perspectives. The importance of a holistic perspective that considers structure, culture and behaviour has been emphasized. Various models of change have been identified. All models and schools of thought emphasis the importance of achieving behavioural change but differ in the degree of involvement of those expected to change. Finally, the link between structure and strategy has been explored as well as the differences in radical and incremental change experiences.

CHAPTER 3 THEORIES OF ORGANIZATIONAL AND TEAM EFFECTIVENESS

3.1 *Introduction*

This chapter explores some of the theoretical material on organizational and team effectiveness. First, organizational effectiveness is addressed by discussing the different definitions and assessment approaches to organizational effectiveness. A special focus is placed on the Competing Values Approach developed by Quinn and Rohrbaugh (1981) and on evaluating health services. In the second section, some of the literature on team types, designs and evaluation are explored. Factors that may affect group effectiveness are discussed. Finally, some problems that are specific to the British NHS experience in health team management are explored.

3.2 *Organizational effectiveness*

3.2.1 Introduction

This section on organizational effectiveness commences by exploring organizational assessment research then moves to approaches to measuring organizational effectiveness with a special emphasis on the Competing Values approach. Finally, some research on the complexities of measuring effectiveness in the public sector and in health services in particular are studied.

3.2.2 Organizational assessment perspective

Review of literature reveals that authors have different definitions and assessment approaches to organizational effectiveness. Traditionally, organizational research, for example the works of Gorgopolous and Tannenbaum (1957), Etzioni (1964), Price (1968), Campbell (1977) and Hall (1978), define effectiveness in terms of output and goal accomplishment. During the same period other researchers approached effectiveness from a resource acquisition (Yutchman and Seashore, 1967) and human satisfaction (Barnard, 1938; Bass, 1952; Kahn, 1956; and Cyert and March, 1963) perspective. Numerous models and little agreement over the definition and criteria for organizational effectiveness can characterize this early period (Campbell, 1973; Steer, 1975; Campbell, 1977)[5].

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[5] See Annex 3 for a review of early organizational effectiveness studies.

Lawler, Nadler and Camman (1980), Van de Ven (1980), Goodman (1979), Goodman and Pennings (1980) approached effectiveness from the behavioural and social system perspective. This more holistic approach to measuring effectiveness led organizational assessment researchers to be concerned with establishing a wide range of variables that reflect the functioning of the whole system (Carnall, 1982, p.15). Lawler, Nadler and Camman (1980) defined organizational assessment as;

> *"the process of measuring the effectiveness of an organization from the behavioural or social system perspective. Effectiveness includes both the task performance capabilities of the organization (i.e. how well various components of the organization are structured and function to perform tasks) and the human impact of the system on its individual members. Thus organizational assessment is primarily defined by its focus on the organization as a whole, its concern with the two dimensions of effectiveness and its essentially behavioural perspective."* (Camman, 1980, p.6)

Van de Ven (1980) proposed a framework with four levels of analysis; organization, organizational unit, job, and interaction. Various dimensions including organizational design, work groups, information flows and outcomes were proposed for each level of analysis. The present study focuses on the organization and interaction levels of analysis.

Van de Ven (1980) suggested that:

> *"Organizational performance is the ultimate criterion and starting point in an assessment of organizations. Performance is a complex construct that reflects the criteria and standards used by decision makers to assess the functioning of an organization."* (Van de Ven, 1980, p. 223)

Van de Ven brings to attention that the different decision makers may disagree with regards to the criteria to be used and in his opinion assessment does not require that everyone agree but, rather, that conflicting views be made explicit and that the organization (Van de Ven, 1980, p.223) *"determine on the onset whose value judgements and criteria will be operationalized and measured."*

Thompson (1967) suggests,

> *"that when standards of desirability are ambiguous and when cause/effect knowledge is believed incomplete, organizations turn to (social) reference groups. This immediately confronts us with one of the central questions raised by reference group theory: to which reference groups does the organization turn?"*
> (Thompson, 1967, p. 87)

Thompson (1967) also put forth a group of propositions on how organizations assess themselves. Those that have been found relevant to this study are[6]:

> *'Under norms of rationality, organizations and others assessing them (Prop. 7.1) prefer efficiency tests over instrumental tests, and instrumental tests over social tests. But efficiency test are not possible when technical knowledge is incomplete or standards of desirability are ambiguous. Since both of these conditions exist at the institutional level of organizations (Prop. 7.2), fitness for the future is measured in satisfying terms, especially by comparison with past performance or other organizations.*
>
> *Organizations are multidimensional, and when they cannot show improvement on all dimensions (Prop. 7.3), they seek improvement on those of interest to important elements of the task environment. Organizations (Prop. 7.4) especially emphasize scoring well on criteria which are visible to important elements of the task environment; and when it is difficult to score on intrinsic criteria (Prop. 7.5), organizations seek extrinsic measures of fitness for the future. Finally, organizations assess their components in terms of past efficiency (Prop. 7.6) when technologies are perfected and task environment stable or well buffered.'*
>
> (Thompson, 1967, p. 97)

Carnall (1982, p. 16) when reviewing the organizational assessment approach notes that the problem with such holistic approaches is that they require that once differences of view are recognized, researchers must analyse and compare differences in order to establish the causes and consequences of the differences of values, views and interests within the organization. In addition he notes that;

> *"The organizational assessment approach, which appears to be a methodologically sophisticated combination of goals, system resources and participation satisfaction approaches to organizational effectiveness, appears to focus on system goals, in the main."* (Carnall, 1982, p. 16)

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[6] Other propositions put forth by Thompson (1967) are; *"when technologies are reasonably perfected and the environment reasonably stable (Prop. 7.7), organizations seek to account for interdependence and assess each unit in efficiency terms. But where cause/effect knowledge is incomplete (Prop. 7.8), organizations measure components in terms of organizational rationality; or when the unit is too autonomous to be evaluated by other components (Prop. 7.9), extrinsic measures are used. Finally (Prop. 7.10), when units are subject to multiple criteria, organizations adjust their relative weighting as the organization's relations to its task environment fluctuates."* (Thompson, 1967, p. 97).

Goodman and Pennings (1980) consider the more normative Organizational Development perspective which attempts to specify an ideal type of organization and assess present status to the ideal type[7]. They also describe the organization as a political arena, made up of internal and external constituencies with a dominant coalition negotiating its position and displacing other coalitions.

Thus, organizational assessment writers introduced a more holistic approach to measuring effectiveness (Lawler, Nadler and Camman, 1980; Van de Ven, 1980; Goodman, 1979; Goodman and Pennings, 1980; Carnall, 1982). Goodman and Pennings (1980) considered the normative organizational development perspective, which attempts to specify an ideal type of organization. Researchers thereafter tried to categorize and make the principles of organizational effectiveness more practical by looking for similarities in organizational effectiveness research (Scott and Shortell, 1983; Graetner and Ramnarayan, 1983; Quinn and Rohrbaugh, 1981; Cameron, 1984; Robbins, 1990).

3.2.3 Approaches to measuring organizational effectiveness

Scott and Shortell (1983) identified four factors that affect one's conception of organizational performance: the nature of the organization, the level of analysis, the varying constituencies and time considerations. By nature of organization they mean whether the organization is conceived as mechanic, organic or an open system. By level of analysis they mean whether one is looking at the organization itself, a larger socially defined unit that contains the organization, or subunits contained within the organization. Defining the level of analysis is further complicated by the fact that Scott and Shortell (1983) note that,

> *"system performance at any given level may not be analysable as a simple aggregation of system performance of lower parts and that social organizations are loosely coupled therefore making it possible for the same system to contain both highly effective and ineffective subunits."* (Scott and Shortell, 1983, p.432)

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[7] This is based on the belief *"... that individuals ought to have the opportunity to self actualize and preserve their integrity and uniqueness in an organizational setting ...Organizations should give individuals responsibilities to set their goals and manage their work with respect to these goals. Communication systems should be open in undistorted ... Conflict should confronted and resolved through problem solving...."* (Goodman and Pennings, 1980, p.189).

With regards to varying constituencies, according to Cyert and March's (1963) coalition model of organizations, organizations are usually viewed as shifting coalitions of interest groups, some internal, others external to the organization, that are constantly engaged in negotiating and renegotiating conditions of their participation. Although the presence of one dominant coalition whose interest carries more weight than the others is often seen, today most organizational power is more widely distributed (Scott and Shortell, 1983, p. 424).

From an organizational life cycle view, the time at which the performance of an organization is assessed may influence the judgement reached (Scott and Shortell, 1983, p.424). Studies by Cameron and Whetton (1981) suggest that effectiveness criteria vary according to stage of development. Their findings propose that initial stages of development emphasize factors such as creativity and the mobilization of resources; later stages stress commitment and cohesion among member, and later, formal processes of control and efficiency concerns come forth and the final stages emphasis structural elaboration, decentralization, and flexibility.

Graetner and Ramnarayan (1983) characterized the different definitions and approaches to organizational effectiveness by two major dimensions: focus on definition and intended use of concept. They cross-classified these two dimensions, which resulted in four distinct types of approaches; general output measures, organization-specific output measures, process/structure general measures and process/structure organization specific measures.

General output measures are traditional general output measures (e.g. accounting measures, organizational survival) and organization-specific outcome measure instruments for the measurement of specific organizational goals. Process/structure general measures are measures of theoretical notions on management processes and organizational structure and process/structure organization specific measures measure the efficiency of organization structure and processes[8].

Graetner and Ramnarayan (1983) finally conclude by reminding us the importance of the political model in assessing organizational effectiveness. This approach defines effectiveness in organizations as a state of relations within and among coalitions.

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[8] For a more detailed description of these four approaches see Annex 4.

Perrow (1977) suggests:

> *"Instead of starting with a dependent variable that is presumed public good and asking why we are getting it or not getting it, we should ask "who is getting what" from the organization or "effective for whom?". The question presupposes a definition of organization that is different from that assumed by many schools of thought. If we define organizations .... As intentional human constructions wherein people and groups within and without the organization compete for output of interest to them under conditions of unequal power, we have posed the issues of effectiveness quite differently than in other perspectives."* (Perrow, 1977, p. 101)

Robbins (1990) notes that there is an almost unanimous agreement today that organizational effectiveness requires multiple criteria, that different functions have to be evaluated using different characteristics and that organizational effectiveness must consider both means and ends. He further defines organizational effectiveness as *"The degree to which an organization attains its short-(ends) and long-term (means) goals, the selection of which reflects strategic constituencies, the self interest of evaluator and the life cycle of the organization."* (Robbins, 1990, p. 77)

Robbins (1990) goes about categorizing the approaches into four; the Goal Attainment Approach, the Systems Approach, the Strategic-Constituencies Approach, and the Competing Values Approach.

The problems identified of the Goal Attainment Approach are multiplicity of goals, the different coalition's goals and the fact that what an organization states officially as its goals does not always reflect the organization's goals. (Robbins, 1990; Warriner, 1965). This approach is most useful when organizational goals are clear, time bound and measurable (Cameron, 1984, p.276).

The problem in the Systems Approach is that trying to develop valid and reliable measures for process variables such as "*flexibility of response to environmental changes*" may be difficult and whatever measures used may be constantly challenged. Another problem is that this approach's focus is on the means necessary to achieve effectiveness rather than on organizational effectiveness itself (Robbins, 1990, p. 61). This approach is most useful when a clear connection exists between inputs and outputs (Cameron, 1984, p.276).

The Strategic Constituencies Approach proposes that an effective organization is one that satisfies the demands of those constituencies in its environment from whom it requires support for its continued existence (Pfeffer and Salancik, 1978). This approach is most useful when constituencies have powerful influence on the organization, and the organization must respond to their demands (Cameron, 1984, p.276). Robbins (1990) suggests two main problems with this approach; the difficulty in separating the strategic constituencies from the larger environment and the difficulty in identifying the expectations that strategic constituencies hold for the organization.

3.2.3.1 *The Competing Values Approach*

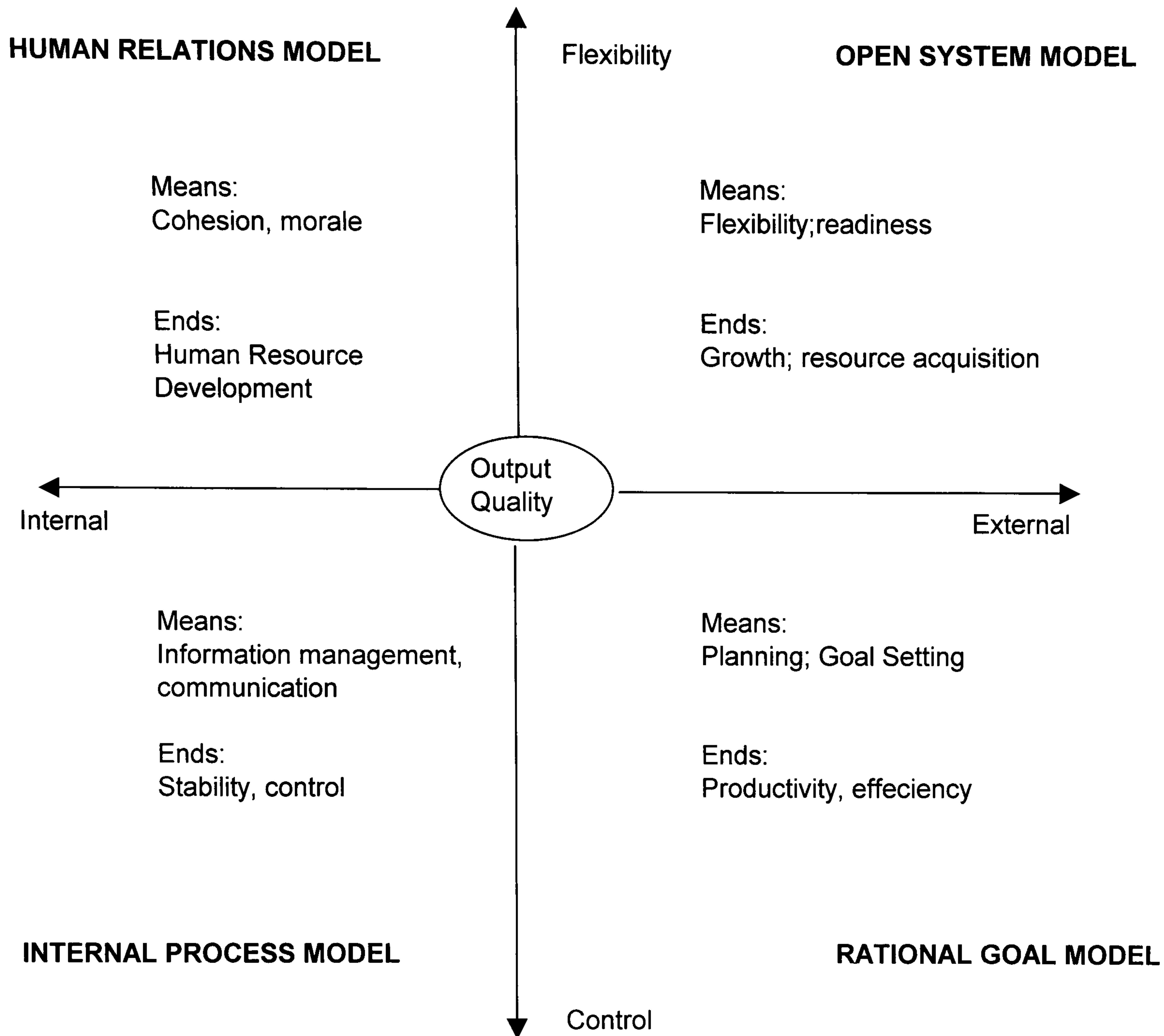
The fourth approach, The Competing Values Approach, offers an integrative framework (Quinn and Rohrabaugh, 1981 and 1983). It is based on the assumption that:

> *"....there is no best criterion for evaluating an organization's effectiveness. There is neither a single goal that everyone can agree upon nor a consensus on which goal takes precedence over others. Therefore the concept of organizational effectiveness itself is subjective and the goals that an evaluator chooses are based on his or her personal values, preference and interests."* (Robbins, 1990, p. 78)

Searching for common themes among the thirty organizational effectiveness criteria compiled by Campbell (1977), Quinn and Rohrabaugh (1981) found three basic sets of competing values; flexibility vs. control, people vs. organizations, and means vs. ends. These values were further combined into eight sets of organizational effectiveness criteria and these eight criteria combined into four distinct and contrasting models (See Figure 3.1 The Competing Values Framework):

The Human Relations Model: Defines organizational effectiveness in terms of a cohesive (as means) and skilled (as ends) workforce. It emphasizes people and flexibility.
The Open System Model: Defines effectiveness in terms of flexibility (as means) and the ability to acquire resources (as ends).
The Rational-Goal Model: The existence of specific plans and goals (as means) and high productivity and efficiency (as ends) is used as evidence of effectiveness.
The Internal-Process Model: Emphasizes people and control and stresses adequate dissemination of information (as means) and stability and order (as ends) in the assessment of effectiveness.

Figure 3.1: Competing Values Framework (Quinn and Rohrbaugh, 1983)



In offering an explanation of the Competing Values framework, Quinn and Rohrbaugh (1981) note that:

> *"The human relations model with its effectiveness criteria reflecting people and flexibility stands in stark contrast to the rational goal model's value-based stress on organization and stability. The open-system model, defined by values of organization and flexibility, runs counter to the internal process model, the effectiveness criteria of which reflect a focus on people and stable structures."* (Quinn and Rohrbaugh, 1981, p.138)

The competing values framework has been used to measure organizational effectiveness in UK and Australian higher education institutions (Hatherly and Lysons, 1996; Hatherly et al., 1998). No evidence of the model being applied to assess effectiveness in hospital settings has been found. Being based on subjective, cultural aspects and perceptions the model has also been used to assess organizational culture (Dastmalchain et al., 2000; Cameron and Freeman, 1991; Howard, 1998), organizational design and leadership (Quinn, 1984), organizational structure (Buenger et al., 1996) and ethics (Stevens, 1996).

In a cross-cultural study, Dastmalchain et al. (2000) applied the competing values framework to compare organizational and national culture in Canada and South Korea. No major variation in findings by country were found but significant differences emerged when comparisons where made by industry. Health related industries were found to score highest on the Human Relations model making it a 'clan culture' run like an extended family and where the focus is on employee cohesion, morale and commitment.

The organization's stage in its life-cycle is important at predicting which model of effectiveness will and should take precedence (Quinn and Cameron, 1983; Robbins, 1990). For example, an organization in its beginning stage needs innovation, creativity, enterpreneurialship and flexibility, criteria emphasized by the Open Systems model.

Robbins (1990, p.75) notes that although the competing values model encompasses both ends and means thus overcoming the problems of using merely the goal-attainment or systems approaches, it does not manage to overcome the problem of separating the strategic constituencies from the larger external environment or identifying the expectations of these constituencies. It helps in better assessing the constituencies' perceptions of how well an organization is doing on the eight criteria but does not clarify which criteria the constituencies are emphasizing. He also notes that linking life cycle to organizational effectiveness models is interesting but more research is needed.

In this section we explored how Scott and Shortell (1983) suggest that the nature of the organization, the level of analysis, the varying constituencies and time considerations affect one's perception of organizational performance. Graetner and Ramnarayan (1983) in a review of organizational effectiveness measures identified four types of measures; general output measures, organization-specific output measures, process/structure general measures and process/structure organization specific measures.

Robbins (1990) concludes that organizational effectiveness assessment requires multiple criteria, that different functions have to be evaluated using different characteristics and that organizational effectiveness measures must consider both means and ends. He categorizes the different approaches to organizational effectiveness into four: the Goal Attainment Approach, the Systems Approach, the Strategic-Constituencies Approach, and the Competing Values Approach.

The Competing Values approach assumes that there is no best criterion for evaluating organizational effectives and that evaluation is a subjective process (Quinn and Rohrabaugh, 1981 and 1983). This integrative framework which encompasses measures of both means and ends has been used to assess organizational effectiveness (Hatherly and Lysons, 1996; Hatherly et al., 1998), organizational culture (Dastmalchain et al., 2000; Cameron and Freeman, 1991; Howard, 1998), organizational design and leadership (Quinn, 1984), organizational structure (Buenger et al., 1996) and ethics (Stevens, 1996). Although this framework does not succeed in separating the strategic constituencies from the larger external environment or identifying the expectations of these constituencies (Robbins, 1990), it has been selected as measurement tool in this study for its comprehensiveness.

3.2.4 Effectiveness in public sector (non-profit) and health sector

Health service effectiveness measurement is conceptually difficult. Klein (1982) notes about the NHS that the difficulty in performance evaluation stems from the fact that it is a policy arena *"distinguished by its complexity, heterogeneity, uncertainty and ambiguity"* (Klein, 1982, p.386). He adds that,

> *"its complexity inevitably generates a variety of objectives; heterogeneity reinforces competition between criteria; uncertainty and ambiguity add to the difficulties of appealing to the "facts" as a way of resolving the debate. The dominance of producers means that performance cannot be judged by its success in meeting demands, while the absence of statuary definitions of the clientele means that it cannot be assessed on the basis of legislative criteria"* (Klein, 1982, p.386).

This is further complicated if the service organization is a non-profit public organization. Kanter and Summers (1987, p.154) note that: *"'Doing good' is a matter of societal values about which there may be little or no consensus. It is this factor - the centrality of social values over financial values - that complicate measurement for non-profit organizations."* In addition this is further complicated by the mission-directedness of the organization (Kanter and Summer, 1987).

Kanter and Summer (1987, p.163) identified six dilemmas of non-profit performance measurement in service proving organizations that account for the virtual absence of evaluation systems. First, services are generally intangible and hard to measure (Thompson and McEwen, 1958; Newmann and Wallander, 1978) and in some cases outcomes are inherently unknown (Drucker, 1968). The clients have weaker influences and the needs of donors play a much bigger role (Kanter and Summer, 1987). In addition cases where nonprofits face little competition, recipients of services tend not to provide feedback (Selby, 1978).

Second, because of the existence of divergent goals and objectives, owing to the many constituencies involved, management may refrain from stating the organization's goals in anything but broad terms for fear of alienating major donors (Kanter and Summers, 1987). Third, nonprofits are more likely to focus on input (resource attraction) rather than output (service delivered and goals attained) (Kanter and Summers, 1987).

Fourth, the existence of ambiguous operating objectives creates opportunities for internal politics and goal displacement, for loose coupling between official or stated mission and operative goals (Kanter and Summers, 1987). Fifth, where professionals play important roles, professional standards create rigidities and interfere with new responses to changing constituency needs. This is mainly due to the absence of direct market test of client satisfaction and the willingness of donors to encourage organizations to repeat behaviours and activities even when the clients appear not satisfied (Kanter and Summers, 1987).

Finally, the worthiness of a non-profit's activities tends to be assumed, so that its mere existence is seen as indicative of "good works" or "social morale contributions" and there is no need to show returns and results.

Kanter and Summers (1987) conclude by saying that:

> *"The ideal performance assessment system in a non-profit organization would acknowledge the existence of multiple constituencies and build measures around all of them. It would acknowledge the gap between grand mission and operative goals and develop objectives for both the short term and long term. It would guard against falling into any of the traps ... by developing an explicit but complex array of tests of performance that balance client and donors, boards and professionals, groups of manager and any other constituencies with a stake in the organization."*
>
> (Kanter and Summers,1987, p. 164)

3.2.4.1 *Evaluating health services effectiveness*

Long and Harrison (1985, p. 2) define effectiveness as *"a measure of the technical outcome of health services, in medical, social and/or psychological terms".* Similarly Holland (1983, p. 274) defines effectiveness as *"a measure of the degree to which a particular treatment or pattern of care in the population achieves its objectives in medical, psychological and social terms".* Flynn (1986, p.394) further specifies that it is about the relationship between outputs and outcomes. Holland (1983) differentiates four aspects to effectiveness: population effectiveness, attributable effectiveness, population attributable effectiveness and relative effectiveness.

Flynn (1986) notes that discussions of the outcomes of health services can be elevated *"into deep and meaningful perambulations around the meaning of life"* (Flynn, 1986, p.398), and larger questions about effectiveness can be difficult to answer. This tendency *"may lead management away from strategic questions and towards smaller concerns, away from effectiveness and towards efficiency".* (Flynn, 1986, p. 402)[9].

Burningham (1990) compares performance measurement to Gresham's Law:

> *"The most obvious difficulty is how to measure the outcome or effectiveness of a service, given that it is usually easier to measure its output. But output measures may be misleading or meaningless unless there is reasonable assurance about the effectiveness and quality of the service. The easiest thing to measure are inputs. But this creates its own danger - the equivalent of Gresham's Law: the measurable drives out the unmeasurable and performance review is biased towards reducing or, indeed, increasing cost rather than improving effectiveness"*
>
> (Burningham, 1990, p. 109).

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[9] When discussing health service effectiveness it is not possible to avoid discussing the meaning of health. The World Health Organization's notion of positive health, Holland's (1983) topology of health needs, Susser's (1974) three dimensions of health, Antonovsky's (1980) pathogenic model of disease are all attempts to pin down a definition to heath. However, *"any statement and measure of health is based on a value judgement, itself founded on the premise that health is an ideal"* (Long and Harrison, 1985, p. 18).

The most widely known framework for evaluating health services is Donabedian's (1980) model of structure-process-outcome (Long, 1992 p.60). The most commonly used measures to assess the process level are medical audits and patient satisfaction (Roberts, 1990). Roberts (1990) in discussing some of the outcome measures used in the NHS includes Rosser's (Rosser and Kind, 1978) description of illness in two dimensions - disability and distress, health indexes, William's (1985) Quality Adjusted Life Years (QALYs), hospital deaths, perioperative deaths via CEPOD (Confidential Enquiry into Perioperative Deaths) and short term clinical outcomes.

In the absence of clear effectiveness measures, researchers have turned towards more familiar measures that could be transported to the concept of effectiveness. Flynn (1986) recognizes that effectiveness is difficult to measure and may require the qualitative assessment of the service or program or trying to determine the relative effectiveness of parts of the service.

Long (1992) described assessing effectiveness as identifying the objectives of the program, drawing up indicators to see the extent to which they are being met and comparing the end-state achieved with that desired. *"Such a description rests easily within the notion of quality assurance (whose steps are the same). The criterion of effectiveness is equivalent to a focus on outcome in Donabedian's framework."* (Long, 1992, p. 62).

Burningham (1990) proposes some customer-related measures to assessing effectiveness which he notes would be good indicators even in monopolies eg. level of patient complaints, level of customer demand, customer retention, surveying customer's opinion, and customer suggestions as well as *"inspecting and controlling the quality of the service itself in relation to accepted standards - by evaluating the process rather than the outcome"* (Burningham, 1990, p. 114).

Another characteristic which makes effectiveness measurement difficult is that the translation of output to impact required professional input (Flynn, 1986; Bourn, 1992; Long, 1992). Bourn (1992) notes,

> *"those transmutations will always be problematic, since we will always be able to find professional doctors, ... who take contrary or different views in question; this is inevitable, since the framework of thought and analysis of the various professional and expert groups are always subject to revision".* (Bourn, 1992, p. 43)

It is for the above conceptual and technical complexities in measuring effectiveness that effectiveness has not been very popular among practitioners and researchers. In comparing the different criteria of evaluation used to evaluate the British NHS, Long (1992, p. 68) found that effectiveness had a low profile with activities associated to effectiveness being patient satisfaction surveys while efficiency was found to be the main criterion dominating NHS evaluation activities. However, Long (1992) predicts that, in the future, effectiveness measures will gain a high profile and efficiency will lose its dominant position.

3.2.4.2 *Studies on organizational effectiveness in health services*

While there is much literature about effectiveness of health services, little was found regarding organizational effectiveness of health services organizations or similarly, public sector organizations. Boschken (1994, p.308) suggests that this could be due to the fact that much of the literature folds together or confuses two levels of performance evaluation - program results with organizational performance.

Boschken (1994, p.308) proposes that literature on excellence like Peters and Waterman (1982) that focus on the client has led people to lose sight of the fact that public organizations have many different and frequently competing constituencies or stakeholders. He further claims *"prioritising one performance emphasis over others rejects the very meaning of public services in an interdependent plural society"* (Boschken, 1994, p. 312). To this purpose, he recommends a multiple constituencies approach to evaluating resource allocation.

Georgopolous (1972) explains this in terms of the characteristics of health organization whereby the need for clarity of accountability, professional work autonomy and the multiple lines of authority creates a system where effectiveness depends upon the technical and social systems and where coordination of these two elements and the coexistence of multiple authority lines, is vital and difficult.

Scott and Shortell (1983, p.432) found that most studies on performance in health care organizations in the U.S. fall under three categories; studies of resource acquisition, studies of social support and system maintenance and studies of goal attainment. Studies on resource acquisition and performance include Pfeffer's (1978) study of 57 non-profit voluntary short-term general hospitals in Illinois, who demonstrated the importance of the

role of the board in linking the hospital to the environment thus facilitating resource acquisition.

One of the earliest of the social support and system maintenance studies is Georgopoulos and Mann's (1962) study of ten community hospitals. It demonstrated that programmed coordination, in form of rules and procedures and non programmed coordination in form of informal communication, as well as preventative forms of coordination such as ad-hoc task forces to deal with issues affecting several units, were important in assessing health care organizations' performance. Barr and Steinberg (1983), in their study of physicians, found significant relationships between greater physician participation in decision making and physician work satisfaction, more positive attitudes towards patients and greater perceived staff consensus.

Weismann (1981) examined nurses' turn over in two large university affiliated hospitals and found job autonomy to be the strongest predictor of job satisfaction. Similarly in studying turnover, Price and Mueller (1981) found that low degree of work routinization, high instrumental communication, high opportunity for promotion and high participation in decision making all contribute to job effectiveness. Hetherington et al. (1982) also found close supervision and enforcement of rules to be negatively related to job satisfaction.

Hernandez and Kaluzny (1981) in their study of four different work groups (nurses, sanitarians, middle managers, and less skilled workers) in the health sector found that their findings varied from one group to another indicating the need to assess the nature of work of each subgroup separately.

Goal attainment studies suggest that effectiveness and quality of care are linked to the quality of nursing and medical care (Georgopoulos and Mann, 1962), the quality and calibre of medical and nursing staff (Georgopoulos and Mann, 1962; Flood and Scott, 1978), coordination (Shoetree et al., 1976; Argote, 1982; Shoetree and LoGerfo, 1981; Mosely and Grimes, 1976), staff participation in decision making (Neuhauser, 1971; Shoetree et al., 1976; Flood and Scott, 1978; Holland et al., 1981), and highly structured medical staff organization (Roemer and Freidman, 1971).

Hence, when exploring organizational effectiveness in health services researchers found themselves in a complex, ambiguous, heterogeneous political arena (Klein, 1982; Kanter and Summers, 1987; Scott and Shortell, 1983) where assessing organizational effectiveness is difficult and requires a complex and comprehensive evaluation

framework. Most researchers have preferred to focus on evaluating health services effectiveness in terms of program outcomes (Long and Harrison, 1985; Flynn, 1986; Holland, 1983; Burningham, 1990; Donabedian, 1980; Long, 1992; Roberts, 1990; Bourn, 1992), leaving the field of organizational effectiveness in health services still underdeveloped.

Little was found in the literature regarding organizational effectiveness of health services organizations. This absence was attributed the fact that much of the literature on effectiveness folds together or confuses two levels of evaluation; program results and organizational performance (Boschken, 1994) and to the specific nature of health organizations that require that effectiveness depends upon the technical and social systems simultaneously (Georgopolous, 1984). Most U.S. based studies on performance in health care organizations fall under three categories; studies of resource acquisition, studies of social support and system maintenance and studies of goal attainment (Scott and Shortell, 1983).

It is because of the above-mentioned complexities of health service organizations that the Competing Values approach has been selected as it lends itself easily to consideration of ambiguous and political settings. Additionally, the comprehensive nature of the framework would include most elements of studies on performance in health organizations (i.e. resource acquisition, social support, system maintenance and goal attainment).

3.2.5 Conclusion on organizational effectiveness

The early period of studies of organizational effectiveness is mostly characterised by numerous definitions and criteria for organizational effectiveness (Campbell, 1973; Steer, 1975; Campbell, 1977). Organizational assessment writers introduced a more holistic approach to measuring effectiveness (Lawler, Nadler and Camman, 1980; Van de Ven, 1980; Goodman, 1979; Goodman and Pennings, 1980; Carnall, 1982). Researchers thereafter tried to categorize and make the principles of organizational effectiveness more practical by looking for similarities in organizational effectiveness research (Scott and Shortell, 1983; Graetner and Ramnarayan, 1983; Quinn and Rohrbaugh, 1981; Cameron, 1984; Robbins, 1990).

One such approach, the Competing Values approach (Quinn and Rohrbaugh, 1981 and 1983) assumes that organizational effectiveness is subjective, composed of the evaluator's values preferences and interests (Robbins, 1990). Its framework measures

organizational effectiveness through strategic constituencies' perceptions on organizational performance on sets of competing values and allows for organizational life-cycle changes.

The complex, ambiguous and heterogeneous political arena setting of health services makes assessing organizational effectiveness difficult (Klein, 1982; Kanter and Summers, 1987; Scott and Shortell, 1983). Most researchers have preferred to focus on evaluating health services effectiveness in terms of program outcomes (Long and Harrison, 1985; Flynn, 1986; Holland, 1983; Burningham, 1990; Donabedian, 1980; Long, 1992; Roberts, 1990; Bourn, 1992). However, a more comprehensive evaluation framework that takes into account the complexities of public health services is needed. The Competing Values framework could possibly satisfy some of the complexities of health organizations.

3.3 *Team effectiveness*

3.3.1 Introduction

This section explores some of the literature on team types, designs and evaluation. Factors that may affect group effectiveness are also discussed. Finally, some problems that are specific to the British NHS experience in health team management are explored.

3.3.2 Team design, functioning and effectiveness

Hetherington and Rundell (1983) pulling from the definitions of Gibson, Ivancevich and Donnelly (1973, p. 171) propose defining a work group as *"consisting of two or more individuals who voluntarily interact in a task-oriented situation in such a manner that the behaviour and/or performance of each group member is influenced to some extent by the behaviour and/or performance of other members".* They also distinguished between command groups; those allocated by the organization chart and reporting to a director and task groups; those in which employees come together to perform a specific task.

Schweikhart and Smith-Daniels (1996) in studying patient care teams in hospitals identify three types of group structures. The first is the functional team in which the organization structure and role of the caregivers are left unchanged. Multidisciplinary teams are formed with care management functions. In this model, care management and care production remain separate and team members work within their functional boundaries.

The second model is the coordinated team in which the role of the caregiver is expanded and the organization structure is not modified. Care management and care production are integrated via dual reporting relationships and interdisciplinary collaboration, something in between task groups and matrix structures.

The third model found in hospital settings is the focused team in which the structure is modified so that the non-medical professionals in the team report to a unit manager. The multi-disciplinary team subordinates to the unit manager and not their functional hierarchies. This model provides high integration and a learning environment, a model found in clinical directorates.

In their study of health teams in the British NHS both Jaques (1978) and Allen and Grimes (1982) identified the presence, after the 1974 reorganization, of multidisciplinary functional and clinical teams that functioned through consensus management. Functional teams were responsible for functional coordination of various services such as planning, assessment of progress, and performance review. As for clinical teams these were found at the unit and ward level for the accomplishment of direct patient care.

In considering team design and evaluation Alexander et al. (1996) explain the importance of distinguishing between and evaluating both team functioning and team performance. Team functioning is about how cohesively and harmoniously the team operates whereas team performance is about achieving the team's objectives. They also define a well functioning team as one that *"consists of individuals whose work is valued by others, whose inputs are respected by others, and who work with others cohesively and harmoniously"* (Alexander et al., 1996, p.38). Horak et al. (1991) add that an effective team is one that spends minimum energy on 'maintaining' the group morale, satisfaction, and work processes thus focusing its energy completely on task accomplishment.

Factors that may affect group effectiveness are size, occupation of members, leadership, group diversity, decision making processes, goals, communication channels, group norms, and the nature of the tasks at hand (Alexander et al., 1996; Horak et al., 1991; Hetherington and Rundell, 1983). Alexander et al. (1996) note that large groupsize, poor decision making practices, lack of homogeneity of group members' training and skills, and poor leadership can adversely affect group effectiveness. They also note that although heterogeneity in groups may lead to conflict and perceived lower effectiveness, it has

been found by researchers that group diversity has lead to better performance in complex situations.

Similarly, a research by Horak et al. (1991) on medical floor teams notes that clear purpose, task, roles and goals as well as well defined decision-making processes and communication channels, improve team functioning. Hetherington and Rundell (1983) further specify that clear roles, an existence of group norms and habits, small size, and simple tasks improve communication and coordination among team members. They also noted that the type of leadership affects effectiveness, with the main activities of the team leader being support, facilitating interaction, goal emphasis, and work facilitation.

Jaques (1978) and Allen and Grimes (1982) identified some problems that are specific to the British NHS experience in health team management. One was the leadership ambiguity and difficulty in defining the leader of the group: the consultant or the manager. Consequently the administrators were unable to take the strong coordination role that was asked of them since chairmanship was with another professional. They also noted that because of the consensus management system, there was a pressure to agree with team members in order not to paint an inharmonious image of the team to the authorities. Distinguishing between matters that are of joint concern and individual responsibilities was also a problem faced by NHS teams. Finally, probably one other most important complication faced by NHS teams was their lack of authority to commit medical colleagues to their policies and decisions.

Jaques (1978) recommended that clear formulation of the team and its members' duties, responsibilities and functions and giving more responsibility to the clinical representative for committing colleagues would make the team work efficiently. However, he predicted that multidisciplinary clinical teams would disappear as roles were clarified and organization developed network structures.

3.3.3 Conclusion on team effectiveness

Hospitals are settings rich with many different types of teams and committees; functional, co-ordinated, focused/clinical, uni-dimensional, or multi-dimensional (Jaques, 1978; Allen and Grimes, 1982; Hetherington and Rundell, 1983; Sweikhart and Smith-Daniels, 1996); making hospitals interesting settings for research on teams.

In considering team design and evaluation Alexander et al. (1996) explain the importance of distinguishing and evaluating both team functioning and team performance. Team functioning is about how cohesively and harmoniously the team operates whereas team performance is about achieving the team's objectives. They also define a well functioning team as one that *"consists of individuals whose work is valued by others, whose inputs are respected by others, and who work with others cohesively and harmoniously"* (Alexander et al., 1996, p.38). Horak et al. (1991) add that an effective team is one that spends minimum energy on 'maintaining' the group morale, satisfaction, and work processes thus focusing its energy completely on task accomplishment.

Factors that may affect group effectiveness are size, occupation of members, leadership, group diversity, decision making processes, goals, communication channels, group norms, and the nature of the tasks at hand (Alexander et al., 1996; Horak et al., 1991; Hetherington and Rundell, 1983). Alexander et al. (1996) note that large group size, poor decision making practices, lack of homogeneity of group members' training and skills, and poor leadership can adversely affect group effectiveness. They also note that although heterogeneity in groups may lead to conflict and perceived lower effectiveness, it has been found by group researchers that group diversity has lead to better performance in complex situations.

Hetherington and Rundell (1983) further specify that clear roles, an existence of group norms and habits, small size, and simple tasks improve communication and coordination among team members. They also noted that the type of leadership affects effectiveness, with the main activities of the team leader being support, facilitating interaction, goal emphasis, and work facilitation.

3.4 Conclusion

Some of the theoretical materials on organizational and team effectiveness have been exposed. The different definitions and assessment approaches to organizational effectiveness have been explored. One approach, the Competing Values approach (Quinn and Rohrbaugh, 1981 and 1983), which assumes that organizational effectiveness is subjective, composed of the evaluator's values preferences and interests, has been discussed in detail. Finally, the difficulties in assessing organizational effectiveness in the complex, ambiguous and heterogeneous political arena that is the public health services have been emphasized.

Then, literature on team types, designs and evaluation has been explored. The importance, when considering team design and evaluation, of distinguishing and evaluating both team functioning and team performance has been stressed (Alexander et al., 1996). Some factors that may affect group effectiveness have been discussed. Finally, some problems that are specific to the British NHS experience in health team management were explored.

CHAPTER 4 ORGANIZATIONAL CULTURE

4.1 *Introduction*

This chapter explores organizational culture. The different definitions and approaches to studying culture are described before a discussion of the link between organizational culture and effectiveness is offered. The evolution of professionalization and the interprofessional relations of the main health professions are then studied. Finally, the role of national culture and the characteristics of Arab management culture are described.

4.2 *Approaches to studying culture*

The understanding of culture is important for studies of organizational analysis[10]. Many definitions of organizational culture have been put forward[11] but the most widely accepted definition of organizational culture is that of Edgar Schein (1992). In summarizing the existing definitions Schein put forward the following definition:

> *"A pattern of basic assumptions –invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems."* *(Schein, 1992, p. 9)*

There are several approaches or debates in the field of organizational culture that cross over each other in places[12]. For the purpose of this study two categorizations of the different approaches have been selected; the interpretative vs. functionalist distinction and Martin and Meyerson's (1987) three perspectives framework.

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[10] Schein (1992) notes that cultural assumptions are not just about style and people but that they also dominate managerial decisions about strategy, structure and systems.

[11] A survey by Ott (1989) of 58 published sources identified over 70 different phrases used to define organizational culture.

[12] Culture has been studied from numerous approaches; anthropological, sociological, social psychology and even economics. The latter regards culture as a variable which can be used to explain the superior or inferior performance of organizations (Broadfieldet al., 1998). However, the concept of culture is rooted in the theories of group dynamics, group growth (Schein, 1982), and studies on professional cultures (Alvesson and Berg, 1992)

1. Functionalist versus Interpretative (also called culture-as-a-variable versus culture-as-a-metaphor):

Smircich (1983) distinguished two groups of researchers in organizational culture. The first took a positivist perspective basing itself on open system ideas. It viewed culture as something an organization "has", in some way similar to the integrationist (Martin and Meyerson, 1987) perspective presented lower. This approach has given rise to a considerable volume of work that attempts to identify cultures that promote success (for example the works of Ouchi, 1981; Peter and Waterman, 1982; and Deal and Kennedy, 1982) and has gained popularity mostly with the non-academic circles (Broadfield et al., 1998)[13].

The second approach adopted a phenomenological standpoint and views culture as something that an organization "is"; something out there, separate from the people, manufactured by employees as they interact with one another (Buchanan and Huczynski, 1997). This approach has mostly appealed to academics (for example, Gregory, 1983; Smirchich, 1983; Morgan et al., 1983; Anthony, 1994 and Meek, 1988) as they try to understand how organizational members experience cultures and how this affects the way they behave (Broadfield et al., 1998). This approach can be likened to the differentiation perspective **(Martin and Meyerson, 1987)** described lower.

Legge (1995, pp 185-187) developed a table, Table 4.1 in the following page, of the main characteristics of the two:

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[13] Buchanan and Huczynski (1997, p.515) describe this perspective as serving four functions:
"It provides a sense of identity for employees, increasing their commitment to the company, making their work more intrinsically rewarding and making them identify more closely with fellow workers.
It allows them to "make sense" of what goes on around them, enabling them to interpret the meaning of different organizational events.
It helps to reinforce the values of the organization, that is, of senior management.
It serves as a control devise for management with which to shape employees behaviour."

Table 4.1 Legge's (1995) characterization of approaches to studying culture

Culture as a variable	Positivist Anthropology/ biology Single, agreed upon culture Physical reality Provides an adaptative-regulating mechanism to maintain status quo Directed by actions of senior management changing artefacts and espoused values Senior management only manipulate culture for corporate success
Culture as a metaphor	Phenomenological Social psychology Several, parallel, subcultures Mental state Culture conflicts can engender change Reproduced by all culture members in an ongoing way through their negotiation and sharing of symbols and meanings

(From: Buchanan and Huczynski, 1997, p. 514)

Cameron and Ettington (1988) suggest that the essence of this difference lies in the anthropological perspective, which considers culture as a dependent variable, while the sociological perspective treats the concept of culture as an independent variable (Maassen, 1996).

2. Martin and Meyerson's (1987) framework

Martin and Meyerson's (1987) and Martin (1992) distinguish three perspectives that dominate research on organizational culture:

1. Integrationist cultural perspective

Studies under this perspective portray culture as a monolith, characterized by consistency, organization-wide consensus and clarity. It takes the view that these integrating features will lead to improved organizational effectiveness through greater employee commitment and control. Authors who write from this perspective include Schein (1986) and Ouchi (1981).

2. Differentiationist cultural perspective

Studies under this perspective portray sub-cultures as islands of consensus and clarity in a sea of ambiguity. Differentiated subcultures may co-exist in harmony, conflict or indifference to each other and there is no agreement among differentiationists as to whether a particular cultural arrangement improves organizational effectiveness. Authors who write from within this perspective include Smirchich and Morgan (1982) and Riley (1983).

3. Fragmentation perspective

Studies under this perspective view culture as a loosely structured and incompletely shared system (a web) that emerges dynamically as cultural members experience each other, events and the organization's contextual features. Ambiguity is inevitable and pervasive, and clear consistencies like clear inconsistencies are rare. Consensus and dissent co-exist and from this point of view no clear organization-wide or sub-cultural consensus stabilizes. This approach to organizational culture is the most recent and has so far attracted the least number of studies. One reason for that offered by Buchanan and Huczynski (1997) could be that it is a perspective that offers little for either academicians or managers who seek clarity.

Martin and Meyerson's (1987) three perspective framework is not meant to pigeonhole individual researchers but to offer a framework for deciphering what has and has not been learned from the proliferation of organizational research (Frost et al., 1991). Although individual researchers may write from one single perspective or change perspective across studies, Martin and Meyerson argue that any cultural context contain elements that can be understood only when all three perspectives are used (Frost et al., 1991)

Martin and Meyerson argue that perspective preference may vary according to position in the organization. Higher-ranking managers tend to see the organization from an integrationist perspective while lower levels are more likely to express views more in line with the differentiation perspective because their status puts them at a distance from and even perhaps in conflict with managerial perspective (Frost et al., 1991).

Perspective preference is also emotionally and politically grounded. *"People vary in the extent to which they are comfortable with homogeneity, conflict and ambiguity.*

Furthermore, certain political ideologies are more congruent with one perspective than another" (Frost et al., 1991, p. 159).

In reviewing the various approaches to organizational culture, Maassen (1996) concluded that to this date;

> "*there is a lack of agreement on the valid interpretation of organizational culture. There is no common theoretical ground and from an epistemological point of view organizational culture is at least a controversial concept. Even the distinction between treating it as something an organization is, versus something an organization has, doesn't do enough justice to the complexity of the concept*" (Maassen, 1996, p.27).

This research draws from the interpretative and differentationist perspectives. It views culture as phenomenological made up of several parallel subcultures (Gregory, 1983; Smirchich, 1983; Mogan et al.; 1983; Anthony, 1994; Meek, 1988) in which the subcultures may co-exist in harmony, conflict or indifference to each other (Smirchich and Morgan, 1982; Riley, 1983). This can be witnessed in the extensive study of professional cultures, interprofessional relations and national culture. However, this research also draws from the integrationist perspective when exploring cultural strength and the link between culture and effectiveness. It also uses Schein's (1992) definition of culture as a starting point to develop questions on culture.

4.3 *Organizational culture and effectiveness*

The concept of effective and ineffective cultures has interested organization culture researchers. Martin (1992) summarized these studies in terms of the three perspectives presented above (i.e. integrationist, differentiationist and fragmentation perspectives). She found that most integration studies,

> "*make claims that cultures characterized by consistency, organization-wide consensus, and clarity will lead to greater organizational effectiveness, as indicated by greater cognitive clarity, commitment, control, productivity and profitability*" (Martin, 1992, p.104).

The integration studies linking organizational culture to superior performance have a more popular appeal such as the studies of Schein (1984), Deal and Kennedy (1982), Peters and Waterman (1982) and Goldsmith and Clutterbuck (1984), which consider strong cultures to be associated with superior performance. Luthans (1995) considers that cultural strength is a function of two factors, sharedness and intensity. Sharedness

corresponds to homogeneity, expressed as the extent to which all organizational members have the same core values whereas intensity corresponds to the degree of commitment of organizational members to these values.

Kilman et al. (1985) identified three factors important in the culture-performance link; cultural direction, cultural pervasiveness and cultural strength. Cultural direction expresses the extent to which a culture helps an organization achieve its goal, whether it is a positive or negative culture. Culture pervasiveness relates to the extent to which an organizational culture is homogeneous and cultural strength relates its influence on people. A strong positive culture would be beneficial whereas a strong negative culture is likely to have an adverse effect on the organization.

Other than the writings of popular integrationist writers, there is little evidence of a strong link between culture and organizational performance (Broadfield et al., 1998). Work such as that of Peter and Waterman (1982) found no coherent link between culture and performance. Their measurement methods were found questionable and some of the firms that were held as examples of successful companies were in serious financial difficulty (Broadfield et al., 1998). Strong culture was also found to be a good predictor of only short-term success (Gordon and DiTomaso, 1992).

Additionally Legge (1995) noted another measurement problem to establishing such a link. Researchers have to demonstrate that a highly performing company with a strong culture cannot achieve the same performance level with a weak culture. Beaumont (1993) added that the corporate culture of a particular multinational company may complement and be appropriate to some of the national cultures of the countries in which it operates but inappropriate in another national context.

The second group of researchers, those with a differentiation perspective, vary in the extent to which they claim that particular culture configurations lead to improved organizational effectiveness. Martin (1992) summarizes that;

> *"some differentiation studies claim that, because of inconsistencies and a lack of organization-wide consensus, supposed benefits do not occur. Other differentiation studies question the wisdom and ethics of value engineering for profit. Finally, some differentiation studies see conflict expression as constructive – a different approach to deciding what effectiveness might be"* (Martin, 1992, p. 104).

In fragmented studies of culture, ambiguity, which is the dominant concept of this perspective, varies from one organization member to another. Fragmentation studies sometimes include a variety of opinions about whether ambiguity has a positive or negative effect on performance, and those that stress the benefits of ambiguity generally do not argue that it should be controlled.

Other fragmented studies abstain from arguing a link between ambiguity and effectiveness and simply examine ambiguity as an inescapable attribute of working life whereby arguing a link between ambiguity and effectiveness is futile. Martin (1992) concludes by noting that the fragmentation perspective is the most appropriate for analysing the multiple constituencies and constantly changing public sector bureaucracies.

Hatch (1997) identified two perspectives of analysing organizational culture, symbolic-interpretivist and modernist. Symbolic interpretive researchers advocate studying artefacts and symbols in the situations and locations in which they occur via ethnographic observation and allowing organizational members to use them and interpret their own world. The goal of such researchers is to contextualise the culture and understand it from inside.

On the other hand, modernist research is decontextualized, and aims at developing generalized knowledge that can be applied across cultures, which they view as more practical and economical than the context sensitive time-consuming symbolic-interpretive research (Hatch, 1997, p. 232).

Most modernist studies look for a statistical relationship between variables representing organizational culture and performance and so far, researchers have given great attention to the variable cultural strength (Hatch, 1997, p.232). The first researchers to describe cultural strength are Deal and Kennedy (1982) who describe cultural strength as the extent to which organizational members share core values. Deal and Kennedy (1982) measured this by the presence of many symbols and artefacts associated with core values, another way would be to ask survey respondents about the extent to which they agree or disagree with certain value statements. Kotter and Heskett (1992) used a different model for measuring the cultural strength of over 200 corporations. They asked financial analyst and managers of firms that were in competition with the organizations they wanted to study to rate the cultural strength of the competing company (Hatch, 1997).

Hatch (1997) noted that similarly, Danison (1990) in his research on the relationship between environment, strategy and culture used modernist principles. He concluded from his research that organizations,

> *"operating in rapidly changing environments will perform best if they either value flexibility and change (an adaptability culture) or participation and high levels of organizational commitment (an involvement culture). In stable environments, Denison argues, successful organization either share a vision of the future (mission culture) or have strong values for tradition, established procedures and conformity (a consistency culture)"* (Taken from Hatch, 1997, p. 234).

Kilman et al. (1985) developed a Cultural Gap Survey to measure a company's existing culture and identify the differences between that and the "desired" culture via questionnaires to managers in about 24 organization. Their reasoning is that the greater the gap, the greater the probability that the existing norms create an ineffective culture.

The Hay group (Vestal et al., 1997) developed an organizational assessment tool called the Targeted Culture Modelling to help organizations determine their current and desired cultures. The group identified 56 varied attributes (behaviours or activities) that define a work culture. Using this methodology, cultural profiles were developed by ordering these attributes into seven categories that follow a normal bell-shaped curve.

Similarily, Quinn and Rohrbaugh's (1984) competing values approach to measure effectiveness bases itself on modernist-contingency principles, claiming that organizational effectiveness is subjective and that the organizational goals that the evaluator chooses are based on his or her personal values, preferences and interests. They found the four basic sets of competing values (flexibility vs. control, people vs. organization, and means vs. ends) to be present in all organizations and that the four distinct and contrasting models generated (human relations model, open systems model, rational-goal model and internal-process model) dominate the values of organizations. Though originally intended to assess organizational effectiveness[14] this model has also been used to analyze organizational culture by researchers.

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[14] See Section 3.2.3.1 The Competing Values Approach, p.62.

4.3.1 Conclusion on organizational culture and effectiveness

The concept of effective and ineffective cultures has interested organizational culture researchers. Most popular are the integrationist studies that link organizational culture to superior performance and consider strong culture to be associated with superior performance (Schein, 1992; Deal and Kennedy, 1982; Peters and Waterman, 1982; Goldsmith and Clutterbuck, 1984). In studying cultural strength they proposed factors and attributes such as core values sharedness, intensity, direction, and pervasiveness (Luthans, 1995; Kilman et al., 1985; Deal and Kennedy, 1982), attributes which this research explores. However, there are measurement problems in establishing a link between cultural strength and performance (Legge, 1995). Researchers have to demonstrate that a highly performing company with a strong culture cannot achieve the same performance level with a weak culture.

As for the differentiation perspective, researchers in this group vary in the extent to which they claim that particular cultural configuration lead to improved effectiveness. Similarly, the fragmentation perspective focuses on ambiguity and researchers within this perspective vary in opinion about whether ambiguity has a positive or negative effect on performance.

Most modernist studies look for a statistical relationship between variables representing culture and performance and so far have given great attention to measuring the variable cultural strength (Hatch, 1997; Deal and Kennedy, 1982; Kotter and Heskett, 1992; Danison, 1990). This study explores core cultural values by examining the extent to which organizational members agree or disagree with certain value statements (Deal and Kennedy, 1982). Organizational culture is then profiled using modified versions of Quinn and Rohrbaugh's (1984) competing values framework and the Hay Group survey (Vestal et al., 1997). Finally, working on the premise that the greater the gap between actual and desired culture, the greater the possibility that the existing norms create an ineffective culture, Kilman et al.'s (1985) Cultural Gap Survey is used to explore the gap in the organization under study.

4.4 *Culture and theories of profession*

4.4.1 Review of studies on professionalization[15]

Earliest studies of professions focused on core definitions and typology of professions such as Flexner's (1915) basic characteristics, Carr-Saunders and Wilson's (1933) traits, Millerson's (1964) more general traits and characteristics and Moore's (1970) definition. Later studies approached professionalization as a natural process that comes in stages such as Caplow's (1964) four stages, and Wilensky's (1964) five stages.

Overtveit (1988) in reviewing early studies found them to be in disagreement over the definition of a real profession, arbitrary, idealistic in nature, and politically biased; that is, in favour of the professions which where regarded as having professional status. Nonetheless he noted that the basic characteristic of the ideal profession seem to be a knowledge base, a service ideal and autonomy or public trust, a definition which Abbot further loosened to *'occupational groups applying somewhat abstract knowledge to particular cases'* (Abbot, 1988, p.8).

Interactionalist and power literature of the 1960s focused on how professional associations, by establishing trust and confidentiality advanced and maintained their interests. Via professional autonomy and dominance they maintained power and monopolistic positions (Hughes, 1958; Mc Kinlay, 1973; Freidson, 1968; Freidson, 1970; Klaus, 1971; Johnson, 1972; Larson, 1977).

Becker (1977) proposed that professions should be studied as a *'collective honorific symbol'*. Freidson (1970a) offered a definition of a profession in term of hierarchy of dominance. Krause (1971) distinguished professions from other occupations as being functionally powerful and providing a vital basic need. Larson (1977) viewed professions as market organizations in an economic monopoly; a view that was earlier adopted by Ben David (1958) who studied the role of professionalism in protecting the professionals from structured, rigid employment and competition. Abbot (1988) identified four categories of approaches to professionalization; the functionalist, structuralist, monopoly and cultural authority approach and propose that a new approach, which focuses on the content of professional work rather than their organizational structure, be adopted.

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[15] See Annex 5 for a more detailed review of the studies on professionalization.

More recent studies on professions have suggested that the introduction of corporate capitalism, management science, increased focus on productivity and control will have a 'deprofessionalization', 'deskilling' and 'proletarianization' effect on professions (Haug, 1973; Oppenheimer, 1973; and Braverman, 1974). On the other hand, Overtveit (1988) does not agree with this negative prophecy and notes that such changes may enhance professional status by encouraging delegation and more effective use of professional skills and training.

Finally, in studying the professional-bureaucratic conflict, which was first mentioned by Parsons (1964); Overtveit (1988), Flynn (1992), Davies (1984), Begun et al. (1990), Dawson (1994), Benson (1973), Engel (1970) noted that the professional-bureaucrat conflict is more a theoretical debate around the ideologies of professionalism and particular aspects of Weberian ideal type bureaucracy, than an empirical reality and that the conflicts in the relationships are merely general problem of organizational control and coordination. Overtveit (1988) attributes this realization to the application of theoretical perspectives such as symbolic interactionism and power and politics to health settings.

4.4.2 Interprofessional relations amongst health professionals

To fully understand the interprofessional relations between different health professions one needs to look at theories of professions, the role of client-professional relationships, history of professionalization, occupational closure, and the formation of professional boundaries (Greenwell et al., 1994; Overtveit, 1988; Hughes, 1958) . The health arena is marked with periods of shifting alliances, for example, doctors and nurses cooperating against general management, general management and nursing allying against doctors, or general management and doctors opposing nursing (Greenwell et al., 1994). In the case of the two largest health professions, medicine and nursing, the relationship is even more complex, one in which the professions are complementary as well as being competitive.

Studies in the 1960s distinguished different types of professions and concentrated on their individual characteristics. Carr-Saunders (1955) developed a continuum that distinguished "would-be-professions", "new professions", and "near professions" from "professions". Goode (1969) identified "aspiring professions". Hughes (1958) distinguished between "professions", "near professions", "enterprises", "missions", "arts", "crafts" and "jobs". Similarly, Halmos (1970) classified clergy, doctors, nurses, teachers and social workers as

"personal" service professions and lawyers, accountants, engineers and architects as "impersonal" professions.

Most interesting are the studies relevant to identifying health professions such as those of Etzioni (1969), Friedson (1970a, 1985), and Forsyth and Danisiewicz (1985). Etzioni (1969) identified nursing, social work and teaching as "semi-professions" since "their training is shorter, their status is less legitimated, their right to privileged communication less established, and there is less of a specialized body of knowledge and they have less autonomy from supervision or societal control than "the" professions" (Etzioni, 1969, p.v).

Etzioni (1969) also noted that due to their shorter training and different values from "the" professions, semi professions have more in common with administration. "The semi-professionals often have skills and personality traits more compatible with administration, especially since the qualities required for communication of knowledge are more like those needed for administration that those required for creation, and to a degree, application of knowledge" (Etzioni, 1969, p. xiii). He also noted that most semi professions are women and employed in organizations. Forsyth and Danisiewicz (1985) further divided the semi professions into "client autonomous" and "organization autonomous", the first being in education and the latter in nursing and social work. They also identified another category, "mimic professions", those are profession like and have a code of ethics but no real power.

Friedson (1970b) separated the "dominant professions" such as medicine and law from the "para-professions" He noted that, "*While the members of all may be committed to the their work, may be dedicated to service, and especially to education, the dominant professions stand in a entirely different structural relationship to the division of labor than does the subordinate profession.*" (Friedson, 1970b, p. 137). Friedson also observed that the para-professions are not only subordinate to the professional experts but also to the authority of the bureaucratic office, in either a kind of stratification or function of status, in the hierarchy.

Considering the difficulty in defining a profession so as to identify which profession is one and which are not, some researchers have approached the issue from the sociological and interaction angle, looking at the attempts of people in an occupations to turn into a profession (Hughes, 1958; Strauss et al., 1963; Becker, 1961).

4.4.2.1 *The determination of professional boundaries*

Greenwell et al. (1994) noted that three models of professional relationships regulate hierarchical and work relationship between medicine and nursing in the NHS and these same models can be used to understand most interprofessional relations.

In the first models, medicine and nursing have separate spheres of influence, two separate professions, and their relationship is that of consensus and mutual respect. Each profession has its own hierarchy and is accountable to senior members of the same profession. The drawback of this structure is that it does not encourage horizontally organized teams.

In the second model, the nurse is in a hierarchical system controlled by medical consultants. Doctors make the diagnosis and control treatment decisions and nursies are wholly within consultant authority. This model underestimates the contribution of all other health professions, placing them at a subordinate level, fulfilling the orders of doctors.

The third model is somewhere in-between the two, one in which interdependence is based on discrete areas of expertise, resulting in both hierarchical and symbiotic interdependent relationship. Both professions have different functions, but in some areas common areas they are either equal or one is subordinate to another.

Greenwell et al. (1994) found in their study that historically and professionally, the hierarchical relationship between medicine and nursing in the British NHS has been shifting from one model to another, but that mostly it has been somewhere within the third model of relationships. The centre of the relationship is a struggle for position and power. In addition, they found that state influences and regulations[16], gender social relations[17] and "occupational imperialism"[18] have further influenced this relationship.

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[16] State offered institutional power to the medical profession in the 1858 Medical (Registration) Act; nursing campaigned for years for similar state supported registration. However, state interference in relationships can be seen in projects and proposals that added or removed responsibility from nursing, as well as the introduction of general managers who attempt to control the work of the professions.

[17] As for gender influence, they note that the authority of nursing (which is mostly female) is a reflection of the position of women in the larger society and their political power.

[18] Greenwell et al. (1994) note the presence of medical occupation imperialism in the health field, where medicine plays an important role in structuring the work of the occupations, through involvement in training, recruitment and supervision of the work of other professions.

4.4.3 Interprofessional relations in the NHS

4.4.3.1 *Doctors*

Generally speaking, the medical profession has often been referred to as the exemplar model of professionalization, acquiring power through occupation closure, state support and a distinctive body of knowledge (Greenwell et al., 1994; Parry and Parry, 1976; Friedson, 1970b). It is also considered the most powerful of all occupations, influencing neighboring occupations and society at large. In the UK the medical profession is well secured and legitimized by the state. Doctors are well represented in the National Health Service via representation on important committees. Medical staff, as opposed to those in the US, do not have control over remuneration since they are state employees, but sustained control over clinical practices (Greenwell et al., 1994).

Most studies on the development of the British NHS concluded that doctors have had in the past, most influence on the policy, structure, organization and resources allocation of the NHS (Flynn, 1992). However, recent restructuring in the NHS is changing this image.

The most documented struggles of modern medicine in the British NHS are maintaining medical autonomy amidst government, administrative and managerial interference. The most significant cut back of professional power can be seen in the introduction of general management in the mid 1980s following the Griffith Report. Rather than impose managerial values, the White Paper *Working for All* (Department of Health, 1989), attempted to place managerial values within the professions by promoting performance and cost measures, and doctor-managers of clinical directorates. However, conflicts between the professional values and managerial values required for the new mode of governance have been noted (Butler, 1992; Harrison et al., 1990; Moran and Wood, 1993).

4.4.3.2 *Nurses*

The second most studied health profession is the nursing profession. Nursing has shifted away from the 'Nightingale' tradition of nurses as obedient handmaidens of doctors by seeking state support for a registration scheme and developing a strategy for professionalization. Stacey (1988), Walby (1986), Witz (1992) and Greenwell et al., (1994) note that the disadvantageous position of nursing in the NHS commenced at the foundation of the NHS where nurses, the largest body of health care professions, were not

the Salmon Committee had been seen as a turning point for nursing, as it established the notion that nursing is an independent profession from medicine and they cooperate for the accomplishment of functions. Nurse managers were introduced in planning and administrative committees but the introduction of general management and the Griffith reorganization took nurses off key management teams hence reducing their representation (Stacey, 1988; Greenwell et al., 1994). Now although nursing representation in team has been re-established, nursing representation at senior management remains low (Greenwell et al., 1994).

Another striking difference noted by Greenwell et al. (1994) is that compared to the autonomous medical profession, governance within nursing is close to Taylor's Scientific Management concepts. However, recent changes are shifting away from this form.

Projects for professionalizing the nursing profession include the "new nurse" concept, primary nursing, Project 2000's training and education focus, and the change to more professional code of practice. Similarly, the purpose of the recent change of official abbreviation for a trained nurse to registered nurse is to remove the focus on the differences between the different levels of nurses to the importance of professional registration (Greenwell et al., 1994).

Nursing is under pressure from all angles. When they attempt to professionalise they meet the glass ceiling of the medical profession. When they attempt to move into management unwelcoming mostly male managers meet them. Similarly they are receiving side pressure from therapists and social workers and pressure from below by community care assistants and hospital health support workers (Greenwell et al., 1994). However, historically nurses have been found to ally often with medicine in struggles against the state and managerial values (Greenwell et al., 1994).

4.4.3.3 *Health administrators*

Using five attributes; basis of knowledge, patient focus, exposure to clients while in training, time frame of action, view of resources and professional identity, Shortell (1982) drew up a comparison chart of the differences in socialization processes of the three main health groups. He notes that this helps in understanding the differences in culture of the different professions and brings out the need to develop a management philosophy or strategy that would *"attempt to bring about a more common culture of professional work"* (Shortell, 1982, p. 13).

strategy that would *"attempt to bring about a more common culture of professional work"* (Shortell, 1982, p. 13).

He identified physicians as; having a biomedical basis of knowledge, dealing with individual patients thus having a very narrow patient focus, having had a lot of exposure to patient during training, generally having short range time frame actions and thinking in terms of cause-effect relationships. Their view to resources is generally that of unlimited resources to maximize patient care, and finally they have the most cohesive professional identity.

Nurses are in the middle range between physicians and administrators. Their knowledge comes from a combination of biomedical and social sciences. Their focus is on groups of patients in units and throughout their training they have been greatly exposed to patients. Their time frame for action when monitoring patient care is medium to short-range. They recognize the limitations of resources, but not as acutely as administrators, and their professional identity is somewhat cohesive.

As for administrators, their knowledge comes from social and management sciences. Their focus is on all patients in the organization and the larger community. They have had very little exposure to their clients during their academic training and, their time frame for action is generally medium to long-range where they are involved in planning activities. They view allocation of limited resources as their main challenge, and as a whole, they have the least cohesive professional identity.

Many perceptual studies have been conducted in the US and UK to clarify the collaboration and behavior differences that have lead to conflicts between physicians and administrators (Bettner, 1987; Dawson, 1994; Stewart, 1989). As with the US, generally such studies in the UK have revealed mistrust and suspicion between doctors and managers (Fitzgerland and Stut, 1992). Dawson (1994) in studying the changing relationships in the British NHS, noted that in the first twenty-five to thirty-five years of the NHS, doctors viewed managers as a constraint on resources and representing the interests of the government. Because of their role in providing support services to the doctors, they were also viewed as facilitators but, peculiarly, they could not be seen as subservient facilitators since they had the power to limit professional activity and control resources. Thus, she notes, a relation of "symbiosis and compromise" formed. Flynn (1992) notes that in these early days, the role of the health administrator was mostly a 'diplomat' serving the medical profession.

More recently, NHS restructuring has bridged some of the gaps between the two by challenging medical professional dominance and demanding more accountability from managers (Harrison, 1988; Flynn, 1992; Buxton, Keen and Packwood, 1991; Greenwell et al, 1994; Dawson, 1994). The Griffiths Report "*General Management*" (1983) brought in private management concepts and attempted to professionalize administrators (which were now called managers). This came about by; holding them personally accountable for delivery of services, increasing their pay to make it comparable to clinical professionals, reducing medical dominance by removing the 'consensus management' system and replacing it by individual management responsibility and accountability (Anthony and Reed, 1990).

However, professionalizing the administrative profession was difficult because they are socially fragmented, dependent on the organization, have a diffuse knowledge base, uncodified ethics and entry in their occupation is open (Child, 1969; Dawson, 1994). Additionally the changes brought about by the Griffiths Report were not very welcome by the clinicians who saw it as government attempts to increase constraints on professional autonomy (Harrison, 1988).

The White Paper of 1989 '*Working for Patients*' (Department of Health, 1989) by splitting the system into providers and purchasers has resulted in the creation of autonomous provider units operating in a newly created health care market. The role of the clinical director has evolved and doctors became involved in managerial activity, bridging the gap between the two professions. The introduction of the White Paper changes, have been described as 'the beginning of a new era' (Flynn, 1992) and is hoped that it will create the new professional and managerial culture that Shortell (1982) noted is much needed in health settings.

4.4.4 Conclusion on culture and theories of profession

Studies by Carr-Saunders (1955), Goode (1969), Hughes (1958), and Halmos (1970), attempted to distinguish different types of professions. Etzioni's (1969) classification of health professions into 'professions' and 'semi-professions' was one of the earliest studies on health professions. Forsyth and Danisiewicz (1985) further divided the 'semi-professions' into 'client autonomous', 'organization autonomous' and 'mimic professions'. Similarly, Freidson (1970b) separated the 'dominant professions' from the 'para-professions'.

In a study of work relations between medicine and nursing in the British NHS, Greenwell et al. (1994) identified three models of relationships between which the professions have been shifting as they struggled for position and power. In addition, they found that state influences and regulations, gender social relations and "occupational imperialism" have further influenced this relationship.

The last section of this review explored the characteristics and the professional position of doctors, nurses, and health administrators in the British NHS and U.S. It also explored the shifting interprofessional relations as a result of NHS restructuring. Although these studies are based on British NHS and USA experiences, they are relevant to this research and will be used to explore professional culture and interprofessional relations in the organization under study in Qatar.

4.5 *National culture*

Although Morgan (1986) points out that *"many of the major cultural similarities and differences in the world today are occupational rather than national"* (Morgan, 1986, 113-114) there are many researchers trying to identify the way in which national cultures could have an effect on the behaviour of people in organizations (Darlington, 1996). One of the most important of such researchers is Hofstede (1980). The importance of Hofstede's (1980) work is that not only has it identified specific cultural differences between nations, but it has also demonstrated that organizational culture is an entry point for societal influence on organizations, thus seeing national culture traits as part of the web of meaning that constitutes organizational culture (Hatch, 1997, p. 210). His research has been reassessed by various researchers who found it to be largely validated (Darlington, 1996).

Hofstede's (1980) cross cultural study to identify the differences among 16,000 employees of a multinational company located in 40 countries is based on survey questionnaires aiming to identify the basic dimension of differences between national cultures. His findings pointed out to four dimensions –power distance, uncertainty avoidance, individualism-collectivism and masculinity-femininity, on which the forty countries were rated and located on a "cultural map"[19].

[19] See Annex 6 for Hofstede's (1980) classification of cultures by dimensions.

However, Darlington (1996) notes that caution should be taken when interpreting Hofstede's score, and gives the example of the Iranian culture. The high collectivist score for Iran may lead one to suppose that, in general, Iranians would cooperative well in a team, whereas Tayeb (1979) notes that the background of most Iranians does not push towards co-operation in teams or work groups and that they are can better be viewed as individualistic in culture (Darlington, 1996).

4.5.1 Culture of Arab management

In studying the impact of societal culture on organizations, Hickson and Pugh (1995) identified some cultural influences on Arab management in the Arab Middle East countries, particularly the Gulf countries. They argue that Bedouin tradition of tribal inheritance, Islam with its moral and legal guidance, and rapid westernisation, shape modern Arab management culture.

Probably the most profound cultural influence on Arab culture is its history of nomadic Bedouin tribes with stern Bedouin tribal codes of loyalty and honor in a strongly patriarchal family system in which authority lies with the tribal sheik, and runs from father to eldest son and so on. Although the sheik's authority was supreme, tribal opinion was highly valued (Hickson and Pugh, 1995).

The Bedouin tradition has lead to the rise of a style of organizing called Bedo-cracy or Sheickocracy. Bedo-aucracy is defined as a top-down authority, which may be consultative, and in which members pursue as much their own interests and those of family and friends as the organizational goals.

The second influence, Islam, has reinforced traditional values by making moral guidance explicit in the Quran and Sharia Law, and reinforcing the ethical aspects of management, where practices such as maltreatment of employees is viewed as sinful. Islam also encourages the consultative aspect of authority, where *"wise consultation by those in authority (as distinct from "power sharing") and obedience to a responsively wielded authority are both stressed"* (Hickson and Pugh, 1995, p.192)

The final impact, that of the west, can be seen in its demand for oil, where the pace of change has been forced, and modern forms of organization and management were installed almost before they could be managed, and expatriate support to manage the organizations was brought in. *"The struggle to reconcile these models (specialist*

departmentalization, forward planning, smooth information flows, impersonal control systems, and committed human resources) with traditional ways and Islamic codes, is acute." (Hickson and Pugh, 1995, p.194).

Hickson and Pugh (1995) note that two fundamental paradoxes seen in Arab management are managing authority and managing relationships. With a disposition to handling authority centrally with high power distance, Arab managers also aspire to an "open door" consultative approach. Also, managers pursue their individual interests through collective means and personal relationships. Centralization of power together with acceptance of pursuit of personal interests have led to a flexible form of organization in which posts and departments are created based on personal reasons.

Such personalized concepts of power have led failures of an organization to be blamed on the head and the solution is seen as his removal as much as analysing the situation. Also the centrally planned economy and the State ownership of organizations in the region raises the level at which decisions can be taken, resulting in the autonomy of each management being reduced.

The concept of relationship and loyalty is important in this region. Managers accomplish their functions through informal means and depend greatly on personal ties, trust and loyalty. The line between business affairs and personal life is blurry and managers place great efforts in caring and helping relationships with their personal and organizational problems. A research conducted by Muna (1980) suggests that executives prefer loyalty from their immediate subordinates (71 percent of the respondents) to efficiency (29 percent of respondents).

As for the lack of planning, some argue that this may be due to the implicit assumption in Islam that the future is best left to God, thus creating a latent fatalistic outlook to management, and others argue that it is more due to political and economic instability, which makes planning difficult. As for time management, the clock is valued less than human and social considerations.

Attiya (1992) reviewed Arabic literature on Arab management style and found that management was found to be formalistic, with excessive emphasis on control and compliance with rules and regulations and minimal planning. Leadership was found to be authoritarian, with personalistic handling of decision-making, and consultative. However, Attiya (1992) warns against attributing too much to Islamic culture. He suggests that lack

of planning could be rather due to shortage of planning specialists and reliable useable data. Similarly, he suggests that the existence of both authoritarian and consultative styles of management may be a result of switching from one to another to suit contingent situations.

A literature review on Arab management style made by Al-Faleh (1987) summarizes the paradoxes and dualities of Arab management:

- Management style is authoritarian.
- Formal hierarchy is respected with reverence and obedience.
- The environment is one of centralization and little delegation.
- Aptitude and performance is less important than status, position, and seniority.
- Decision-making is at the highest levels of the organization.
- Decision-making is based on paternalistic and familial patterns and influences in lieu of democratic processes.
- Decisions and agreements are regularly renegotiated.
- Management is consultative rather than involving.
- Decision-making practices are unstructured and informal.
- Crisis management and reactive management are the norm.
- Affiliation and power need are the main motivational forces of employees.
- Social formalities and obligations are crucial to organizational members.
- Innovation, initiative and risk taking are badly perceived and punished.
- The impression is one of low trust among employees.
- The environments are high in political gamesmanship.
- Information systems are closed with low information sharing.
- The work environment continually changes.
- There are high levels are uncertainty at work.
- Subordinates are obedient and avoid opposition and confrontation.
- Management style is person orientated as opposed to task oriented.
- Kinship ties and nepotism are expected and loyalty is significantly valued over competence.
- The use of family ties and connections is an integral part of performing management activities.
- There is less value and emphasis placed on punctuality and time commitment than in the West.

4.5.2 Conclusion on national culture

Although the researcher agrees with Morgan's (1986) point that 'many of the major cultural similarities and differences in the world are occupational rather than national', specially in hospital setting where professional cultures have been found to be particularly strong, a study of culture without exploring national culture would be incomplete. One of the most important studies on national culture is Hofstede's (1980) cross-cultural study. Not only has it identified specific cultural differences between nations but it has also demonstrated that organizational culture is an entry point for societal influence on organizations (Hatch, 1997). Although largely validated by researchers caution should be taken when interpreting Hofstede's scores (Darlington, 1996).

Research on Arab management culture has proposed that bedo-aucracy (or sheickocracy), Islam, and rapid westernization have created a particularly paradoxal culture (Hickson and Pugh, 1995). The culture was characterized as being centralized, having constant change with high levels of uncertainty, having closed information systems and low levels of disclosure, being loyal and obedient to formal hierarchy and preferring consultation rather than participation of organizational members. It was also found to rely on informal means to conduct work, to rely on personal judgments and interests, and have little planning activities. Organizational members were found to be motivated by affiliation and power needs rather then performance objectives and the atmosphere was found to be of low trust with political gamesmanship (Al-Faleh, 1987; Attiya, 1992; Muna, 1980).

The researcher tends to agree with Attiya (1992) who warned against attributing lack of planning to Islamic culture. This researcher's view are that the attributes described above are organization-bound rather then nation-bound and could be used to describe any organization that is centralized with weak standardization of work resulting in the organization being a political arena.

4.6 *Conclusion*

This research is rooted in the interpretative and differentiationist perspectives. It views culture as phenomenological, made up of several parallel subcultures (Gregory, 1983; Smirchich, 1983; Mogan et al., 1983; Anthony, 1994; Meek, 1988) in which the subcultures may co-exist in harmony, conflict or indifference to each other (Smirchich and Morgan, 1982; Riley, 1983). This can be witnessed in the extensive study of professional cultures and interprofessional relations. However, this research also draws from the

integrationist, modernist perspective when exploring cultural strength and the link between culture and effectiveness.

Some of the different definitions of and perspectives to studying culture have been explored. The difficulties in establishing a link between organizational culture and performance have been discussed with a particular emphasis on measuring the variable cultural strength (Hatch, 1997; Deal and Kennedy, 1982; Kotter and Heskett, 1992; Danison, 1990) and its attributes such as core values sharedness, intensity, direction, and pervasiveness (Luthans, 1995; Kilman et al., 1985; Deal and Kennedy, 1982). Drawing from studies such as Kilman et al.'s (1985) Cultural Gap survey and the Hay Group's (Vestal et al., 1997) culture attributes assessment survey this research explores the attributes of a group of hospitals' culture and the gap between the actual and desired culture.

The development of professionalization studies is explored starting from early core definitions and typologies of professions (Flexner, 1915; Carr-Saunders and Wilson, 1933; Millerson, 1964; Moore, 1970) to the more recent 'deprofessionalization' debate (Haug, 1973; Oppenheimer, 1973; Braveman, 1974). The classification of health professions (Etzioni, 1969; Forsyth and Nanisiewicz, 1985; Freidson, 1970) was also explored before studying the work relations, professional positions, and shifting interprofessional relations of doctors, nurses and health administrators in the British NHS and the U.S.. Although these studies are based on British NHS and U.S. experiences, they are relevant to this research and will be used to explore professional culture and interprofessional relationships in the organization under study in Qatar.

Finally, although the researcher agrees with Morgan (1986) that *'many of the major cultural similarities and differences in the world are occupational rather than national'* (Morgan, 1986, 113-114), especially in hospital setting where professional cultures have been found to be particularly strong, a study of culture without exploring national culture would be incomplete. After reviewing Hofstede's (1980) research on national culture and research on the attributes of Arab management culture (Hickson and Pugh, 1995; Al-Faleh, 1987; Attiya, 1992; Muna, 1980) the researcher concludes that the characteristics attributed to Arab management are organization-bound rather than nation-bound and could be used to describe any organization in which centralization with weak standardization of work have resulted in the organization becoming a political arena.

CHAPTER 5 RESEARCH PHILOSOPHY AND METHODOLOGY

5.1 *Introduction*

This chapter discusses the research philosophy and methodologies of this study. It commences by exploring some of the philosophical underpinnings of this research by exploring theory development and methodological eclecticism within the interpretative paradigm. In the second section, it describes the quantitative and qualitative investigation methodologies used in this case study and notes some preliminary findings.

5.2 *Research philosophy*

This section reviews some of the philosophy underpinning this research. First, the different paradigms of theory development in organizational research are enumerated and a description of the interpretative paradigm is given. Second, some methodologies and investigations for theory development are explored. Finally, methodological eclecticism within one paradigm is explored through triangulation of research methods.

5.2.1 Theory development and the interpretative paradigm

Theories are bounded by the implicit values of the theorists. Theorists are influenced by history and culture (Reed, 1996) and the pursuit of scientific knowledge generally is rooted in assumptions and paradigms (Kuhn, 1970). Consequently, different ways of approaching theory building exist due to the differences in fundamental assumptions between paradigms. The four main philosophical views in organizational studies as identified by Gioia and Pitre (1990) are the functionalist, interpretive, radical humanist and radical structuralist paradigms each holding its own rhetoric, theory building approaches and knowledge[20]. This research draws from the interpretative paradigm.

The interpretive paradigm is based on the assumption that reality is a social construct; that people in organizations construct and sustain their own organizational realities (Gioia and Pitre, 1990). The theory building process tends to be inductive in which the researcher becomes involved in the events studied by attempting to see from the perspective of the organization member's experience of the area of study. Theory takes the form of descriptions, insights, and explanation of events so that the interpretive system

of the organizational members is revealed (Miles and Huberman, 1984; Weick, 1989). The theory building process is iterative, cyclical and non-linear. The researcher moves from analysis, theory generation and data collection back and forth. Revisions and modifications to hypothesis and data collection methods are considered part of the process, and the end result of the process is generally a grounded middle range theory.

For this research, the theory building process was iterative in that, once the initial hypotheses were set, data were collected over two separate sessions in order to permit revision of data collection methods[21]. However, in contrast to some interpretative research (Henwood and Pidgeon, 1993; Dingwall, 1981), findings were not fed back to the subjects of research for revision and discussion.

Interpretive research relies often on idiographic researches such as case studies. However, within the positive normal view of social science, case studies have been considered somewhat epistemologically inferior at explaining knowledge (Tsoukas, 1989). They are viewed as having low external validity, that is, it is difficult to generalise findings beyond the cases researched and thus not legitimate for general theoretical claims. In addition to producing idiosyncratic theory, they produce mid-range theories or they stagger under the volume of data collected from the cases from which they are tempted to build theories that try to capture everything (Eisenhardt, 1989). They are considered more as pilot phases of research programs. Tsoukas (1989) reminds of the importance of replication, one of the most important criteria for assessing knowledge contribution, in case studies. However, as Tsang and Kwang (1999) note, since organizations are open systems where studies are rarely conducted under conditions of closure (meaning that the exact same circumstance may not be repeated), a failure to replicate should not be automatically considered as a falsification of the theory advanced.

However, proponents of the qualitative, interpretative methodologies advocate that these overcome some major drawbacks of positivist, quantitative methodologies (Yin, 1994; Miles and Huberman, 1984; Henwood and Pidgeon, 1993; Eisenhardt, 1989; Marshall, 1985); first, the problem of fixing meaning to variables that are renegotiable in relation to their context of use; second, the neglect of the uniqueness and particularity of human experience; third, the problem of *'overwriting of internally structured subjectivities by externally 'objective' systems of meaning'* (Henwood and Pidgeon, 1993, p.16). Nonetheless, guidelines for sound theory building in the interpretative paradigm have

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[20] See Annex 7 for the main paradigms as presented by Gioia and Pitre (1990).

been proposed to overcome the critiques of the positivists (Yin, 1994; Miles and Huberman, 1984; Henwood and Pidgeon, 1993; Eisenhardt, 1989; Marshall, 1985)

Eisenhardt (1989), adopting a positivist view of research, proposed an eight-step road map for developing testable hypotheses and theory from case study research that are generalizable across different settings. The first step is getting started and proposing broad tentative research questions with some reference to relevant literature. The second step is selecting cases for theoretical, not statistical, reasons. The third step is crafting instruments and protocols by combining multiple data collection methods. The use of different methods in case studies enhances confidence in the findings and increases the likelihood of taping on any new insights. The fourth step is to enter the field. In this stage, data analysis and data collection are overlapped in order to allow the researcher to take benefit of the flexible data collection methods.

The fifth step is to analyse data, first within the case, then search for cross case patterns. This part is the most difficult because the data collected could be overwhelming but determining these patterns is the most important part of theory building from case studies. The sixth step is to start shaping hypotheses by looking for overall impressions, themes, concepts and relationships between the variables that have emerged from data analysis. The seventh part is comparing the emergent concepts, theory or hypotheses with existent literature and the final step, closure, is reached when saturation has been achieved. That is, when adding new cases or going back and forth between theory and data will only provide minimal incremental improvements to the theory.

Case study theory building has the advantage of being intimately linked with empirical reality thus enabling the development of testable, relevant and valid theory (Eisenhardt, 1989). It provides opportunity for creative insights from juxtapositioning paradoxical events thus enabling new, measurable, testable and empirically valid theories to be developed. And multiple cases enable, if desired, to move from 'mid range' theories to 'grand' theories via both theory building and theory testing studies. In addition, narratives from case studies have been found to be extremely effective in building process theory, for their stories are abstract conceptual models that may be used to explain observed data, and lead to the causal sequence of events (Pentland, 1999).

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[21] Summer 1998 and Summer 1999.

5.2.2 Theory development

The lack of consensus over a precise definition of what constitutes a theory, compounded with the issue of theoretical perspective, explains why it is difficult to develop strong theory in behavioural sciences and organizational studies (Straw and Sutton, 1995). Broadly, a theory is any coherent description or explanation of observed or experienced phenomena (Gioia and Pitre, 1990); a story about why acts, events, structure and thoughts occur (Straw and Sutton, 1995); a linguistic device used to organize and communicate a complex empirical world and explain causal relationships (Bacharach, 1989).

More precisely, a theory is an account of *'relationships between units observed or approximated in the empirical world.'* (Bacharach, 1989, p.498). Theories are composed of constructs and variables. Propositions connect the constructs to each other, and hypotheses connect the variables. This whole system of constructs, variables, propositions and hypotheses is bounded by the theorists' assumptions and values.

A good theory is one that explains, predicts and delights (Weick, 1995). It is one that provides a value-added theoretical contribution by answering the questions 'Who?', 'What?', 'When?' 'Why?' and 'How?'. But most importantly, it explains rationale by answering the question 'Why?' (Van de Van, 1989). A good theory goes beyond the demonstration of empirically derived patterns. It tries to understand and explain the reasons for occurrences and non-occurrences by exploring micro processes as well as the social phenomena and presenting them in logical and convincing arguments (Straw and Sutton, 1995).

What is clearer is what theory is not. There is a general consensus among organizational studies researchers over the elements that do not compose a theory. References, data, lists of variables or constructs, diagrams, hypotheses, typologies, or metaphors are not theories per se (Straw and Sutton, 1995; Bacharach, 1989). However, these elements may be considered as tools in theory development and typologies and metaphors may sometimes be forerunners to theories.

Literature on theory development is scant, mostly normative, and tends to focus on the outcomes and products rather than the actual process of theory development (Weick, 1989). Theory development is a continuum that starts with guesses and speculations and ends with explanations and models. This process requires activities such as abstraction,

generalization, searching for relations, selecting, explaining, synthesizing and idealizing (Weick, 1995).

Whetton (1989) views theory development as building blocks composed of asking the questions 'What?', 'How?', 'Why?', 'Who?', 'Where?' and 'When?'. The first question to be asking is 'What?'. That is, which factors (concepts, variables, and constructs) are to be regarded as part of the explanations? Is the explanation comprehensive and does it include all the relevant factors? Are all factors adding value and parsimonious or should some be removed from the explanation? One may start by including many factors and gradually narrow down factors to achieve comprehensiveness and parsimony. The second question would be; 'How' are these factors related? A diagram with arrows and boxes may help operationalize this stage, especially when the relationships are complex.

The answers to these 'What?' and 'How?' questions compose the domain or subject of the theory. They describe and, combined together, produce the typical model which is composed of hypotheses and propositions and which becomes the framework for interpreting patterns in the empirical observations. The next stage of theory building is understanding the 'Why?', for without understanding the 'Why?', the end result would be a weak theory and an empirically dominated discussion of the study's results.

The third question, the 'Why?' question, requires a logical and clear explanation of *'the underlying psychological, economic or social dynamics that justify the selection of the factors'* of the study and the proposed causal relationships found in the empirical observations (Whetton, 1989, p.491). This would demonstrate the theory's underlying assumptions. Whetton (1989) notes that, together, the 'What', 'How' and 'Why' provide the essential ingredients of a good theory; description and explanation.

However for the theory building process to be complete, boundaries need to be set to the theory. Temporal and contextual factors such as 'Who?', 'Where?', and 'When?' provide the boundaries and limits of generalizability and thus may be described as the range of the theory. Generally, an initial basic theory is developed and the boundaries of a theory are discovered during the theory testing phase in which the theory is tested in various settings and its limitations become apparent (Whetton, 1989).

Weick (1989) undertook a review of some of the classical normative literature on theory development such as the works of Homans (1964), Kaplan (1964), Bourgeois (1979) and Campbell (1974) and found them to be too mechanistic, too linear problem solving

directed, and counterproductive to creativity during the theory development process. To this purpose Weick (1989) proposed a novel way of viewing theory construction, one of disciplined imagination.

Weick (1989) equates the theorizing process to artificial selection in which the theorists choose the problems statement, and decide when thought trials have solved the problems they posed, thus, becoming the source of variation and selection. In that case, the probability of attaining a good theory increases with the use of a greater number of diverse criteria applied to a conjecture. This can be done by *'self conscious manipulation of the selection process'* (Weick, 1989, p.519). Diversity or heterogeneity among thought trials requires one to transcend paradigmatic thought for heterogeneity within one paradigm is most unlikely. This, Weick (1989) suggests, can be achieved via heterogeneous research teams, or adopting eclectism or generalist thoughts.

In order for such research to be possible this implies that traditional research evaluation become more 'tolerant' (Straw and Sutton, 1995). Good theories have traditionally been those who are falsifiable, useful, parsimonious, value-added, generalizable, transformational, logically coherent, and have good fit with the data (Bacharach, 1989; Eisenhart, 1991). Miles and Huberman (1984) proposed a parallel criterion of 'trustworthiness' to facilitate theory building using qualitative methodologies. Additionally, as DiMaggio (1996) notes, good theory is difficult to produce because 'goodness' is multidimensional.

For disciplined imagination research Weick (1989) proposes that validation is no longer a criterion for selecting and retaining a thought trial during the theorizing process and that theoretical contribution is closer to suggesting relationships and connections that had gone unnoticed or that may change perspectives or actions. An appropriate substitute for validity in this case, Weick suggests, is plausibility. Thought trials should be tested for significance by the reaction they cause to the researcher. Reactions such as 'that's absurd', 'that's irrelevant', or 'that's obvious' suggest that the thought trial should not be retained. But if, however, the reaction is 'that's interesting', then this thought trial is plausible and should be retained for development.

Other criteria may also help the researcher in the selection process. 'That's connected' may uncover unexpected connections and their implications. 'That's believable' may be used in narratives and case studies to assess whether the story may be a prototype story. 'That's beautiful' in which the thought trial is selected for aesthetic reasons, and finally

'that's real' relies on selection based on experience, and practice in the real world via validity tests.

A difficult issue to manage in the theory development process is achieving the right level of generalization and abstraction. Within generalization are the different levels on which theorizing can take place. Empirical generalization is high in details but limited by strict boundaries of time or space whereas theoretical generalization produces grand abstract theoretical statements that lack empirical detail but are less limited by a time or space boundary (Bacharach, 1989). These two levels together compose a sound theory.

Osigweh (1989) notes the importance of having the proper levels of abstraction in order to avoid concept stretching (broadening of the concept beyond meaningfulness) and proposes a ladder of abstraction composed of three main level of abstraction on which concepts may be positioned. High abstraction concepts are universal conceptualisations that aim at global extension but may lose in this process precise meaning. Middle abstraction concepts produce middle level theories that are neither global nor universal. Low abstraction concepts are specific, precise in meaning but low in extension coverage. In order to achieve the right level of abstraction, Osigweh (1989) proposes the use of a negative approach in which concepts are defined by what they are not thus setting the boundaries and attributes of the concept. In this way, when the concept moves up the ladder to a high abstraction position it becomes an empirical universal rather than a conceptually stretched philosophical universal.

5.2.3 Combining research methods

A growing number of researchers seem to be incorporating elements of both qualitative and quantitative traditions in their research design (Deacon et al., 1998). Hammersley (1996) notes three ways in combining quantitative and qualitative methods in research design; triangulation, facilitation, and complementarily.

Triangulation is one of the most common ways in which the integration of quantitative and qualitative research is conceptualised (Deacon et al., 1998). At first used mainly with quantitative research strategies, it is now considered the best strategy for combining quantitative and qualitative methods.

By triangulating, findings generated by one method can be validated by checking them against findings generated by another method. Hence, greater confidence in findings is

achieved as a result of different measurement processes being used to investigate a hypothesis. Researchers under the qualitative school of thought recommend that the approach should be as open and as unstructured as possible so that the focus of the investigation is as uncontaminated by prior conceptions as possible (Deacon et al., 1998). As a result, the outcomes of the integration of quantitative and qualitative research methods may yield unexpected results.

Triangulation can be planned or unplanned but as researchers frequently do not make explicit whether the exercise was planned, it is difficult to establish with any certainty whether or not triangulation was planned. The results of triangulation my corroborate each other or may clash. In case the triangulation has been unplanned the researcher may have not contemplated the possibility of a clash between sets of findings and he is faced with how to deal with the clash. However, considering the growing popularity of research using combined research designs in the last five or so years there are few clashes (Deacon et al., 1998).

Deacon et al. (1998) note two ways of handling instances of clashes in which there is a clear inconsistency between data derived from quantitative and qualitative research. First, to prioritize one set of evidence over the other (e.g. to adopt the findings of qualitative research as more valid, to declare one set of data is wrong due to errors during methodologies, or to declare one set as more epistemologically reliable.) Second, to attempt to elaborate an explanation that could accommodate their apparent tensions.

The authors believe that there is *'no point in developing a multi-method approach if the researcher resorts to methodological purism at the first sign of trouble*' and declares one methodology more correct than the other (Deacon et al., 1998, p. 57). Clashes should lead to reappraisal and re-analysis of findings, which would reap long-term analytical rewards that outweigh the short-term inconvenience of clashes.

5.2.4 Conclusion on research philosophy

This research is rooted in the interpretative paradigm in which the theory building process tends to be inductive and in where the researcher becomes involved in the events studied by attempting to see from the perspective of the organization members' experience of the area under study (Gioia and Pitre, 1995). In light of positivist critiques on case study methodologies, this research moves towrads Eisenhardt's (1989) eight-step road map for

developing testable hypotheses and theory from case study research that are generalizable across different settings as a general guideline.

In addition to using traditional means for theorizing such as Whetton's (1989) building blocks composed of asking the questions 'What?', 'How?', 'Why?', 'Who?', 'Where?' and 'When?'. This research attempts to be more playful with findings following some principles of disciplined imagination research (Weick, 1989).

Finally, in order to enhance confidence in findings and achieve methodological eclecticism, this research uses planned triangulation of qualitative and quantitative research methods (Eisenhardt, 1989; Deacon et al., 1998; Hammersley, 1996). Where clashes between data derived from quantitative and qualitative research are found, explanations that could accommodate their apparent tensions are sought rather than prioritising one set of evidence over the other.

5.3 *Quantitative methodologies*

5.3.1 Introduction

The quantitative tools used in this study are two questionnaires. The first is a comprehensive seven-section questionnaire that explores organizational effectiveness, culture and structure. The second questionnaire focuses on team structure, functioning and effectiveness and complements the first, more general, organizational level questionnaire.

5.3.2 Comprehensive questionnaire on culture, structure and organizational effectiveness

The first questionnaire is a comprehensive questionnaire broken down into seven sections. The first four sections assess organizational effectiveness as perceived by the respondents and have been modelled on the Competing Values Approach developed by Quinn and Rohrbaugh (1981 and 1983) and further expanded by Robbins (1990). The fifth section assesses perceptions on organizational structure and change and is based on a review of the relevant literature. The sixth section assesses beliefs and assumptions of respondents on interprofessional work and the seventh section assesses organizational culture by using a simplified version of the Targeted Culture Model developed by the Hay Group (Vestal et al., 1997) and questions on culture drawn from the literature.

Table 5.1: Breakdown of Comprehensive Questionnaire presents a breakdown of the comprehensive questionnaire's themes, sections, issues explored, questions' description, and chapters in which findings are explored[22]. The pilot test demonstrated that 28 minutes were needed for a complete response.

TABLE 5.1: Breakdown of Comprehensive Questionnaire

SECTIONS AND THEMES	SOURCE	CHAPTERS FINDINGS DISCUSSED	QUESTIONS DESCRIPTION
Section 1; Competing Values Framework; Human Relations Model	Quinn and Rohrbaugh (1981 and 1983) Robbins (1990)	Nine	*Four questions* that assess harmony and coordination amongst staff, staff morale and skills.
Section 2; Competing Values Framework; Open System Model	Quinn and Rohrbaugh (1981 and 1983) Robbins (1990)	Nine	*Twenty-five questions* that assess the corporation's responsiveness to industry changes and customer needs, its ability to predict and anticipate future changes, adaptability, innovation, and change processes. Also assesses the budget priorities of the corporation, its ability to attract qualified staff.
Section 3; Competing Values Framework; Rational Goal Model	Quinn and Rohrbaugh (1981 and 1983) Robbins (1990)	Nine	*Nine questions* that assess the corporation's mission, objectives, its outputs and productivity.
Section 4; Competing Values Framework; Internal Process Model	Quinn and Rohrbaugh (1981 and 1983) Robbins (1990)	Nine	*Seven questions* that assess information flow, organization of work processes, work stability, and work control.
Section 5; Organization Structure	Organization Literature	Six and Seven	*Sixteen questions* that assess the organization structure, its flexibility, and individual's freedom to structure their own work. Also assessed are communication, change and the use of committees and teams.
Section 6; Beliefs and Assumptions	Organization Literature	Eight	*Six questions* that assess beliefs revolving around the extent of the medical staff's involvement in management and administrative staff's involvement in medical and nursing issues.
Section 7; Effectiveness and Culture	Hay Group Vestal et al. (1997) Schein (1992) Culture Literature	Eight	*Four questions* assess staff's perception of the corporation's dominant features, the factors that are important for the success of a corporation like HMC and advices they would give new staff at entry.

[22] Annex 8 is a list of the questions in the questionnaire and Annex 9 a sample of the questionnaire and letterhead distributed to respondents.

5.3.2.1 *Case and Sampling*

The Corporation studied, Hamad Medical Corporation (HMC), is a government corporation, independent of the Ministry of Health and composed of the only three hospitals in Qatar; Hamad General Hospital (HGH), Rumailah Hospital (RH), and the Women's Hospital (WH). In 1999 of the 5215 total employees 1740 were nursing, 555 medical, 572 administration, 368 paramedical, and the remaining a mix of support services[23].

A stratified sample was taken for each hospital ensuring that each subgroup has been represented in the sampling frame (by profession and hierarchy) in order to enable cross tabulation[24]. The questionnaire was distributed to 300 individuals of whom 171 responded (57 percent response rate).

5.3.2.2 *Analysis Methodology and Presentation of Findings*

Responses to the questionnaire were analyzed with the help of SPSS software. Each question was tested against the variables profession and hospital to determine how responses varied by profession and by hospital. The Chi square test (significant at 5 percent and 10 percent) was applied to establish a significant relationship and Cramer's V level of association was used to understand the nature of the relationship. Throughout the study, findings are analyzed within case (i.e. by hospital) or profession and cross-case and cross-profession in order to find patterns.

For findings of the Competing Values framework, by transferring the responses into Excel, 'radar' graphs plotting the results of each section on one graph were extracted in order to permit easy comparison of results by section. These are presented and discussed in Chapter Nine.

Findings of the sections on organizational structure and culture were presented in individual Excel produced tables throughout Chapters Six to Nine to illustrate, validate, contradict, or complement interview findings. Additionally, wherever relevant, responses to a specific question is drawn out from the Competing Values framework and presented in Excel tables.

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[23] Source: HMC, Statistical Report for Active Staff, Personnel, 1999.
[24] See Annex 10 for Sampling Matrix for organizational effectiveness, culture and structure questionnaire.

The last open-ended question in section seven was coded manually, grouped and the codes added up and presented in a graph to give an overview of the most frequent answers. These responses are used in Chapter Eight when exploring organizational culture.

5.3.2.3 *Descriptive statistics and preliminary findings*

Basic descriptive statistics were first taken. Of the 171 respondents, 45 percent of respondents were nurses, 15 percent doctors, 16 percent corporate departments staff and eight percent administrators (See Table 5.2: Respondent's Profession). Table 5.3: Respondent's Hospital indicates that 36 percent of these were from HGH, 26 percent from corporate departments, 20 percent from WH, and 17 percent from RH. Table 5.4: Respondent's Years of Services, demonstrated that respondent's years of service in the corporation varied roughly equally from 1-5 years all the way to more than 15 years of experience.

Table 5.2 Respondent's Professions

Profession	Frequency	Percent
Medical	25	15
Administration	13	8
Nursing	77	45
Paramedical	9	5
Therapy	9	5
Support Services	10	6
Corporate Departments	28	16
Total	**171**	**100**

Table 5.3 Respondent's Hospital

Hospital	Frequency	Percent
Hamad General Hospital	62	36
Women Hospital	35	20
Rumailah Hospital	29	17
Corporate Departments	45	26
Total	**171**	**100**

Table 5.4 Respondent's Years of Service

Year of Service	Frequency	Percent
1-5 years	38	22
6-10 years	36	21
11-15 years	41	24
More than 15 years	46	27
Missing	10	6
Total	**171**	**100**

As for respondent's age, Table 5.5: Respondent's Age, indicates that the majority of respondents, 36 percent, were aged 31-40. The second largest group, 33 percent, were aged 41-50. Slightly more respondents were female, 56 percent, than male, 41 percent (See Table 5.6: Respondent's Gender). Finally, Table 5.7: Educational Background indicates that the majority, 45 percent, of respondents were university graduates followed by 29 percent being postgraduate and 13 percent with a secondary education.

Table 5.5 Respondent's Age

Age	Frequency	Percent
Less than 20	2	1
20-30	18	11
31-40	61	36
41-50	56	33
51-60	17	10
Missing	17	10
Total	**171**	**100**

Table 5.6 Respondent's Gender

Gender	Frequency	Percent
Female	95	56
Male	70	41
Missing	6	4
Total	**171**	**100**

Table 5.7 Respondent's Qualifications

Qualification	Frequency	Percent
Less than secondary	5	3
Secondary Education	23	13
University Graduate	77	45
Post Graduate	50	29
Other	13	8
Missing	3	2
Total	**171**	**100**

As for the findings of the Chi square test, where significant relationships were found by profession and hospital, tables were drawn in order to understand which variables affected the responses more. (See Table 5.8: Significant Relationships by Profession and Table 5.9: Significant Relationships by Hospital). Generally, responses demonstrated a higher level of significance relationships by profession than by hospital especially in the sections two to six. This indicates that the respondent's profession was more likely to influence responses than the hospital the respondent comes from.

Table 5.8 Significant Relationships by Profession

Section 1 Human Relations by Profession		
Question	**Chi Square**	**Cramer's V**
Medical-Medical working	.008	.246
Paramed-Corp.Depts working	.034	.236
Nursing-Nursing relations	.046	.227
Nursing-Paramed relations	.000	.298
Nursing-Therapy relations	.005	.269
Nursing-Corp. Depts relations	.034	.236
Paramed-Paramed relations	.035	.243
Paramed-Corp.Depts relations	.016	.245
Paramed-Supp. Ser relations	.014	.247
Therapy-Therapy relations	.000	.280
Therapy-Supp. Sers relations	.024	.240
Admin-Admin relations	.002	.267
Admin-Corp.Depts relations	.001	.266
Admin-Supp. Servs relations	.009	.251
CorpDept-Supp.Sers relations	.023	.235
Supp.Ser-Supp.Ser relations	.022	.242
Administration morale	.012	.242
Corp.Depts morale	.015	.240
Medical skills	.002	.259
Section II Open Systems by Profession		
Staff encouraged	.024	.241
Budget for new services	.027	.233
Nursing budget processes	.003	.255
Community donations	.011	.243
Hiring nursing staff	.001	.268
Hiring admin/support staff	.000	.270
Section III Rational-Goal by Profession		
Dept objectives	.015	.246
Volume of work	.049	.227
Department productivity	.005	.259
Section IV Internal Processes by Profession		
Information Conveying	.040	.229
Information obtaining	.000	.291
Section V Structure by Profession		
Planning Dept structure	.040	.229
Dept:Information travel	.028	.238
Dept effect of committees	.007	.254
Corp effect of committees	.073	
Section VI Culture by Profession		
Corp medical involvement	.028	.239

Table 8.9: Significant Relationships by Hospital

Section 1 Human Relations by Hospital		
Question	**Chi Square**	**Cramer's V**
Medical-Medical working	.010	.267
Medical-Nursing working	.001	.270
Medical-Paramed working	.036	.226
Medical-Corp Depts working	.014	.256
Medical- Supp. Sers working	.040	.226
Nursing-Corp. Depts working	.049	.203
Medical-Nursing relations	.008	.228
Medical-Corp Depts relations	.042	.205
Nursing-Therapy relations	.022	.194
Nursing-Supp. Sers relations	.020	.217
Paramed-Supp. Ser relations	.005	.235
Admin-Admin relations	.042	.205
Admin-Supp. Servs relations	.001	.252
CorpDept-Supp.Servs relations	.007	.249
Admin morale	.033	.228
Corp.Depts morale	.026	.231
Nursing skills	.011	.242
Therapy skills	.004	.256
Section II Open Systems by Hospital		
Budget for new services	.010	.255
Hiring admin/support staff	.000	.291
Section III Rational-Goal by Hospital		
Section IV Internal Processes by Hospital		
Section V Structure by Hospital		
Section VI Culture by Hospital		
Admin nursing involvement	.004	.236

5.3.3 Questionnaire on team structure, functioning and effectiveness

A second questionnaire, which draws on team literature but mostly on the works of Alexander et al. (1996) team structure, functioning and effectiveness, was constructed and distributed in order to complement the first, more general, organizational level questionnaire. Since hospital settings rely heavily on committee and team work a study on hospital structures and effectiveness would not have been complete without a study on team structures and effectiveness.

The questionnaire distributed contained three sections. The first requested general information on the respondent's profession, hospital, and role in the committee or team. The second posed eighteen multiple-choice questions on the team's objectives, organisation, functioning, membership, discussion and decision-making processes, decision-making implementation, goal achievement and overall effectiveness.

The final part was composed of two open-ended questions on what can be done to improve the effectiveness of the team; what can be done by top management to improve the effectiveness of this team/committee? And what can be done by the team leader/chairman to improve the effectiveness of this team/committee? This was done in order to extract qualitative information that go beyond the limited questions posed in the earlier sections[25]. The pilot test revealed that it took around twelve minutes to complete the questionnaire.

In order to facilitate analysis, the questions were then regrouped into five; general questions (five questions), questions on team functioning (eleven questions), questions on team performance (three questions), self assessed effectiveness (one question), and ways to improve effectiveness (two questions)[26].

5.3.3.1 *Case and sampling*

Working from Hetherington and Rundell's (1983) definition of work groups this questionnaire was developed and targeted for command groups, those allocated by the organization chart and that report to a director or leader. A 1997 internal survey revealed that there were over one hundred command groups at HMC, some entitled committees, others teams[27].

A total of 100 questionnaires were distributed to committee and team members in Corporate Departments, HGH, WH, RH and 70 were returned completed. The sample included committees and command teams operating at the corporate, hospital and departmental level. A cross-section of multi-profession and within profession teams and committees was insured[28].

5.3.3.2 *Analysis methodology and presentation of findings*

The first and second sections of the questionnaire were analyzed with the help of SPSS software. As in the comprehensive questionnaire, each of the eighteen multiple choice

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[25] See Annex 11 for a sample of the actual Team Questionnaire.
[26] See Annex 12 for a list of the questions asked in their respective re-grouping.
[27] 40 corporate committees, 42 committees and teams in HGH, 20 committees and teams in the WH and 13 committees and teams in RH (Source: HMC, Committee and Teams survey 1997, Administration)
[28] See Annex 13 for the sampling matrix used for the Team Questionnaire.

questions were tested with the Chi square test and Cramer's V level of association against the variables profession and hospital to see whether there was a significant relationship between the characteristics and variables. Here again, the responses to the last section, the open ended questions, were coded, grouped and the codes added up to give an overview of the most frequent answers[29].

The findings of this questionnaire are presented in different tables and used to explore team effectiveness in Chapter Nine. Tables that present findings on team performance and functioning are listed, then added up, the responses by profession and by hospital in order to give a total score for team performance and team functioning. Responses to self-assessed team effectiveness are presented in individual tables. As for the open-ended questions on what contributes to team effectiveness, a table of the frequency of each response is prepared in order to extract and discuss the most common responses.

5.3.3 Descriptive statistics and preliminary findings

As noted in Table 5.10: Respondent's Profession, of the 70 respondents, 33 percent of respondents were Nurses, 20 percent Medical Staff, 17 percent Administrative staff, 14 percent Corporate Staff, 9 percent Paramedical Staff and finally 6 percent Therapy Staff. Respondents were from the three hospitals and the corporate departments. Table 5.11: Respondent's Hospital shows that 37 percent of respondents were from Corporate Departments, 27 percent from HGH, 21 percent from RH, and 14 percent from WH.

Table 5.10: Respondent's Profession

PROFESSION	FREQUENCY	PERCENTAGE
MEDICAL	15	21
NURSING	23	33
ADMINISTRATION	12	17
THERAPY	4	6
PARAMEDICAL	6	9
CORPORATE	10	14
TOTAL	**70**	**100**

Table 5.11: Respondent's Hospital

HOSPITAL	FREQUENCY	PERCENTAGE
HAMAD GENERAL HOSPITAL	19	27
WOMEN'S HOSPITAL	10	14
RUMAILAH HOSPITAL	15	21
CORPORATE DEPARTMENTS	26	37
TOTAL	**70**	**100**

[29] See Annex 14 for the Codes and Description of Codes used in the Team Questionnaire.

Table 5.12: Team Creator indicates that 46 percent, nearly half, of the committees and teams surveyed were created by department heads. 24 percent were created by the Managing Director, 14 percent by the Medical Director, 9 percent by the Administrative Director and only 6 percent by the Board of Directors. As seen in Table 5.13: Respondent Role, the majority of respondents were team members (60 percent). A substantial number were chairpersons or team leaders (26 percent) and only 9 and 8 percent were respectively committee secretary and assistant chairman.

Table 5.12: Team Creator

CREATED BY	FREQUENCY	PERCENTAGE
MANAGING DIRECTOR	17	24
ADMINISTRATIVE DIRECTOR	6	9
MEDICAL DIRECTOR	10	14
DEPARTMENT HEAD	32	46
BOARD OF DIRECTORS	4	6
MISSING	1	1
TOTAL	**70**	**100**

Table 5.13: Respondent Role

ROLE	FREQUENCY	PERCENTAGE
CHAIRMAN/LEADER	18	26
ASST. CHAIRMAN	4	6
MEMBER	42	60
SECRETARY	6	8
TOTAL	**70**	**100**

Table 5.14: Reason for Holding Meeting, describes the reason for holding the committee or team meeting and shows that the majority, 50 percent, of the committees surveyed were decision making committees. Small minorities of the committees were discussion committees (4.3 percent), information committees (1.4 percent) and support providing committees (1.4 percent). 21.5 percent of the committees surveyed were a combination of decision-making, discussion, information and support providing committees. Equally, 21.5 percent of the committees were held for other reasons.

The committees/teams were composed of one profession, a combination of two professions or a combination of three or more professions. Table 5.15: Team Composition by Hospital shows that when looking at HMC as a whole 37.1 percent[30] of the committees in HMC were homogeneous, 11.4 percent were composed of a combination of two professions and the majority, 50 percent of the committees, were composed of a combination of three or more professions.

[30] Of the 37.1 percent 20 percent were nursing staff, 11.4 percent were medical staff, 2.9 percent were therapy staff, 1.4 percent were administrative staff, 1.4 were corporate departments staff.

TABLE 5.14 Reason for Holding Meeting

Hospital/Area		Reason for Holding Committee						Total
		Decision-Making	Discussion	Information	Providing Support	Other	All the above	
HGH	Count	7				6	6	19
	% of Total	36.8				31.7	31.6	100.0
WH	Count	4		1	1	2	2	10
	% of Total	40.0		10.0	10.0	20.0	20.0	100.0
RH	Count	7	3			1	4	15
	% of Total	46.7	20.0			6.7	26.7	100.0
Corporate Depts	Count	17				6	3	26
	% of Total	65.4				23.0	11.5	100.0
Total	**Count**	**35**	**3**	**1**	**1**	**15**	**15**	**70**
	% of Total	**50.0**	**4.3**	**1.4**	**1.4**	**21.4**	**21.4**	**100**

TABLE 5.15 Team Composition by Hospital

Hospital/Area		Composition								Total
		Medical Only	Nursing Only	Admin.Only	Therapy Only	Corp. Only	Two professions	Three or more professions	Missing	
HGH	Count	5	6				2	6		19
	% of Total	26.3	31.6				10.5	31.6		100.0
WH	Count		3					7		10
	% of Total		30.0					70.0		100.0
RH	Count	3	3		2		3	4		15
	% of Total	20.0	20.0		13.3		20.0	26.7		100.0
Corporate Depts	Count		2	1		1	3	18	1	26
	% of Total		7.7	3.8		3.8	11.5	69.1	3.8	100.0
Total	**Count**	**8**	**14**	**1**	**2**	**1**	**8**	**35**	**1**	**70**
	% of Total	**11.4**	**20.0**	**1.4**	**2.9**	**1.4**	**11.4**	**50.0**	**1.4**	**100**

In HGH, 57.9 percent of the committees were homogeneous, 0.5 percent were composed of two professions and 31.6 percent of three or more professions. In WH, 30 percent of committees were homogeneous, and the remaining 70 percent were committees composed of three or more professions. In RH, 63.3 percent of the committees were homogeneous, 20 percent were composed of two professions and 26.7 percent were composed of three or more professions. Finally, in the corporate departments, 15.3 percent of the committees were homogeneous, 11.5 percent of two professions and finally, 69.1 percent of three or more professions.

The results of the Chi square test applied (significant at 5 percent and 10 percent) in Table 5.16 Significant Relationships For Team Questionnaire demonstrated that only in the cases of 'objective[31] with profession' and 'organized with profession[32]' has a significant relationship been found. In both cases the Cramer's V level of association was moderate. As with the first more comprehensive questionnaire, these findings indicates that the respondent's profession was more likely to influence responses than the hospital the respondent comes from.

Table 5.16 Table of Significant Relationships for Team Questionnaire

Team's characteristics	**Chi Square**		**Cramer's V level of association**
Variables	**Profession**	**Hospital**	
Objectives	0.082 **	0.302	0.323
Organized	0.002 *	0.173	0.393
Members	0.372	0.295	Not relevant
Size	0.379	0.177	Not relevant
Participation	0.923	0.769	Not relevant
Opinion	0.382	0.372	Not relevant
Seriousness	0.616	0.744	Not relevant
Communication	0.640	0.300	Not relevant
Discussion	0.627	0.537	Not relevant
Decision	0.453	0.893	Not relevant
Consensus	0.302	0.156	Not relevant
Implementation	0.684	0.298	Not relevant
Resolution	0.512	0.678	Not relevant
Effectiveness	0.550	0.119	Not relevant
Goal Attainment	0.333	0.360	Not relevant
Utility	0.513	0.575	Not relevant

* Significant at 5%, $p<0.05$
** Significant at 10%, $p<0.10$

[31] Question asked was 'Is the objective/goal of this committee/team clear to all members?'
[32] Question asked was 'Are the meetings well organized with agenda distributed and minutes taken?'

5.3.4 Conclusion on quantitative methods

Two questionnaires were developed, distributed and analysed. The first was comprehensive, exploring organizational effectiveness, culture, and structure. The second focused on team functioning, and performance and self assessed effectiveness. An overview of the sampling methodology, questionnaires content, analysis methodology, basic descriptive statistics and preliminary findings were given.

5.4 *Qualitative methodologies*

5.4.1 Introduction

Having described the quantitative instruments used, this section reviews the qualitative instruments used. It describes the interviews design, content, and analysis methodology. Next, it explores the analysis methodology of the extensive documents collected.

5.4.2 Interviews on structure, change and culture

Interview questions were semi-structured, open-ended and covered the main issues of organization structure, coordination, organizational structural change and internal processes. They were found to be productive in describing perceptions, behaviours, feelings and thoughts of individuals as well as describing past events such as change processes and perceptions of these processes.

Two sets of interview questions were designed; the first for departmental heads and departmental employees and the second for executive and corporate staff[33]. The corporate and executive staff interview varies in that it has an additional question on corporate structure. The first two questions relate to decision-making, centralization of decision-making and participation in decision making. The third question relates to information and communication. The fourth question explores coordination and interprofessional relations. The fifth question explores the departmental structure, its efficiency and ways of improving it. The sixth question (only for executive and corporate staff) explores the organizational structure, its efficiency, its strengths and weaknesses, and ways of improving it. The final question explores the level and nature of participation in departmental or organizational structural changes.

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[33] See Annex 15 for interview questions to departmental heads and Annex 16 for interview questions to executive and corporate staff.

5.4.2.1 *Methodology and analysis*

An interview sampling matrix was prepared in order to ensure accurate representation of organizational members[34]. After permission was obtained to conduct interviews within the organization, a total of 114 interviews were conducted. Interview responses were transcribed, coded and then quantified so as to identify the most common responses.

In order to help with analysis, two analysis guides were prepared, one for responses by profession[35] and the other for responses by hospital[36]. These guides served as a summary of each answer's coded responses. These two guides were then put together in one final analysis guide that described responses by hospital and by profession[37]. This process facilitated the search for cross-case patterns. In addition to these analysis guides quotes were extracted to illustrate findings from the interviews, questionnaires and documents analysis.

5.4.3 Documentary analysis

An extensive document collection was undertaken. These documents were carefully read and the relevant ones summarized. Quotes were also extracted from some documents to illustrate or further explain findings.

Information on the organization and organization structure was obtained by exploring documents such as the corporations' constitution, standard practices, the commissioning reports, the Master Plans, legislation, government discussion papers, previous consultant reports, previous organization structures, job descriptions and meetings and debates records.

Information on effectiveness was obtained by examining the corporation's mission, objectives and annual/monthly reports for output, performance and productivity. Information on the different professions in HMC and their relationship was obtained from manpower listings, job descriptions of professions and minutes of common meetings. Finally, information on change was obtained via documented past minor and major change processes.

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[34] See Annex 17 for Interview Sampling Matrix
[35] See Annex 18 for the Analysis Guide by Profession
[36] See Annex 19 for the Analysis Guide by Hospital
[37] See Annex 20 for the HMC Analysis Notes

5.4.4 Conclusion on qualitative methodology

A total of 114 interviews were conducted. Interview responses were transcribed, coded and then quantified so as to identify the most common responses. Analysis guides were prepared and quotes were extracted to illustrate findings from the interviews, questionnaires and documents analysis. Extensive and vast arrays of documents were collected. Relevant documents were summarized and illustrative or explanatory quotes extracted.

5.5 *Conclusions and preliminary findings*

This study is inductive in that the researcher becomes involved in the events studied by attempting to see, through the perspective of the organization member's experience, the area of study. It attempts to overcome some of the positivist critiques on case study methodologies by following Eisenhardt (1989)'s eight-step road map for developing testable hypotheses and theory from case study research as a general guide. This research also attempts to be more playful with findings following some principles of disciplined imagination research proposed by Weick (1989). Finally, in order to achieve methodological eclecticism within the interpretative paradigm this research uses planned triangulation of qualitative and quantitative research methods (Eisenhardt, 1989; Deacon and al., 1998; Hammersley, 1996).

A combination of qualitative and quantitative methods was used for investigation. Two highly framed questionnaires were distributed. The first explored effectiveness, organization structure, change and culture and was distributed to 300 individuals of which 171 responded. The second explored teams effectiveness and was distributed to 100 organizational members of which 70 responded. A total of 114 interviews were conducted which covered organizational structure, structural changes and interprofessional relations. An extensive documents collection was also undertaken. Questionnaires were analysed with the help of SPPS, interviews were coded then quantified so as to identify the most common responses and relevant documents were summarized. Quotes from interviews and documents are used to illustrate and explain findings. Where there are variations between the qualitative and quantitative findings these contradictory findings are expressed and an explanation sought.

This chapter has been mainly concerned with an account of the methods and instruments used in the empirical enquiry, a discussion of which follows. Some broad findings of substance are, however, noted here, before tackling of detailed findings in successive chapters. That is, that in both questionnaires the tests of significant relationships revealed that higher levels of significance were found by profession than by hospital. In the comprehensive questionnaire this was found in the responses to sections two to six (open system, rationale goal, internal process, organization structure and beliefs and assumptions) and in the team questions in responses to questions on objectives and organizations. This suggests that respondent's profession was more likely to influence response than respondent's hospital.

CHAPTER 6: HISTORY AND BACKGROUND OF ORGANIZATIONAL STRUCTURE OF HAMAD MEDICAL CORPORATION

6.1 *Introduction*

This chapter explores the evolution of hospital organizational structure and the management of structural change. Its first objective is to explore the evolution of hospital organizational structure by studying the development of HMC's structure. Issues pertinent to hospital structure design such as balance of power, centralization, leadership, multidisciplinary work groups, coordination, and the balance between differentiation integration are addressed. A more in-depth discussion of organizational structure will be given in Chapter Seven. The second objective of this chapter is to study structural change management by exploring the different restructuring attempts, the change models applied, and the success and failure of changes.

First, the case scene is set with a brief overview of the historical development of health services in Qatar. Second, a detailed account of the evolution of HMC's organizational structure is given. This is followed by a study of the structural change attempts, and change management practices in general, at HMC. Finally, conclusions about structural evolution and structural change are drawn.

6.2 Historical development of health services in Qatar

Understanding the development of health services in Qatar is important in understanding the independence and dominance of the governmental corporation under study. In the span of the last 55 years the State of Qatar has moved from traditional herbal and spiritual medicine to organized primary, secondary and tertiary care delivery. Historically, health care in Qatar has been essentially hospital-based with two bodies providing most health services in the country; the Ministry of Health and HMC.

Health care delivery in Qatar has been essentially hospital-based care ever since the first organized health service, a one physician 30 bed-capacity hospital, opened in 1945. Before that, traditional herbal and spiritual treatments were the only forms of health care (Younis, 1993). The Department of Public Health was established in 1951 and pursued an agenda of organizing health services in the State (Stephan, 1992). In 1957 the 120 beds Doha General Hospital/Rumailah Hospital was opened followed soon after in 1959 by the 80 bed obstetrics and gynaecology Women's Hospital (Younis, 1993).

In 1971, at Independence of the State of Qatar, the Department of Medical and Public Health was developed into the Ministry of Public Health. In 1978 a 'Master Health Plan' was developed by the Qatar Ministry of Health, the WHO, the Danish National Board, the Royal College of Surgeon in Ireland, Harvard University and other independent health figures in public health *(The Master Plan, 1978).* The Plan was based on the WHO declaration of Alma-Ata and laid grounds for establishing health centres throughout the country covering the whole population and for increasing hospital bed capacity by expanding existing hospitals and creating Hamad General Hospital (HGH), a new 650 acute care hospital *(The Master Plan, 1978).* Consequently, by 1978, the Ministry of Public Health included the Departments of Hospital Services, Public Health, Preventative Medicine and Primary Health Care and actively pursued the establishment of primary health centres and commissioning of HGH.

By 1982 HGH was opened and Hamad Medical Corporation (HMC) was established so as to make the new hospital managerially independent from the Ministry of Health. Soon after, the Women's Hospital (WH) and Rumailah Hospital (RH) were incorporated transferring all the hospital management responsibilities from the Ministry of Health to HMC.

Today, two bodies provide most health services in Qatar, the Ministry of Health and Hamad Medical Corporation. The function of the Ministry of Health is providing primary and tertiary care. As for HMC, its function is to provide secondary acute care. Other health service providers in Qatar are the Ministry of Defence, Qatar Petroleum (QP), and private clinics but these provide mostly outpatient services.

At the time of research. HMC had included HGH (650 beds), RH (250 beds) and WH (280 beds). However, there were future plans for incorporating the Primary Health Centres and the Medical Offices Abroad as their performance were found unsatisfactory under the Ministry of Health and it was believed that they would benefit from being under the Corporation's management[38]. A new hospital in the north of Qatar was also planned and will be incorporated[39]. Additionally, in the absence of significant private or public competition, the Corporation's hospitals dominate the health industry in Qatar.

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[38] Interviews with Managing Director and Administrative Director
[39] Interview with Administrative Director

6.3 *Evolution of organization structure of Hamad Medical Corporation*

6.3.1 Introduction

The evolution of HMC's organizational structure is explored by breaking down the different phases of the structure in periods. The first period starts in 1979 and may be characterized as the formation of the organization and the gradual growth of its structure. 1990 brought with it the first attempt to restructure the organization. The period from 1991 to 1996 was one of incremental changes to the structure. In 1997 the second major restructuring effort was attempted and 1998 brought with it a change in direction for the organizational structure. Additionally, in order to simplify the organizational structures to their most important components and hence better analyse their evolution, Mintzberg's (1979a) components of structure is applied. Finally, a deeper understanding of the evolution is achieved by charting the changes in structure and their implication on the differentiation-integration balance.

6.3.2 Formation and structuring of HMC

From inception, HMC has had independence from the Civil Service bureaucracy and has been set up on Western management principles. A dual-authority structure in which organizational functions were split between the Administrative and Medical Directors was set up and has remained the same from 1982 to 1988 with minor, yet significant, modifications. However, as the organization grew and health administration practices improved in the West, a need for a change in structure to suit the growth stage of the organization and internal practices emerged.

6.3.2.1 *From start-up to growth*

In 1972 the Emir of Qatar decided that there was a need to establish a large general hospital. An international health consultancy team was called upon to design the hospital and by 1974 site work commenced (Younis, 1993). Planning commenced in the form of a series of meetings chaired by a member of the Emiri Diwan and in 1979 the Emir appointed, by decree, the Board of Directors *(Decree 35, 1979)* of HGH chaired by the Minister of Health. The Decree also gave HGH an independent corporate status, enumerated the functions of the Board, the organization, and the Managing Director.

Corporate Status was granted in order to make the hospital more efficient by freeing it from the Civil Service bureaucracy[40].

On the 22nd February 1982 the hospital formally opened. Once HGH was opened the Board submitted a proposal to the Emir to incorporate HGH, RH and WH into Hamad Medical Corporation. In 1987 The Emir released a legislation incorporating HGH, RH, WH, and any other hospital to be established by the corporation into HMC and changing the Board name to Hamad Medical Corporation Board of Directors *(Legislation 38, 1987)*.

A commissioning team composed of American hospital administrators presented the Board with several organizational structures from U.S. University Hospitals, Saudi King Faisal Hospital, and the British NHS and after review it was decided to structure HGH in a dual authority structure with a Board of Directors, Managing Director, Medical Director and Administrative Director[41]. The rest of the organization would be divided under the Medical and Administrative Director.

Having approved the organization structure, the Board reviewed applicants from the USA and a Managing Director, Administrative Director, Medical Director, Nursing Director and directors for various support services and paramedical departments were selected[42]. Pay scales were also reviewed by the Board and approved by the Emir[43]. Finally, by 1983 the Standard Practices (or policies) of the Corporation were completed and approved by the Board of Directors and these same standard practices are still applied now with only a few modifications and additions[44].

The simple dual-authority structure was adequate for one hospital, HGH, but as RH and WH were transferred to the corporation they were added to the structure without major modifications; the areas of responsibilities of each Assistant to the Administrative Director simply increased. This arrangement was satisfactory up until 1987 after which it started demonstrating weaknesses[45].

However continuous improvement of the structure was found to be difficult as;

> *'the problem is that the group that structured the corporation did not document work and areas of responsibilities of each department. There was no record at all of what*

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[40] Interviews with Managing Director, Planning Coordinator and Administrative Director
[41] Interviews with Managing Director, Planning Coordinator and Administrative Director
[42] Interview with Managing Director
[43] Interview with Managing Director
[44] Interview with Managing Director and Administrative Director
[45] Interview with Administrative Director

was going on. As a result it is weak now. Maybe that is because it was individuals and not a contracted group that set up the organization.' (Interview with Administrative Director)

Exploration of an organizational structure of the Corporation of 1987 reveals a dual-authority structure headed by the Managing Director in which the three hospitals are managed as one entity with no distinct identities[46]. No organization structure for the period 1981 to 1986 has been found but, from the interview and documents findings, it would be logical to assume that the structure was similar with the gradual inclusion of RH in 1982 and the WH in 1984.

Chart 6.1 is a simplification of what the structure means in terms of structural elements and Mintzberg's (1979a) components of structure. The Managing Director had three departments reporting to him. Two of these had staff functions and one had line functions. The rest of the organization was split between the Medical Director and Administrative Director. Reporting to the Medical Director were the separate hierarchies of medical staff, nursing staff, paramedical and therapy staff. As for the Administrative Director, two distinct hierarchies report to him. First, the hierarchy of assistant directors and their assistants for the clinical services in WH, RH, and HGH and second, the hierarchy of assistants and directors for support services.

This structure confirms interesting hospital structuring elements. As with most hospitals, there is no single line of authority or hierarchy (Georgopolous and Mann, 1962; Georgopolous, 1972; Shortell, 1982). The medical, paramedical, nursing and administrative staff each have their respective hierarchies yet the organization is structured as a dual-authority hierarchy giving professionals and administrative staff roughly equal power and influence.

The organization taking shape is mechanistic in that it resembles the traditional bureaucratic form (Burns and Stalker, 1961b). It appears to have the characteristics of the form identified by Mintzberg (1979a) as a professional bureaucracy. The Managing Director, Administrative Director and Medical Directors form the strategic apex. The clinical service administrators, those that coordinate professional work, form the middle line. There is an underdeveloped (one unit only) techno-structure, a large support staff group and an important operating core that is composed of professional hierarchies. The

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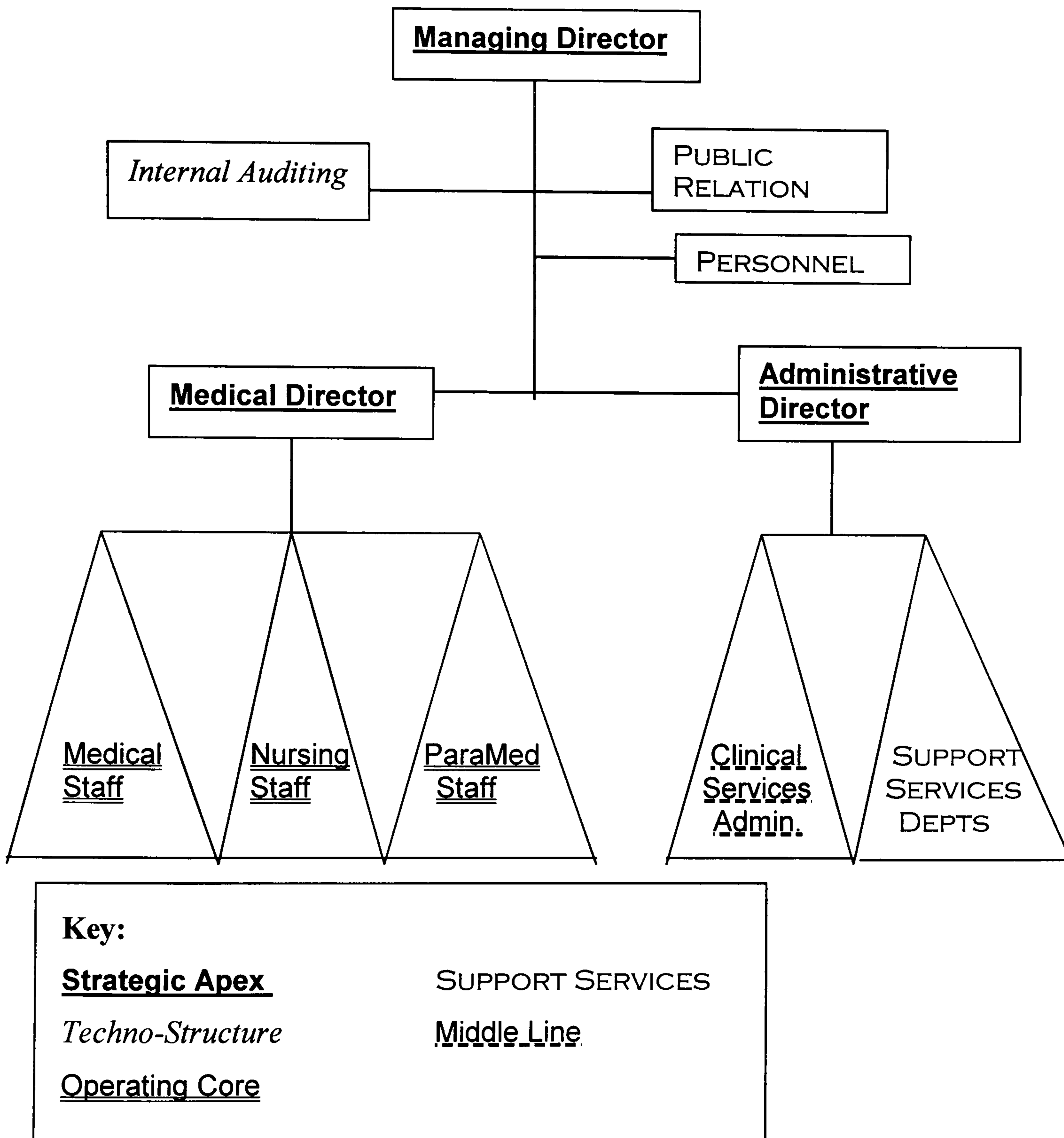
[46] Annex 21 HMC Formal Organizational Chart, 1987

structure also reveals high centralization as support services such as Personnel and Public Relations, one of which has line functions report to the Managing Director.

CHART 6.1 APPLICATION OF MINTZBERG'S(1979) COMPONENTS ON 1987 HMC ORGANIZATIONAL STRUCTURE



Key:

Strategic Apex

Techno-Structure

Operating Core

SUPPORT SERVICES

Middle Line

In 1988, when the Assistant Directors were reshuffled minor changes were made to the structure of which three were significant *(Memorandums Organizational Changes 8th April and 29th November 1988)*; Personnel Department was made to report to the Administrative Director rather than the Managing Director, Engineering was transferred from the Assistant Director for HGH to the Administrative Director, and finally Social Services were transferred from Public Relations to the Assistant Director for RH.

The implication of these changes on the organization structure is that it is the beginning of the formation of a central administration. Central activities are removed from hospital administrator's authority and line functions are devolved from the Managing Director to the Administrative Director. This is the beginning of a shift from one entity to a multi-organizational corporation.

In 1989, as health care practices in the West improved, and the organization moved in its life cycle from start up to growth, it was becoming apparent to the corporation's administration that the Corporation needed restructuring;

> 'The management arrangements in the corporation have remained virtually unchanged since they were set up at the beginning of this decade, whereas the needs of the Corporation have been changed from a start-up situation to one of continuing development and control. Over the same period, management practices in the western world have advanced considerably starting with experiments in the USA and now developed further in other countries.'
> '*Memorandum: On Proposed Organizational Structure, 1989*'

6.3.2.2 *Governance and leadership from 1979 to 1989*

Before moving on to the organizational structure in 1990, an overview of the governance and leadership of HMC from 1979 to 1989 is important to better understanding structural elements. The first Board of Directors was composed in 1979 and it was the most stable and active in the history of HMC. The chairman was the Minister of Health, the vice-chairmen the Undersecretary of Health and the members were from the corporation and other governmental industries. From 1979 to 1989 the same Minister of Health chaired the Board. From 1979 to 1983 the Board was actively involved in the corporation's management meeting over 87 times which averages to around 21 meetings a year. From 1984 to 1989 the Board met 59 times which averages to around 11 meetings a year *(Minutes of Board Meetings, 1979-1991 and 1996-1998).*

Until quite recently, the post of Managing Director had remained vacant, as the Minister of Health, who was also the Chairman of the Board, would assume the responsibilities of the Managing Director. Only in 1997 was a Managing Director appointed. The dual role of the Minister- Managing Director places pressure on the Administrative and Medical Directors. During the period 1981 to 1989 there were six Administrative Directors with short tenures of one or two years each. The turnover of Medical Directors was slower whereby during

the same period there were four Medical Directors each with a two-year tenure *(List of Administrative and Medical Directors, 1999).*

Exploring the governance and leadership of HMC reveals that, although HMC is independent from the Civil Service, there remains a high level of external control on the organization, as it is a government organization. The Board Chairman is the Minister of Health and the Vice-Chairman the Undersecretary of Health and as the period 1981-1989 demonstrates, the Board was active in the corporation's management. Additionally, the Minister-Managing Director reinforces the control of the Board of Directors and hence Minister of Health. This high external control affects the organization as it was found that the greater the external control on an organization the more centralized and formalized its structure (Mintzberg, 1995).

In review of the findings on the formation and structuring of HMC, HMC was initially set up in 1982 as an independent organization free from the burdens of Civil Service bureaucracy and was commissioned by a team of American administrators. Hence, it was set up on western practices and independent from local public administration influences. A dual authority organization structure in which the hierarchies of medical, nursing, paramedical and administrative staff report to either the Administrative or Medical Director was set up and the top positions were filled with western, mostly American, directors. As RH and WH were added to the structure and the organization grew in size, a structural change was needed to accommodate for the organization's life stage and catch up on improved Western administrative practices.

The first organizational structure available confirms the multiple lines of authority context of hospital structures (Georgopolous and Mann, 1962; Gorgopolous, 1972; Shortell, 1982) yet the dual hierarchy structure implemented by the corporation gave professionals and administrative staff roughly equal power and influence. Its characteristics are bureaucratic, highly centralized and may be equated to Minzberg's (1979a) professional bureaucracy form. By 1988 the structure was beginning to shift from a one entity to a multi-organizational corporation. Finally, although the corporation is independent from Civil Services a high level of external government control is maintained through the governing body and leadership of the organization. This in turn reinforces centralization and formalization of the structure (Mintzberg, 1995).

Although Standard Practices had been thoroughly documented by 1983, it was believed by organizational members that the lack of documentation of work and areas of

responsibilities of each department by the commissioning team that had structured the organization and the first group of managers has made it problematic for later organizational members to accomplish structural changes to the hospital.

6.3.3 1990 devolution trial at the WH

1990 marks the Corporation's first major restructuring attempt whereby an external consultant was brought in to propose a structure that would address the increasingly apparent structural and processes weaknesses and set an action plan for implementation. A radically different structure was proposed for implementation, first at the WH, then successively at HGH and other areas. However, the experience did not have the ambitious impact on the organization that it was expected to have.

The leadership of HMC was completely changed throughout 1989 and 1990. A new Board of Directors, new Chairman of the Boards, and a new Administrative Director were appointed in 1989 and in 1990 a new Medical Director was appointed. By 1990 major organizational structure and processes weaknesses were apparent. There was a lack of strategic planning, lack of thorough policies and procedures, lack of interface and coordination of administrative responsibilities with medical staff and a lack of proper training and career development for national staff. Additionally, there was no quality or resource monitoring and controlling systems, which was attributed to the lack of involvement of medical staff in management *(Memorandum: On Proposed Organizational Structure, 1989).*

In 1990 a consultant was brought in to propose a plan that would address the above-mentioned weaknesses, promote multidisciplinary work and decentralize the organization. It was the opinion of senior medical, administrative and nursing staff that *'the existing administrative arrangements are too functionally based, with little opportunity for multidisciplinary working at patient level and this therefore, is influencing patient care' (Introduction of Devolved Administration Proposal for Women's Hospital, 1st February 1990).* Additionally, decentralization was viewed as necessary as minor administrative matters were consuming much of top management's time:

> 'The Managing Director and the Medical and Administrative Directors have expressed the view that too much of their time is consumed by minor administrative matters and are of the opinion that steps should be taken to formally delegate responsibility throughout all the levels of the Corporation so that decision making is at the lowest practical operational level. The Managing

> Director has agreed therefore that a trial of devolved management arrangements should take place in the Women's Hospital followed by another in the Department of Accident and Emergency'.
> *(Introduction of Devolved Administration Proposal for Women's Hospital, 1st February 1990)*

The new administrative structure proposed to introduce a multi-disciplinary approach at operational levels, devolve activities to the lowest practical level, involve clinicians in administration and decision-making and develop quality assurance programs.

A Devolution Steering Committee composed of the Managing Director, Administrative Director, Medical Director and Director of Nursing was created to oversee and evaluate progress and an action plan was set whereby by June 1990 implementation should commence in the WH. One Assistant Director from HGH was nominated to work alongside the Women's Hospital Director to gain experience and implement the same process in HGH.

The proposed organizational structure for WH was radically different from the existing organizational structure in that it tried to create an independent identity to the hospital by decentralizing all hospital functions from the Corporation and giving the hospital a governing body[47]. It proposed to promote multi-disciplinary work by placing major administrative and clinical responsibilities on the three service groups. Its distinguishing characteristics were:

- **Hospital Executive Committee:** A governing body for the hospital with the overall responsibility of running the hospital within HMC's objectives, providing high quality patient care within the resources, policies and procedures laid by the Corporation. The committee's function would include setting and implementing hospital goals and policies, developing medical, health professional and other staff, reviewing quality of patient care, setting and controlling budget and finally reporting periodically to the HMC Steering Committee. Its members are the Hospital Director, Chairman of Obstetrics and Gynaecology, Assistant Director of Nursing, and Chief of Neonatology. No chairperson to the committee had been named and it was left to the Hospital Executive Committee to select its own Chairman.
- **Hospital Director:** The Assistant Administrative Director title would be changed to Hospital Director and would be responsible for the management of the hospital,

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[47] Annex 22 Proposed Organizational Structure for WH, 1990.

coordinating liaison among the governing body, the medical staff and the departments of the hospital. The Director would be responsible for organizing the administrative functions of the hospital and as a member of the Hospital Executive committee would be responsible for calling meetings, producing the agenda, taking the minutes and, where necessary, seeking the approval of the Management of the Corporation.

- **Clinical Service Groups:** Three clinical groups were proposed. Each group would comprise a medical representative, the Hospital Director, the Hospital Nursing Director, and a senior nurse of the group. The responsibilities of these groups would be to oversee the delivery of the services provided, develop policies and procedures, review services provided, plan for the improvement of services, prepare and control budgets, and develop and carry out quality assurance programmes.

The new structure did not propose any changes to the medical structure. It proposed to facilitate multi-disciplinary working at operational levels by making amendments to the administrative and nursing structures and merging the two. Areas of Corporate administrative responsibilities would be devolved and would report to the Hospital Director e.g. admitting, medical records, outpatient, patient accounts, housekeeping, security. Similarity, professional support services reporting to the Corporate Departments were placed under the responsibility of the Hospital Director with the provision of professional consultation with the Corporate Departments.

As for the nursing structure, managerial responsibility for the nursing staff was given to the Hospital Director but professional responsibility and accountability would be to the Corporation's Director of Nursing who would be responsible for nursing standards, policies, procedures, quality assurance, infection control, nursing education and recruitment. A new financial accounting system that would enable accountability by hospital cost centre was now needed but the lack of information systems meant that for the time being some charges in supplies, especially from professional services such as laboratory and pharmacy, would not be fully accounted for.

Such structures, which revolve around more permanent teams, have often been used in hospitals to improve coordination and professional involvement in management (Kimberly, Leatt and Shortell, 1994; Charns and Tewksbury, 1993). These structures have been called mixed organization or parallel organizations and offer more integration than the traditional functional model, which were found to encourage differentiation and

revolve around permanent teams without interfering with professional hierarchies. This structure has some of the characteristics of the matrix structure, particularly with the introduction of dual authority and responsibilities for team members. Due to that, it has in some cases been regarded as a prelude for the matrix form (Kimberly, Leatt and Shortell, 1983; Dixon, 1977).

The reluctance in naming a team leader reflects the peculiar health setting arrangements whereby the balance of authority is delicate. HMC's original organizational structure is one that gave the medical and administrative directors roughly equal power and authority. Naming a team leader for the WH's governing body would indicate that one is superior to another and destabilise the balance.

Implementation commenced in the WH but after a few meetings the Clinical Service Groups ceased meetings, the Assistant Administrative Director title was never changed to Hospital Director and he faced resistance from Corporate Departments to decentralize their areas of responsibilities that were located in the WH to his management. Memos from the Administrative Director were at various intervals sent to the Corporate Departments to remind them that administrative issues pertaining to their departments in the WH should be referred to the Assistant Hospital Director *(Administrative Memorandums 1996 and 1998)*. The only areas where complete decentralization was achieved are administration, admitting, medical records and outpatient.

Although the Clinical Service Groups have ceased the Hospital Executive Committee has remained active since implementation and has been holding regular bi-monthly meetings since[48]. The experience was not repeated in other parts of the corporation and thus the devolution was mainly internal to the WH and did not have a major effect on the corporation as a whole.

In conclusion, the events surrounds the 1990 devolution are summarized. In 1990 a consultant was brought in to propose a structure that would address the organizational structural and processes weaknesses, promote multi-disciplinary work and decentralize the organization. A radically different organizational structure that gave the hospital an independent identity within the Corporation by ensuring decentralization of all hospital functions and giving the hospital a governing body was proposed for implementation first at WH followed by HGH. Additionally, the structure proposed more integration via

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[48] Interview with Administrative Director

permanent multiprofessional teams resembling in characteristics mixed organizations (Kimberly, Leatt and Shortell, 1994; Charns and Teuksbury, 1993). The reluctance in naming a leader for the hospital governing body reflects the organization's desire to maintain a delicate balance of power.

Only certain element of the proposed structure succeeded in 'freezing', namely the decentralization of some administrative functions to the WH administration and the WH Hospital Executive Committee. There was resistance to decentralization from some of the corporate departments and the multi-professional clinical service groups failed in sustaining interest. As a result, the experience was not repeated in other areas of the corporation and it failed to have the ambitious impact on the organization that it was expected to have.

6.3.4 Organization structure from 1990 to 1996

In the period 1990 to 1996 interesting gradual changes occurred in the organization structure. The complexity of the structure was gradually becoming more apparent and the organization was taking the form generally attributed to the divisional bureaucracy (Minzberg, 1979a; Kimberly, Leatt and Shortell, 1994; Shortell, 1985; Packwood et al., 1992).

The period 1990 to 1996 saw the turnover of four Chairmen of the Board of Directors, two Administrative Directors and three Medical Directors. From 1990 onwards for the first time the medical and administrative structures were portrayed together in official organizational charts. This indicates a growing interest in seeing the organization as one entity and how the medical hierarchy relates to the administrative hierarchy.

An organizational chart of the corporation of 1992 indicates that it differed from the organizational structure of 1987 in that more responsibility was given to the Administrative Director as responsibilities such as Personnel, Nursing, Engineering, Security and Planning departments were added to the Administrative Director[49]. Similarly more responsibility has been given to the Medical Director as responsibilities for the departments of Quality Assurance, Medical Education and Dietetics and Nutrition were added to the Medical Director. Additionally the areas of responsibility of the Assistants

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[49] Annex 23 HMC Formal Organizational Structure, 1992.

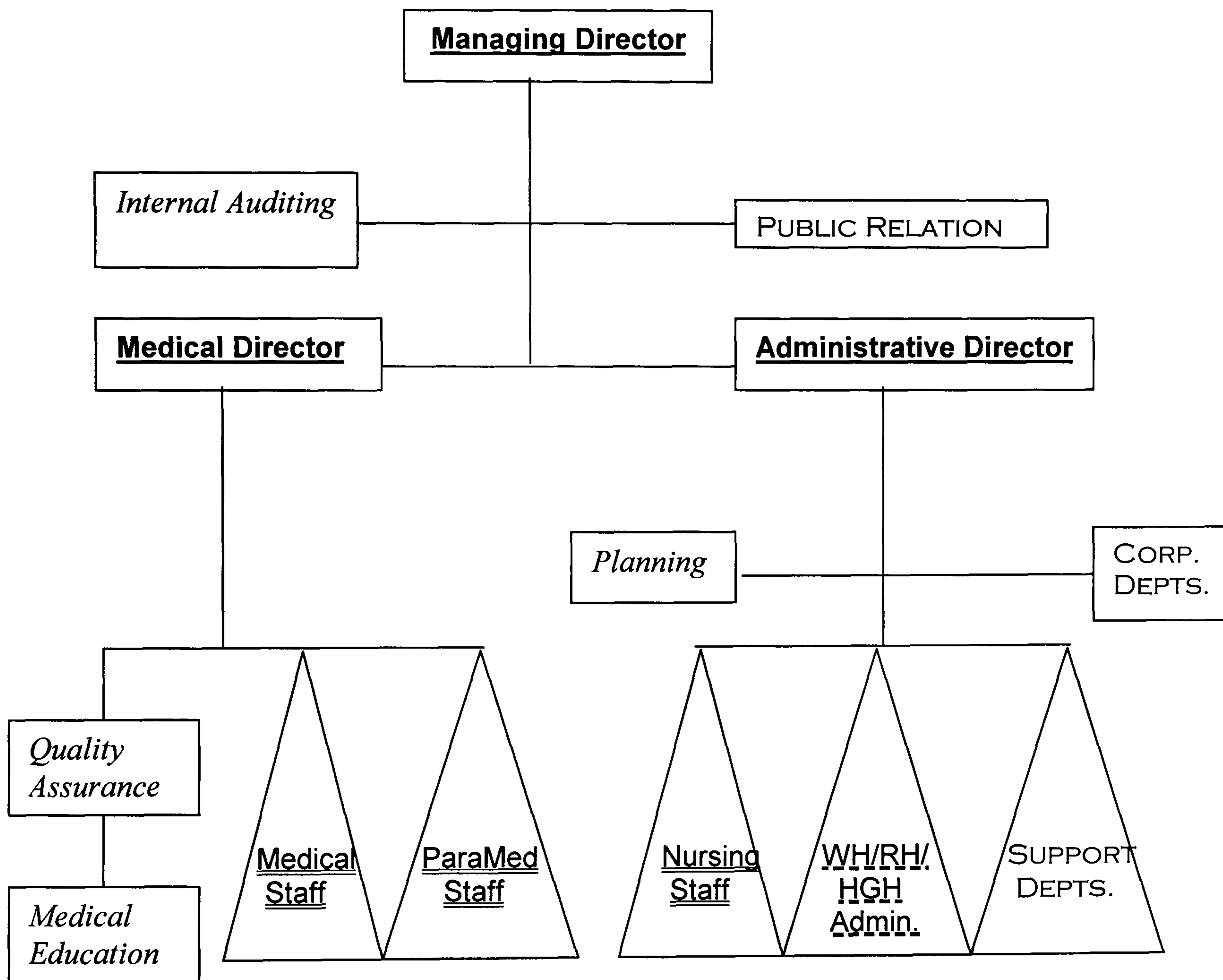
had been restructured. For example, in 1987, in-patient and outpatient services in HGH were under different Assistants but in 1992 they were under one Assistant.

Chart 6.2, a simplified version of HMC's organizational structure in 1992 applying Mintzberg's (1979a) components of structure, shows that the organization's corporate departments are increasing. The Managing Director has two staff function departments, the Medical Director had an additional two and the Administrative Director one. This growth of techno structure departments such as auditing, quality assurance, medical education and planning indicates the need for planning, controlling and standardization as the organization grows in size. The support services that support the operating core have also become more distinct giving the organization a clearer corporate administration. The operating core continues to be formed of the different professional hierarchies and the divisional managers (hospital managers), which form the middle line, are gaining semi-independence.

An HMC organizational structure chart for the period 1994-1996 reveals that minor changes to the structure have been made on the Medical Director's side and around the Managing Director. In 1996 there were many circulars and memorandums regarding conflicts between Administrative and Medical staff and medical staff not passing administrative issues through Administration *(Memorandum: Administrative Issues, 1996).* As a result a Chairmen- Administrators meeting was activated in which the chairmen would meet the administrators every three months to enhance cooperation *(Memorandum: Chairmen of Department's Meetings, 1996*).

Chart 6.3 is a simplified version of HMC's organizational structure for the period 1994-1996 applying Mintzberg's (1979a) components of structure. It shows that the staff function departments reporting to the Managing Director have increased. The operating core remains the largest group of the organization but it is further complicated as the administrative hierarchy of HGH has been split again into inpatient and outpatient administrations. The creation of an assistant post for medical affairs and the creation of Chairmen- Administrators meetings demonstrate that problems of coordination were occurring and needed to be addressed. This is understandable as the different hierarchies had no structured direct coordination lines nor did they have direct coordination lines with the hospital administration (who form the middle line responsible for coordinating professional work).

CHART 6.2 APPLICATION OF MINTZBERG'S (1979) COMPONENTS ON 1992 HMC ORGANIZATIONAL STRUCTURE



Key:

Strategic Apex

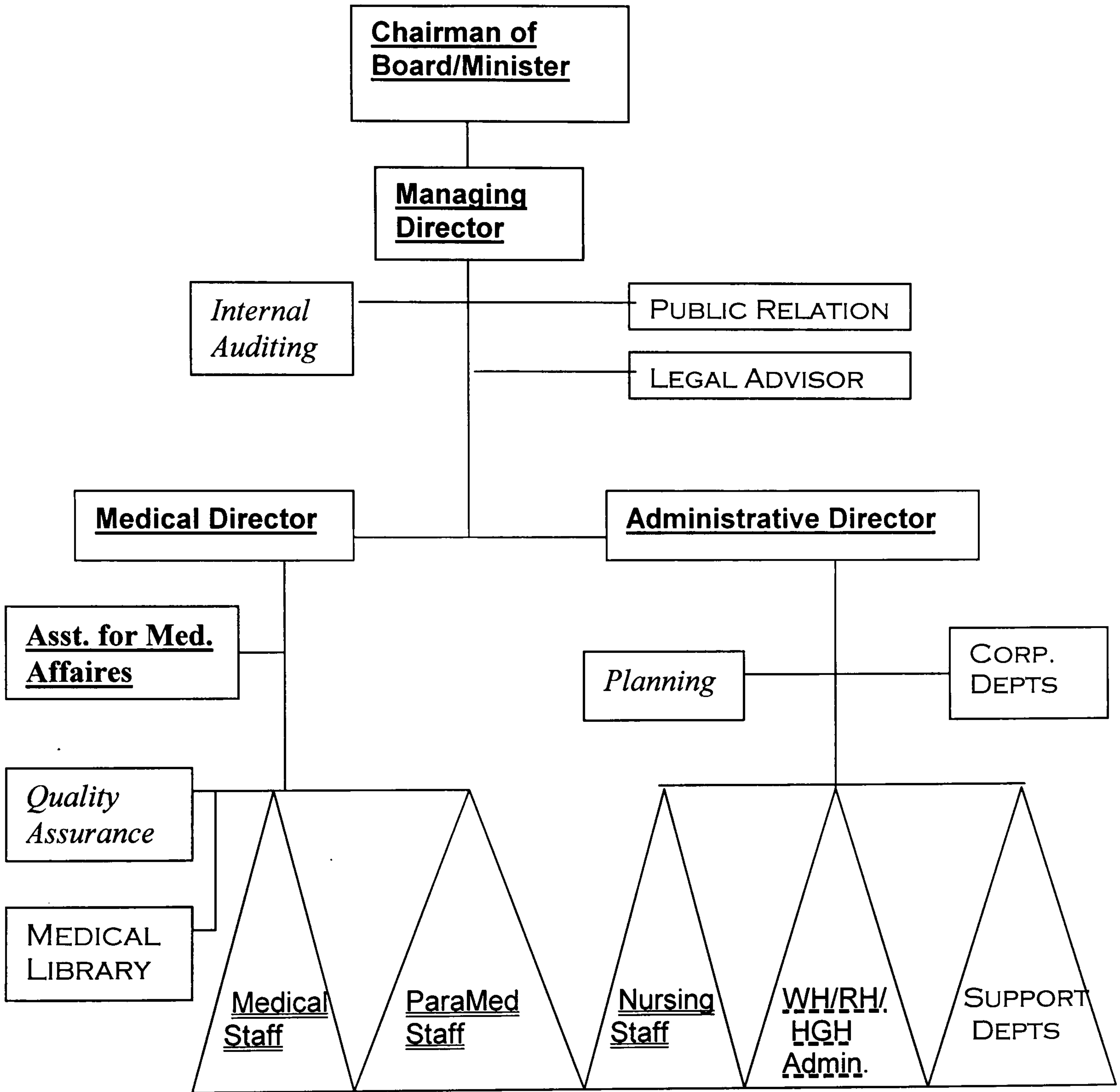
SUPPORT SERVICES

Techno-Structure

Middle Line

Operating Core

CHART 6.3 APPLICATION OF MINTZBERG'S (1979) COMPONENTS ON 1994-1996 HMC ORGANIZATIONAL STRUCTURE



Key:

Strategic Apex

Techno-Structure

Operating Core

SUPPORT SERVICES

Middle Line

In summary, in the period 1990-1996 the structure had become more divisionalized with the operational core, support staff, strategic core and techno-structure becoming more apparent. Each section had increased in size but the most apparently dominating group was the operational core. Within the operating core, there were hierarchies of medical, paramedical, nursing and administrative staff. The lack of coordination mechanisms between the hierarchies of the divisional hospital administrators and the professional staff had led to conflict. As a result, an administrative post was added to the medical hierarchy as a liaison with administration and a Chairmen-Administrators committee was formed.

6.3.5 1997 restructuring

1997 brought with it the second major restructuring attempt. A new top management team revived the WH Devolution attempt and introduced a more ambitious corporate wide restructuring attempt. A new management structure, which focused on decentralization of authority and matrix management principles was proposed and, after discussions and modifications, was implemented. However, as with the attempt of 1990, this restructuring attempt failed to succeed, especially after the removal of the top management team.

6.3.5.1 *The 1997 major restructuring attempt*

In 1997 new Managing, Administrative and Medical Directors were appointed and wanted to realign the corporation by focusing on *'integrated quality care'* by *'creating a management system which fosters multidisciplinary team working and decentralization thus strengthening medical-administrative relations and improving communication' (HMC Achievement Review and Overall Plans, 1997).* An action plan was set which commenced with assessing the corporation's current situation via activities such as departmental status reports, committee status reports, revision of Standard Practices and building Departmental Manuals.

Based on the work attempted in 1990 to devolve the WH, a new management structure, which focused on decentralization of authority, and matrix management principles was proposed in May 1997. The main organizational chart remained the same with some minor amendments[50]. The major amendments were made at the hospital levels were management of the hospitals were organized by a hierarchy of committee and teams levels.

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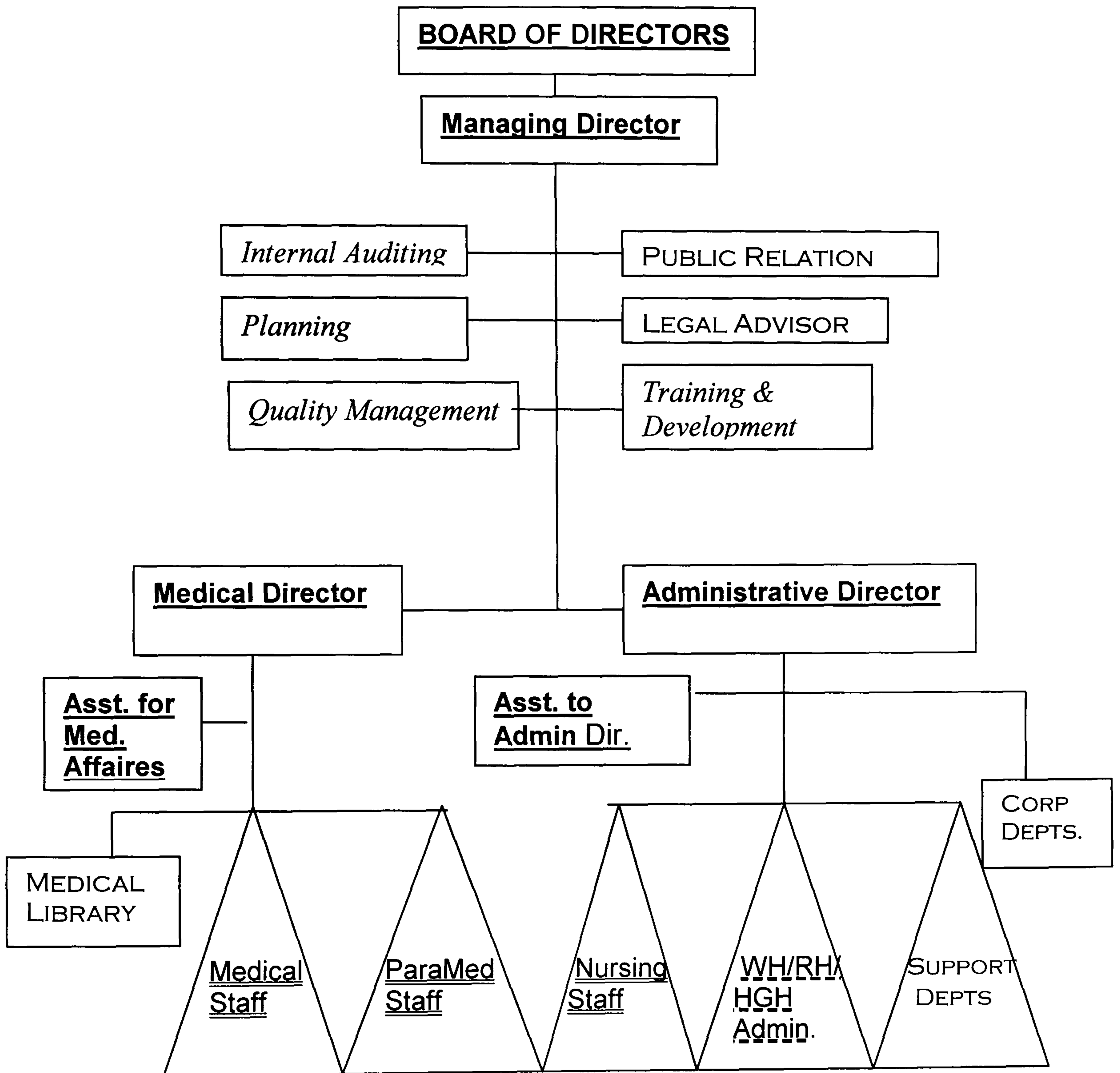
[50] Annex 25 HMC Organizational Structure, 1997.

Chart 6.4, the simplification of the HMC's organizational structure in 1997, applying Mintzberg's (1979a) components of structure, demonstrates that now all staff functions have been transferred to the Managing Director and the Strategic Core has slightly increased in size with the addition of the assistants to the administrative and medical directors. The support and techno-structure departments have remained the same size. The divisionalized structure has been reinforced by the clearer distinction of corporate administration from hospital administration. At the operational core, although the different professions still have their individual hierarchy, coordination lines have been drawn at different levels of the hierarchy to form a hierarchy of work groups, pooling together at the hospitals, hospital departments and hospital units.

The proposed hospital structures were designed under the assumption that *'delegating authority and responsibility down to the lowest management level practicable should result in faster delivery of services' (Proposed New Management System, 1997)* The Assistant Hospital Director (AHD) would have overall responsibility for the management of the hospital's non-medical operations. The Medical Chairman would be professionally accountable to the Medical Director and managerially accountable to the AHD. A hierarchy of committees and teams would support the AHD and Medical Chairman:

- The **HMC Steering Committee** oversees the implementation of the new management system and is composed of the Managing Director, Medical Director and Administrative Director.
- The **Hospital Executive Committee (HEC)** serves as governing body of the hospital and is composed of: The Administrative Director, AHD of the Hospital, Medical Director, Asst Medical Director, the Director of Nursing and the Asst Director of Nursing for the Hospital. The Hospital Executive Committee was left to organize itself, select its chairman and set its duties and responsibilities. The AHD would act as the Coordinator of the committee, responsible for calling meetings, producing agenda, keeping records and ensuring implementation of committee decisions
- The **Departmental Management Team (DMT)** has the overall responsibility to the Hospital Executive Committee for the day-to-day management and operation of its Clinical Department. It is composed of: Chairman or Head of the Clinical Department, AHD, Asst Director of Nursing or Senior Nurse of the Clinical Department. Like the HEC the DMT was left to organize itself and the AHD was appointed as Coordinator of the team.

CHART 6.4 APPLICATION OF MINTZBERG'S (1979) COMPONENTS ON 1997 HMC ORGANIZATIONAL STRUCTURE



Key:

Strategic Apex — SUPPORT SERVICES

Techno-Structure — Middle Line

Operating Core

- **Clinical Management Teams (CMT)** will be created by the DMTs where deemed grouping of units will result in improved coordination and faster service delivery. Suggested composition was: Chief or Head of Unit or Speciality, AHD, Asst Director of Nursing for the Department, Senior Nurse. The objectives, functions and responsibilities of the CMT would be drawn up by the team and approved by the DMT.

The Administrative Director held separate meetings with the Medical Chairmen and the AHDs to discuss the proposed structure in which the following critiques were made of the structure *(Minutes of Chairmen and Administrative Meetings on Management System in May 1997; Nursing Executive Committee Meeting, June 1997)*:

- Medical Chairmen felt strongly against participating only at the DMT level, and felt that they should participate in the Hospital Executive Committee and Steering Committee.
- Medical Chairmen felt strongly against being chaired by the AHD at DMTs.
- Administrators felt that this structure would encourage centralization and hinder devolution of each hospital by limiting the scope of the AHD. The Hospital Executive Committee takes over many of the day-to-day management functions of the AHD.
- Administrators disagreed on the size and membership of the Steering Committee.
- Administrators also felt that there were too many meetings for the AHDs and Directors of Nursing to attend at the hospital and departmental level. Especially for the AHD as he was expected to call, set agenda and take minutes.
- Administrators felt there was no need for Clinical Management Teams on a regular basis that DMT meetings would suffice and unit meetings should be ad-hoc.
- Nursing did not comprehend the role of the DMTs and unit committees within the nursing hierarchy; *'if a lower group represented by head nurses will work on a sort of independent basis, then, what will be the role of the next superior in the Nursing hierarchy.' (Nursing Executive Committee Meeting, June 1997)*
- Nursing found that performance evaluation criteria of this system are not clearly defined.
- Nursing also noted that the lines of communication between the management system and the support services are not clear.

As can be seen there was already early disagreement over the number, size and level of the different committees, the committee's leadership and a general confusion over roles,

responsibilities and accountability within the web of committees and its effect of departmental authority.

A revised structure was then distributed to the chairmen and administrators for their comments before final implementation[51]. The main variations were:

- The addition of the Medical Advisory and Administrative Advisory Committees which were existing ad-hoc committees chaired by the Managing Director. The addition of these two committees meant that it was through these committees that Chairmen and Administrators would participate in Corporate Management and communicate to the Steering Committee.
- The Hospital Executive Committee membership was completely changed to: AHD (facilitator with co-coordinating functions), Chairmen of Departments and the Senior Assistant Director of each hospital. The Administrative and Medical Directors, as members of the Steering Committee, were ex-officio members of all HECs.
- The DMT would be chaired by the Chairperson of the Department, and its members would be the Administrator (also coordinator of the team) and Assistant Director of Nursing of the Department.
- The composition and grouping of CMTs was left to the discretion of the DMT.

However, administrators and chairmen felt that there were still weaknesses to the structure and that the revision did not address the issues pointed out in the meeting. These main weaknesses were identified as being (*Memorandum: HGH Management System Comments, 1997*; *Administration Memorandum: Comments on Management System, 1997*; *Memorandum: Nursing Comments on Management System, 1997):*

- **Chairmanship** of the HEC. Both administrators and medical chairmen wanted to chair the committee. It was believed that the non-specification of chairmanship could lead to more problems as the roles of each member is not clear and each individual had different perceptions of by whom and how the hospital should be run.
- **Size of HGH HEC**. All together with the nine chairmen, the administrator and the senior nurse membership would be 11. This was felt as being too large for efficient functioning of the committee. Splitting the committee into two was proposed.

- The **role and functions of each member of the DMT** were not clear to the members especially whose role it was to ensure implementation of committee or team decisions.
- Finally it was believed that for the structure to succeed it was important that the **job descriptions** of the main organizational members be clear and that there be a clear description of relationships between the Medical directors/chairmen, administrators, and director of nursing/senior nurses.

On the 16 June 1997 the final structure, implementation guidelines and a guide of relationships and functions was released for implementation of phase one (activating the HECs) and reporting to the Steering Committee progress by August 1997. The chairmanship of the HEC was not resolved in a definitive manner, the AHD remained facilitator, but with a new guideline *'The Committee will elect its Chairman from among themselves. Chairmen will serve on rotation basis every 4 months.' (Memorandum: Hospital Executive Committees, June 1997)*. The size of HGH HEC was left as it is and guidelines on what should be the roles of the medical, administrative and nursing staff were issues in a Standard Practice *(HMC Standard Practice No. 14, June 1997).*

Thus, as in the WH devolution attempt, the delicate issue of leadership of the hospital governing committee was left unresolved, and the democratic election solution confirms a desire to maintain equal power between the medical and administrative staff. No clear job descriptions nor descriptions of roles and functions were developed to support the proposed structure and a vague set of role guidelines were distributed for implementation. Additionally, the eleven member governing committee for HGH was large. This again reflects a democratic desire to involve all senior executive medical, paramedical, nursing and administrative staff in hospital governance.

6.3.5.2 *The reliance on committees*

As the newly proposed structure relies heavily on committees and management teams a survey of all existing committees was conducted in 1997 by the Corporation's Administration *(Committees/Management Teams Survey, 1997)* and demonstrates that there are four types of committees at HMC; corporate committees, ad-hoc corporate committees, hospital committees, and departmental/unit committees.

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[51] See Annex 26 Restructuring of Organizational Structures Attempts, HMC, 1997 for the proposed structures.

A total of 40 corporate committees were found to exist; 25 of these are medical committees and fifteen are administrative. Most of these committees are active and meet regularly. Some others do not have a regular meeting schedule and only meet at the request of the chairman, or when it is estimated that there is enough work to summon a meeting for. In addition to these 40 committees, corporate ad-hoc committee are formed for a short period of time with a specific mandate (e.g. evaluation, disciplinary, improvement projects) and disintegrated as soon as their mandate is over.

Most of the corporate committees surveyed in 1997 existed in 1989 *(Summary of committees covered and not covered by Standard Practices, 1989)* and 1991 *(Medical Committees, 1991)*. However, more departmental committees can be seen in 1997 than in 1991, not only in the WH where there was an active effort to devolve but in the other hospitals too. This indicates a general trend towards decentralization through committees.

Hospital Committees were first introduced in the corporation in 1990 with the first efforts to devolve the WH from HMC central administration. The 1997 attempt to decentralize and introduce a *'new management system'* further reinforced the Women Hospital Committees and introduced Hospital Committees in HGH and RH. However, at HGH and RH the HEC with its web of reporting committees did not succeed as it did at the WH. The WH HEC continued to meet from 1990 to 1999 regularly but its web of committees did not succeed to sustain its momentum. As for HGH and RH the HEC of the first did not function well at all while the HEC of the latter met on and off until by the end of 1999 it became an occasional event (*Minutes of RH Executive Committee Meeting, 29th June, 1997*).

The first HEC meetings at HGH were full of tension as some of the medical chairmen did not see the purpose of this committee, that the Medical Advisory Committee and the Administrative Advisory Committee were sufficient for planning and communicating *(Minutes HGH Executive Committee Meeting, 29th June, 1997)*. The large number of members made the meetings difficult to coordinate and the variety of issues to be discussed made the committees long and unfocused for the members *(Minutes of August and September Meetings HGH Executive Committee)*. Many preferred the Departmental Management Team to discuss planning and management of their departments directly and by 1998 no more HGH Executive Committee meetings were held[52].

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[52] Interviews with Administrative Director and AHD for HGH.

As will be discussed in Chapter Seven, most departments in all three hospitals have similar departmental committees; an advisory team, an education and scholarship committee, promotion and recruitment committee, quality assurance committee, complaints committee and a management committee. The 1997 decentralization attempt proposed unit and departmental committees. The unit committees in the WH and the other hospitals failed to catch momentum. Yet the departmental committees, composed of the chairman, administrator and nursing trio was found to improve efficiency and succeeded in all three hospitals.

It was hoped during the 1997 attempt to create a structure which revolves around 4 committees (HMC Steering Committee, Hospital Executive Committee, Departmental Management Team and Unit Management Team), that they would substitutes and take over the functions of some of the corporate committees, thus decentralizing and reducing the number of committees at HMC *(Committees/Management Teams Survey, 1997).* However, the management system committees did not succeed in replacing the running corporate and departmental committees.

In conclusion, the restructuring experience of 1997, as with the devolution experience of 1990 in the WH, did not last long and the results were similar. Here again, only the Hospital Executive Committees at WH and RH had some success. The top management team that had introduced this restructuring attempt were removed by the end of the year from office and with that the implementation of the new structure ceased.

Like many hospitals for which application of a true matrix is difficult, HMC had developed characteristics of matrix structures, particularly in the form of multi-disciplinary teams (Kimberly, Leatt and Shortell, 1994; Dixon, 1977), but the ambiguities surrounding this form; the dual responsibilities, authorities and reportability, proved to be difficult to surmount. Additionally, the attempt to create a hierarchy of accountable committees and teams resembles the early NHS structure's reliance on committees and boards to achieve devolution (Jaques, 1978; Allen and Grimes, 1982).

Interestingly, two hospital governing committees and most departmental committees did sustain the interest of organizational members. The success of the hospital governing committees would seem to reflect a desire for autonomy from the Corporate Administration as well as a desire for shared governance of the hospital. As for the success of the departmental committees this seems to indicate a desire to improve departmental management and a perception that having a chairman-administrator-nursing

trio involved in the department's management would improve efficiency. This could be perceived as the first steps towards clinical directorates models of departmental structure (Packwood et al., 1992; Buxton et al., 1991).

6.3.6 1998/99 structure; restructuring hospital management

A change in Chairman of the Board and Managing Director, Administrative Director and Medical Director in 1998 led to a change in direction for the structure of the organization. Although it was in the vision of the new team to move towards semi-independence of each hospital with a governing board for each hospital, matrix management principles were not viewed as the means to that. Rather, decentralizing of hospital management to hospital administrators and restructuring the managerial functions within the hospitals were viewed as the step toward decentralization.

In 1998 the top management team was replaced with a new Managing Director, Administrative Director and Medical Director but this time the management team were not completely new to their posts. The Managing Director had been on and off Board member and Managing Director since 1981 and the Medical Director had been Medical Director in 1992.

The new management team believed in the importance of decentralizing hospital management as the size of the corporation has become too large to manage centrally[53]. With regards to the structure their aim was to confirm the AHD and a group of administrators at each hospital by strengthening their position through decentralization of functions to them[54]. But the majority of the restructuring efforts to be carried out at this initial stage were in restructuring the compensation packages and grading levels of employees as it was clear to the Managing Director and his team that the existing grading and compensation packages needed immediate attention[55].

From the committee and team based structure implemented in 1997 only the Hospital Executive Committees were working. Although it was in the vision of the team to move towards semi-independence of each hospital with a governing board for each hospital the

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[53] Interview with Administrative Director
[54] Interview with Administrative Director
[55] Interview with Managing Director

approach of the Management Systems proposal of 1997 was not viewed as the method to achieve it[56].

Organizational structure efforts were placed on reinforcing the managerial responsibilities of administrators at hospital levels and restructuring the managerial functions of the hospitals internally. AHDs were requested to define the responsibilities of their assistants for administration, and present the administrative organizational structure of their hospital that will facilitate the smoothest delivery of services *(Memorandum: Organizational Structure, February 1998)*. These structures were studied by the Administrative Director, and refined with the AHDS. Most amendments were made to the structure of HGH and RH and recommendations were given to change the grades and posts of assistants for administration so as to make a ladder of responsibilities for administrators *(HGH Organizational Structure, 1998; WH Organizational Structure, 1998; RH organizational structure 1998).*

Chart 6.5 is the new HGH administrative organizational structure. The creation of three new job descriptions and grade scales for the assistant for administration for OPD services, Administrator for A & E and departmental administrator were necessary for this structure to function without overlap of functions. This meant more administrators in HGH with more defined responsibilities *(Memorandum: Proposed HGH Administration structure, February 1998*). Chart 6.6 is the new RH administrative organizational structure where an additional assistant for administration post was created. Chart 6.7 is the structure of WH, which remained the same. Hospital structures will be further studied in Chapter Seven.

The overall organizational structure of the Corporation in 1999 had not dramatically changed except for the creation of several new departments reporting to the Managing Director such as the Tendor Committee, Health Media Department, and the newly annexed Department of Overseas Medical Services[57].

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[56] Interview with Managing Director
[57] Annex 27 HMC Formal Organizational Structure, 1999.

Chart 6.5 HGH Administration Structure

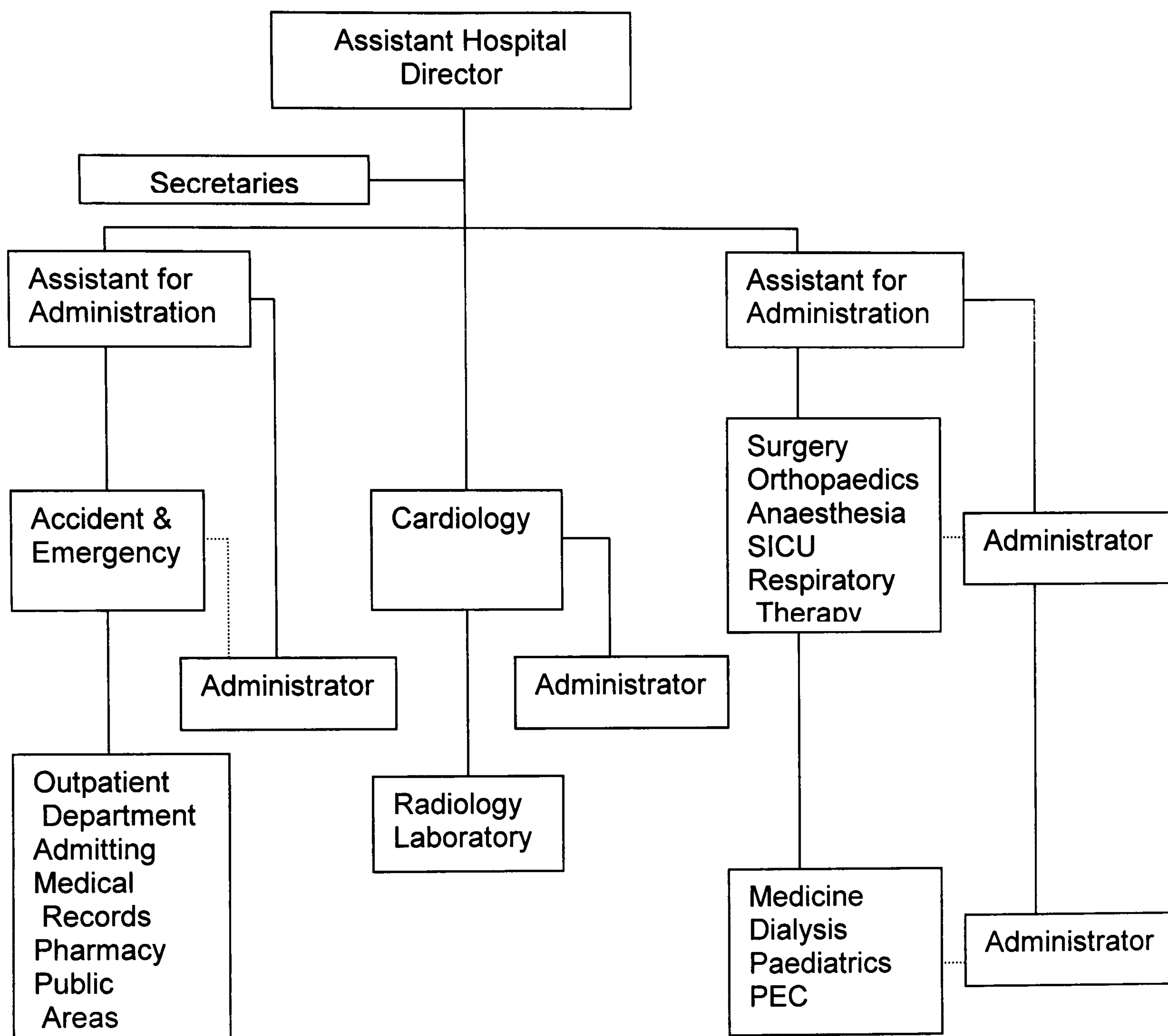


Chart 6.6 RH Administration Structure

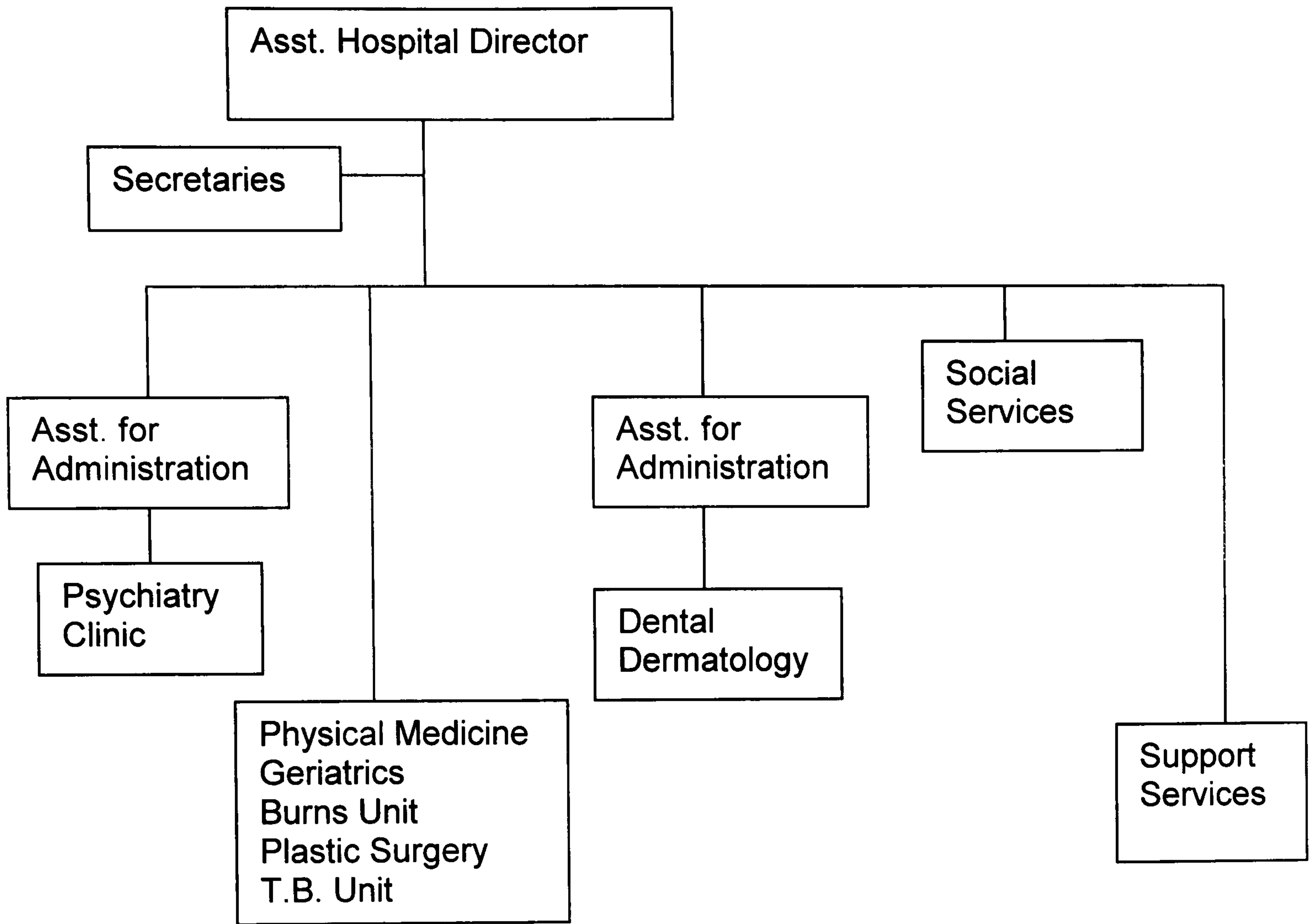
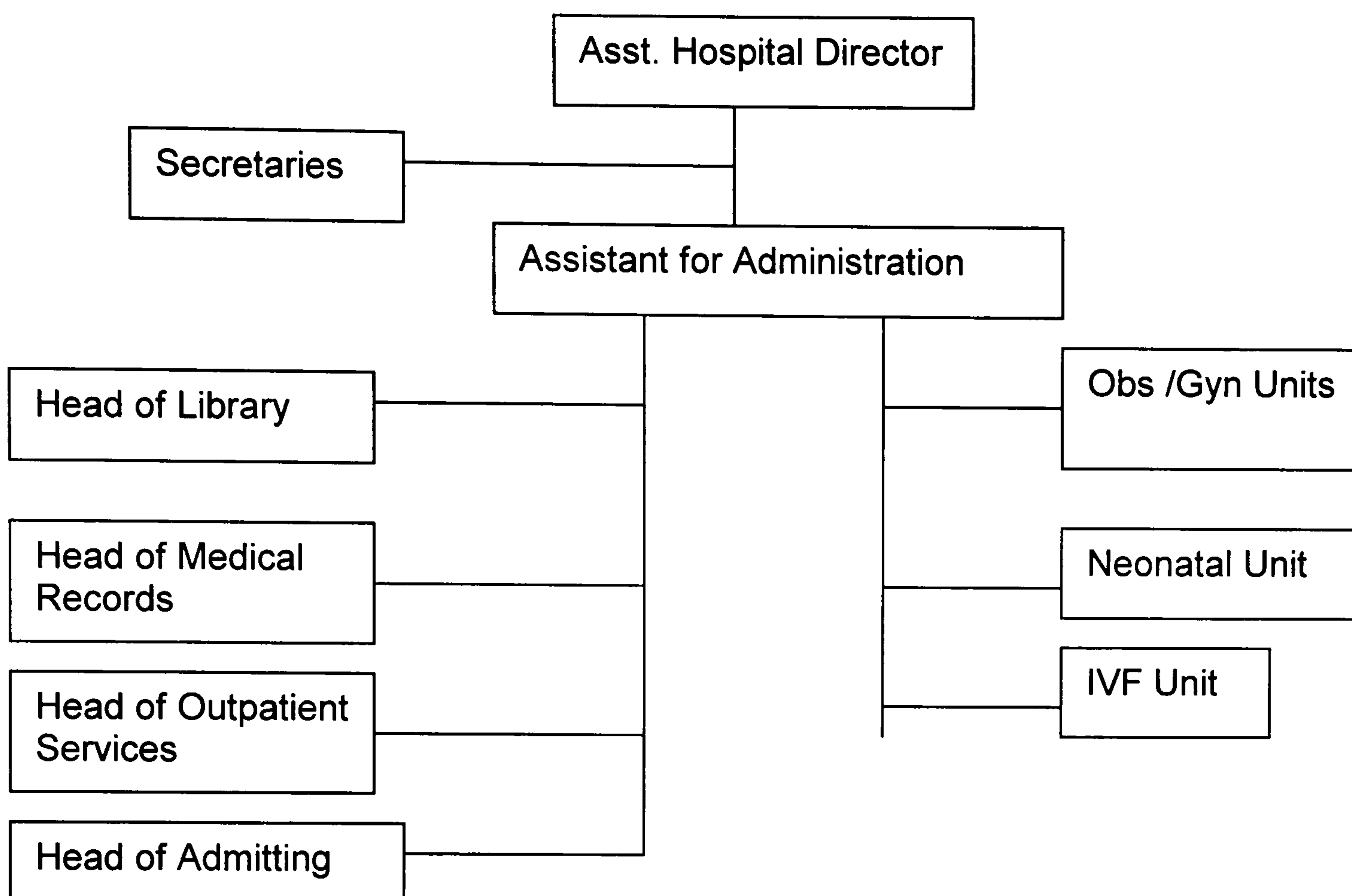


CHART 6.7 WH ADMINISTRATIVE ORGANIZATIONAL STRUCTURE, 1998



Thus, with regards to organizational structure in 1999, this period could be characterized as one of additional growth and stronger hospital identity. Overall, the organization grew in size with the addition of corporate staff level functions and new responsibilities. At the hospital levels, managerial responsibilities were decentralized to the hospital administrators and managerial functions were restructured as additional administrators were recruited with new job functions. This re-enforcement of management functions and accountability seems to echo the efforts of the British NHS in the 1980s (Griffith, 1983) to strengthen management. The impact of these new changes will be further discussed in the next chapter as the details of the existing organizational structure are analysed.

The decentralization of hospital management to hospital administrators reinforces the divisional structure of the corporation. A move away from group-based structure recently attempted towards a more traditional bureaucratic structure, which Jaques (1990, p.262) typifies as being *'the only effective organization form'*, can be witnessed. Each hospital is developing its own professional bureaucracy with the governing body, the hospital administrator and the medical chairmen at the strategic apex; a hierarchy of administrators as middle management; support services; and an operating core of professional staff. Finally, the introduction of general management at the hospital level also confirms Mintzberg's (1995, p.361) finding that *'the larger an organization the more*

elaborate its structure, the more specialized its job units and the more developed its administrative structure'.

6.3.7 Evolution of HMC organizational structure

At its inception in 1982 HMC was set as a dual-authority bureaucratic structure with a Board of Directors, Managing Director, Medical Director and Administrative Director. The rest of the organization, including the three hospitals, was divided under the Medical and Administrative Directors. The structure throughout the years has remained a dual-authority bureaucratic structure punctuated by two restructuring attempts.

Each attempt lasted approximately one year at the end of which the organization reverted back to the dual-authority bureaucratic system while keeping minor elements of the restructuring attempts. Both restructuring attempts were motivated by a change in top management and the same structural weaknesses that were attributed to the dual-authority bureaucratic structure; lack of strategic planning, lack of policies and procedures, lack of interface and coordination between the medical and administration functions and lack of resources and service quality controls.

Table 6.1 describes the evolution of HMC's organizational structure for 20 years, from 1979 to 1999. It traces the main events, governance and leadership changes, organizational issues and structural characteristics throughout the years. It also indicates the levels of integration-differentiation that each structure provides. It shows that over the years, the organization developed from a simple dual-authority bureaucratic structure to a complex divisional structure with each hospital developing into professional bureaucracies.

The evolution chart demonstrates that throughout the years the organization has gradually grown into a divisionalized dual-authority bureaucracy. When comparing this to the differentiation-integration table developed in the literature review[58], it demonstrates that as the organization grew it moved towards more integration (from quadrant two, professional bureaucracy, to quadrant three, divisional model) yet it leaned more towards the differentiation side. The two restructuring attempts of 1990 and 1997 attempted to move the structure towards more integration (end of quadrant three and quadrant four; mixed and matrix model) but failed and the organization moved back to the divisional model.

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[58] See Table 2.2, Chapter 2, p.39.

Table 6.1: Evolution of HMC's Organizational Structure 1979-1999

	1979	1982	1983	1984	1985	1986	1987	1988	1989
EVENT	HGH granted independent corporate status	HGH officially opened RH incorporated		WH incorporated					
GOVERNANCE AND LEADERSHIP	- Board of Directors (BOD) appointed - Senior managerial posts filled with American recruits.	New Admin. Director	New Medical Director		New Admin. Director New Medical Director	New Admin. Director	New Medical Director	New Admin. Director	- New BOD and Board Chairman. - New Administrative Director
ORGANIZATION	American commissioning team appointed		Standard Practices completed and approved by BOD						Beginning of awareness of organizational and structural weaknesses
STRUCTURE CHARACTERISTICS	Two tier bureaucratic structure decided upon. Roughly equal power between medical and administrative hierarchies.	Growth of structure as RH added to structure		Growth of structure as WH added to structure				Characteristics of professional bureaucracy , an underdeveloped technostructure, important supports services. Centralized. Formation of central admin. And shift from one entity to multiorganizational corporation.	
DIFFERENTIATION-INTEGRATION QUADRANT	II	II	II	II	II	II	II	II	II

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EVENT	Consultant hired to propose devolution plan.									
GOVERNANCE AND LEADERSHIP	New Admin. Director New Medical Director		New BOD and Chairman of Board New Admin. Director New Medical Director	New BOD and Chairman of Board	New BOD and Chairman of Board	New Medical Director	New BOD and Chairman of Board	New Managing, Admin. and Medical Directors	New BOD & Chairman of Board New Managing, Admin and Medical Directors	
ORGANIZATION							Medical-Administrative conflicts			Restructuring compensation packages and pay scales
STRUCTURE	Devolution attempt at WH. Proposed decentralization; hospital governing body & integration via multiprofessional team. Only hospital governing board and decentralization of certain hospital functions succeeded.		Overall growth of each dept. Characteristics of divisional structure with important technostructure & support services. Hospital divisions gaining more independence. Increased decentralization to the Admin Director.		Further growth in functions Increased administrative responsibilities of Medical Director and need for a liaison with Administrative hierarchy		Reactivation of Chairmen-Administrators meetings	Corporate restructuring attempt based on matrix mgt principles Increased size of corporate management. Hierarchy of committees and teams in hospitals. Governing boards & departmental teams survived	Decentralization of hospital functions to hospital administrators. Reinforcement of divisional structure. Administrative restructuring of HGH and RH and introduction of general management.	Growth with the addition of new functions. Divisional structure with individual hospital developing into professional bureaucracies.
DIFFERENTIATION-INTEGRATION QUADRANT	IIIc	IIIa	IIIa	IIIa	IIIa	IIIa	IIIa	IIIc, IV	IIIa	IIIa

This seems to indicate that hospitals, and this one in particular, need to maintain a certain balance between the levels of differentiation and integration. In this case, at this moment in time and under these conditions, the divisionalized model offers the required balance as restructuring attempts reverted back to the divisionalized model.

6.3.8 Analysis of evolution of organizational structure

This section explored the evolution of hospital organizational structures by studying the development of HMC's structure from 1979 to 1999. HMC was set up as a dual-authority bureaucratic structure in which the hierarchies of medical, nursing, paramedical and administrative staff report to either the Administrative or Medical Director. Although the corporation is independent from Civil Service a high level of external government control is maintained through the governing body and leadership of the organization.

The first organizational structure available confirms the multiple lines of authority context of hospital structures (Georgopolous and Mann, 1962; Gorgopolous, 1972; Shortell, 1982) and the delicate balance of power. Its characteristics are bureaucratic, highly centralized and may be equated to Mintzberg's (1979a) professional bureaucracy form. By 1988, the structure was beginning to shift from a one entity to a multi-organizational corporation.

In 1990, implementation of a proposal to decentralize all hospital functions and give independence to hospitals through a hospital governing body at the WH, was seen as the solution to emerging structural weaknesses. The structure proposed more integration via permanent multiprofessional teams (Kimberly, Leatt and Shortell, 1994; Charns and Tweksbury, 1993). Only certain elements of the proposed structure succeeded in catching on, namely the decentralization of some administrative functions to the WH administration and the WH Hospital Executive Committee

In the period 1990-1996, the structure had become more divisionalized with the operational core, support staff, strategic core and techno-structure becoming more apparent. The lack of coordination mechanisms between the hierarchies of the divisional hospital administrators and the professional staff led to conflicts and the creation of liaison roles and committees to resolve those.

In 1997, a second restructuring attempt was undertaken. However, as with the devolution experience of 1990 in the WH, this experience did not last long and the results were similar. Like many hospitals for which application of a true matrix is difficult, HMC had

developed characteristics of matrix structures, particularly in the form of multi-disciplinary teams (Kimberly, Leatt and Shortell, 1994; Dixon, 1977), but the ambiguities surrounding this form; the dual responsibilities, authorities and reportability, proved to be difficult to surmount. This hierarchy of committees resembles early British NHS structures (Jaques, 1978; Allen and Grimes, 1982). Only two hospital governing committees and most departmental committees did sustain the interest of organizational members.

The last two years, 1998/99, could be characterized as one of additional growth and stronger hospital identity. The decentralization of hospital management to hospital administrators reinforced the divisional structure of the corporation. A move away from group-based structure towards a more traditional bureaucratic structure can be witnessed. Each hospital is developing its own professional bureaucracy with the governing body, the hospital administrator and the medical chairmen at the strategic apex, a hierarchy of administrators as middle management, support services and an operating core of professional staff.

Tracing the evolution of HMC shows that the organization developed from a simple dual-authority bureaucratic structure to a complex divisional structure with each hospital developing its professional bureaucracies. Attempts to implement matrix like characteristics failed. This indicates that bureaucratic forms of structuring are favoured to organic matrix forms confirming the works of Goergopolous and Mann (1967) that propose that hospital characteristics make them lend themselves to the bureaucratic form and Jaques (1990) who believes that the only appropriate structure in large organizations is the bureaucratic structure and that researchers should move away from forms that go against the accountability systems of organization. These findings demonstrate the relevance (importance) still today of Weber's (1946) classical theory of bureaucracy and its influence on modern structure research.

Exploring the differentiation-integration balance of the structure revealed that at this moment in the organization's life-cycle the divisional model (quadrant III) offers the required balance as restructuring attempts which tried to move towards more integration were reverted back to the divisional model. This seems to confirm the principles of the life-cycle theory, that the developing entity has within it an underlying logic that moves the entity towards a subsequent end-state that is pre-figured in the present (Van de Ven and Poole, 1995). The shift from differentiation to integration to achieve an appropriate balance kindles interest in the population ecology perspective (Hannan and Freeman,

1977) of studying organizations as its demonstrates the organization's ability to adapt and select structural forms that suit its life-cycle.

6.3.9 Conclusion on the evolution of organization structure

This section explored the evolution of hospital organizational structure by studying the development of HMC's structure. In applying Mintzberg's (1979a) components of structure to simplify and better analyse the organization's structure, a detailed account of how the organization evolved from a dual-authority bureaucratic structure, via more organic forms, to a dual-authority divisionalized bureaucracy with each hospital developing its own professional bureaucracy was given.

Findings of this section confirmed the multiple lines of authority and delicate balance of power in hospital settings (Georgopolous and Mann, 1962; Gorgopolous, 1972; Shortell, 1982). They also confirmed the difficulties in applying matrix structures in hospitals (Dixon, 1977; Jaques, 1990; Mintzberg, 1979a) and the success of bureaucratic forms (Georgopolous and Mann, 1962; Gorgopolous, 1972; Jaques, 1990; Mintzberg, 1979a). Finally, exploring the integration-differentiation balance of the structure seemed to confirm principles of the life-cycle theory (Van de Ven and Poole, 1995).

6.4 *Change management*

6.4.1 Introduction

A study of change management processes in the organization is helpful in understanding the adoption and rejection of structural changes. This section analyses the patterns and processes of structural change at HMC and attempts to explore how incremental change was more successful than radical change attempts in the organization. Responses to survey and interview questions directed on organizational change in general, and corporate and departmental structural changes in particular are used to explore change management in the organization.

6.4.2 Patterns of structural change at HMC

Studying the structural changes in HMC from 1979 to 1999 shows steady growth punctuated by two radical change attempts. <u>Table 6.1 The Evolution of HMC's Organization Structure 1979-1999</u>, presented earlier helps in understanding the elements

of the structural growth. HMC's evolution is one of growth for eight years with incremental structural changes, followed by a minor radical change lasting one year, then structural growth with incremental change for another six years, another large-scale radical change lasting one year and finally, growth with incremental change for the last two years.

In exploring the events that preceded and followed the radical restructuring attempts the following commonalities were found; crisis or organizational problems and complete governance and leadership change preceded both radical change attempts. In 1990, before the WH radical change, there was much discussion within the organization of the organizational and structural weaknesses of the corporation. In 1989 a completely new Board of Directors was elected and in 1990 new administrative and medical directors were appointed. Similarly, in 1997 there were internal coordination problems and conflicts before the corporate wide radical change. Likewise, in 1996 a new Board of Directors was elected and in 1997 new administrative and medical directors were appointed. In both cases, the change attempts were followed by complete change of governance and leadership one year after the changes were implemented.

During the periods of growth and incremental change it is interesting to note that the distinguishing characteristics of that period is stability of governance and leadership as in the stability of one person in the governance or leadership group. In the last 20 years of HMC, there has been a high turn over of governance and leadership but, from 1982 to 1989 there was no change in Chairman of the Board and again from 1992-1997 the administrative director remained stable when other posts witnessed high turnover.

The two radical changes were similar in that they attempted to introduce new managerial principles of matrix elements and teamwork that were radically different from the organizational existing practices. They varied, however, in the planning of the change. In the first, external assistance in the form of a consultant was sought during the exploration and planning phases *(Introduction of Devolved Administration Proposal for Women's Hospital, 1st February, 1990)*. In the second, the change was explored and planned internally *(Proposed New Management System, 1997)*. In the first a staged action plan in which implementation would commence at WH, be refined in the process, and move to other hospitals was taken. In the second, a wholescale radical implementation approach was opted for.

Our findings confirm much of the research on radical transformational change. Transformational change has been found to be achieved through three approaches;

leadership, structure and chaotic events (Kouzes and Posner, 1987; Tichy and Devanna, 1986). In our case, the introduction of completely new leadership has been the instrument of change and the ultimate deciding party on the nature and direction of the change. This also confirms studies whereby changes in structure were found to follow changes in strategy (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 198; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984; Minztberg, 1995). As suggested by Common, Flynn and Mellon (1993) here too the organizational problems and weaknesses have acted as additional levers for change.

Although the radical changes were both carried out in action, it is during the 'refreezing' or 'integration' phases of change that difficulties occurred (Lewin, 1958; Bullock and Batten, 1985) and both changes were reversed. It was suggested that radical changes are generally difficult with high probabilities of failure (Greenwood and Hinings, 1997) and that the political nature of hospitals makes it even more so (Packwood et al., 1998). The politically sensitive environment of HMC is obvious in the desire to maintain equal power and authority between professionals and administrators and the high turnover of the governance and leadership group.

The failure of the two radical change attempts and the success of incremental change in periods of growth confirm research whereby radical change in health settings was found difficult and incremental approaches to change recommended (Packwood et al., 1998).

6.4.3 Understanding radical change attempts failure

In order to better understand why the two radical change attempts have failed to refreeze or integrate into the organization, the change management processes and the environment of HMC are explored. This is achieved through exploring responses to interview and survey questions on change in general and on organizational and departmental structural change management.

6.4.3.1 *Organizational change environment*

Organizational members were asked about the level of centralization of decision-making and projects, the nature and level of involvement in changes and projects, their awareness of changes that affect their work and the speed of change implementation. Interview responses revealed that there are great levels of centralization whereby projects are handled at the top and the bottom implement.

'Projects are handled from top and given to us at the end to implement. We should work as a team; we should talk to each other over everything. Now we don't know what is going on. ' (107 HGH ADMIN)

At the department levels, the level of centralization of projects and decisions depended on the management style of the superior.

'For long term planning issues I need approval. It depends on the administrators; some give you more decisions than others' (102 HGH ADMIN)

Respondents revealed that lack of involvement in change decisions lead to decisions that had not been fully studied and difficulties in implementation.

'When top management decide on things, they don't inform us beforehand and don't involve us. They don't look at it from all angles; therefore, it hinders the smooth running of the department. Things are done without consulting with us.' (11 HMC NUR)
'Decisions are rushed and not properly studied. Changes should be studied better. For example, 3 months of study per project, because now many changes are happening. They take decisions then regret it. Also since it is rushed things go wrong in implementation.' (68 HGH PARA)

In addition to not being fully studied, respondents found that change decisions were taken quickly and that they were asked to implement as quickly. As a result, they felt that change decisions were not strategically planned.

'Some decisions come in last minute as an "accomplished fact" and we have a few days to implement. No meetings to organize or enough time to work it through.' (55 HGH MED)
'Decisions are taken suddenly and you are given no time. Then another decision is taken and immediately implemented. We go back and forth without going great distances.'(44 HGH MED)

Lack of involvement, together with the high turnover of management was found to be the reason why there was little continuity of projects.

'Decisions are taken at the top and we are not involved. It's a shame. That's why we don't get projects that continue... Another problem is high turn over of top management, therefore no projects continue. Top management promise but don't deliver because leave.' (35 HMC FIN)

Where there was involvement it was in the form of suggestions going up to management but no feedback is sent back down or the suggestions are rejected with no proper explanation to the reason for rejection.

'We always have once in a blue meetings to ask nurses how to improve but we get no feedback at all on our suggestions' (19 RH NUR).
'I put proposals for improvement and I'm amazed they are rejected. I wish someone could defend them. Important decisions are stopped. Unfair they approve other department's requests and not ours.' (79 HGH ADMIN)

Table 6.2 HMC Employees' Awareness of Changes demonstrates that when asked in the questionnaire whether they felt they were aware of minor and major changes in the organization that affected their work, majority (46 percent) of respondents found that they were 'mostly aware'. The second largest group (26 percent) found that they were 'sometimes aware' and only 13 percent found that they were 'extremely aware'.

Table 6.2: HMC employees' awareness of changes

Hospital	Extremely aware	Mostly aware	Sometimes aware	Rarely aware	Never aware	Missing	Total
HGH	9	31	13	7	2		62
Percentage	*15%*	*50%*	*21%*	*11%*	*3%*		*100%*
WH	3	20	9	2	1		35
Percentage	*9%*	*57%*	*26%*	*6%*	*3%*	*0*	*100%*
RH	3	16	5	4	1		29
Percentage	*10%*	*55%*	*17%*	*14%*	*3%*	*0*	*100%*
CD	8	11	18	6		2	45
Percentage	*18%*	*24%*	*40%*	*13%*	*0%*	*4%*	*100%*
Total	**23**	**78**	**45**	**19**	**4**	**2**	**171**
Percentage	***13%***	***46%***	***26%***	***11%***	***2%***	***1%***	***100%***

Question: How aware are HMC employees aware of major and minor changes that affect their work?

Those who found that they were not made aware of the changes that affect their work found that to be disconcerting and counter productive.

'Sometimes we hear rumours of our unit moving out but nothing from our superiors. Its disconcerting to hear about a possible change from others.' (20 RH NUR)
'Sometimes we don't get information about new changes in medical units and don't know but have to provide our support. Some decisions are taken on providing our services in units without our knowledge. We should know to be able to supervise performance.' (94 HGH PARA)

Also, when asked in the questionnaire how timely was implementation (Table 6.3 Timely Implementation), the majority (27 percent) found that implementation of decided upon changes was 'slow'. An equal number (26 percent) found that decided upon changes were implemented in a 'somewhat' timely manner or 'mostly' timely manner.

Table 6.3: Timely Implementation

Hospital	Always	Mostly	Somewhat	Slow implementation	Extremely slow implementation	Missing	Total
HGH	3	18	20	18	3		**62**
Percent	*5%*	*29%*	*32%*	*29%*	*5%*	*0%*	***100%***
WH		11	13	7	4		**35**
Percent	*0%*	*31%*	*37%*	*20%*	*11%*	*0%*	***100%***
RH		5	13	7	3	1	**29**
Percent	*0%*	*17%*	*45%*	*24%*	*10%*	*3%*	***100%***
CDs	3	11	11	15	5		**45**
Percent	*7%*	*24%*	*24%*	*33%*	*11%*	*0%*	***100%***
Total	**6**	**45**	**44**	**47**	**15**	**1**	**171**
Percent	***4%***	***26%***	***26%***	***27%***	***9%***	***1%***	***100%***

Question: To what extent are changes that have been decided upon implemented in a timely manner?

Thus, overall, findings indicate a high level of centralization whereby projects are handled at the top and the bottom is requested to implement. This indicates a top-down decision making style with coercive implementation rather than normative re-education (Joss and Kogan, 1995). Decisions were found to be quickly taken, not fully studied as involvement of organizational members was little and implementation was requested as quickly. Implementation is generally forward mapped and quick, with a rapid decision-making phase, little involvement and rapid implementation (Joss and Kogan, 1995). However, the level of centralization was found to depend on the superior's management style.

Lack of involvement and high turnover of management were found to lead to lack of continuity of projects. This confirms previous researches that stress the importance of involvement and consultation (Burnes, 1992; Hinings and Greenwood, 1988; Huse, 1980). Where there was involvement, it was found to be bottom up whereby suggestions are forwarded to superiors but no feedback on suggestions was fed back down to

organizational members. This indicates an unsuccessful attempt by organizational members to introduce bottom-up decisions.

Only a minority of survey respondents were 'extremely' aware of changes in the organization that affect their work. The majority were 'mostly' aware and the second largest group were 'sometimes' aware. Not being aware of changes that affect their work was found to be disconcerting and counter productive by respondents. Again, this confirms the importance of involvement of organizational members specially when the intervention is deep and touches individuals and their work (Burnes, 1992; Huse, 1980).

Finally, contrary to interview responses whereby respondents indicated that quick implementation was requested from superiors, the majority of questionnaire respondents found that implementation of decided upon changes was either slow or somewhat timely. This difference could possibly be due to the fact that the questions were on change implementation in general without specification and respondents recalled changes generally according to their experiences.

6.4.3.2 *Structural change mangement*

Organizational members were asked specifically about corporate and departmental structural changes. First, responses to survey questions on the planning, evolution, and changes in their structures are explored. Then, responses to interview questions revolving around involvement in the structuring decisions are explored.

Organizational members were asked questions on how well planned they found their corporate and departmental structures, whether the structures have evolved over time, whether these structures were flexible or rigid, and finally how important was continuity of work during structural changes.

Table 6.4 Planning of Corporate Organizational Structure indicates that most respondents to the questionnaire found that the corporate organizational structure well planned (36 percent) or somewhat well planned (32 percent). With regards to the evolution of the corporate structure, Table 6.5 Evolution of Corporate Organizational Structure, the majority of respondents found that the corporate organizational structure has generally evolved (34 percent) or somewhat evolved (34 percent) over the years. Finally, regarding flexibility and the changing nature of the corporate organizational structure Table 6.6

Corporate Structure's Flexibility and Change, the majority of respondents found the corporation's organizational structure somewhat flexible and changing (57 percent).

Table 6.4 Planning of Corporate Organizational Structure

Hospital	Extremely well planned	Well planned	Somewhat well planned	Not well planned	Not planned at all	Missing	Total
HGH	7	23	22	6	4		62
WH	2	14	13	2	3	1	35
RH	3	13	5	5	3		29
CDs	3	12	15	12	2	1	45
Total	**15**	**62**	**55**	**25**	**12**	**2**	**171**
Percentage	***9%***	***36%***	***32%***	***15%***	***7%***	***1%***	***100%***

Question: Do you think/consider that the Corporate organization structure has been planned?

Table 6.5 Evolution of Corporate Organizational Structure

Hospital	Constantly evolved	Generally evolved	Sometimes evolved	Only rarely evolved	Has not been allowed to evolve	Missing	Total
HGH	7	20	17	10	5	3	62
WH	1	14	13	3	2	2	35
RH	2	9	12	2	2	2	29
CDs	3	15	16	7	3	1	45
Total	**13**	**58**	**58**	**22**	**12**	**8**	**171**
Percentage	***8%***	***34%***	***34%***	***13%***	***7%***	***5%***	***100%***

Question: Do you think/consider that the Corporate organization structure has been allowed to evolve?

Table 6.6 Corporate Structure's Flexibility and Change

Hospital	Fixed and permanent	Somewhat flexible and changing	Extremely flexible and changing	Missing	Total
HGH	11	41	10		62
WH	8	21	5	1	35
RH	10	12	5	2	29
CDs	5	24	15	1	45
Total	**34**	**98**	**35**	**4**	**171**
Percentage	***20%***	***57%***	***20%***	***2%***	***100%***

Question: To what extent is the structure of the Corporation fixed and permanent?

As for planning of the departmental structure, Table 6.7 Planning of Department Organizational Structure, most respondents to the question found their department structure to be well planned (35 percent) followed closely by somewhat well (32 percent). Interestingly, there were significant differences in responses by profession. The majorities of medical, administration and nursing staff found their department structure to be well planned (40 percent, 54 percent, and 40 percent respectively). However, the majorities of paramedical, support services and corporate departments staff found their departments to

be somewhat well planned (33 percent, 60 percent, and 36 percent respectively). The majority of therapy staff found that their department was not well planned or not planned at all (33 percent each).

Table 6.7 Planning of Department Organizational Structure

Professsion	Extremely well planned	Well planned	Somewhat well planned	Not well planned	Not planned at all	Missing	Total
Medical	2	10	7	2	4		**25**
Percentage	*8%*	*40%*	*28%*	*8%*	*16%*		***100%***
Administration	3	7	1	1	1		**13**
Percentage	*23%*	*54%*	*8%*	*8%*	*8%*		***100%***
Nursing	6	31	26	12		2	**77**
Percentage	*8%*	*40%*	*34%*	*16%*		*3%*	***100%***
Paramedical		2	3	2	2		**9**
Percentage		*22%*	*33%*	*22%*	*22%*		***100%***
Therapy		1	2	3	3		**9**
Percentage		*11%*	*22%*	*33%*	*33%*		***100%***
Suport Services		2	6	2			**10**
Percentage		*20%*	*60%*	*20%*			***100%***
Corporate Departments	1	7	10	7	3		**28**
Percentage	*4%*	*25%*	*36%*	*25%*	*11%*		***100%***
Total	**12**	**60**	**55**	**29**	**13**	**2**	**171**
Percentage	***7%***	***35%***	***32%***	***17%***	***8%***	***1%***	***100%***

Question: Do you think/consider that your department's internal organization structure has been planned?

With regards to the evolution of the department structure, Table 6.8 Evolution of Department Organizational Structure, indicates that the majority of respondents found that their department structure has generally evolved (34 percent) or sometimes evolved (34 percent) over the years. Finally, when asked about the flexibility and changing nature of their departmental structure, Table 6.9 Department's Structure Flexibility and Change, the majority of respondents found their department's structure somewhat flexible and changing (47 percent).

Table 6.8 Evolution of Department Organizational Structure

Hospital	Constantly evolved	Generally evolved	Sometimes evolved	Rarely evolved	Has not been allowed to evolved	Missing	Total
HGH	8	27	13	6	7	1	**62**
WH	1	13	12	2	6	1	**35**
RH	1	7	7	5	7	2	**29**
CDs	2	12	19	5	7		**45**
Total	**12**	**59**	**51**	**18**	**27**	**4**	**171**
Percentage	***7%***	***35%***	***30%***	***11%***	***16%***	***2%***	***100%***

Question: Do you think/consider that your department's organization structure has been allowed to evolve?

Table 6.9 Department's Structure Flexibility and Change

Hospital	Fixed and permanent	Somewhat flexible and changing	Extremely flexible and changing	Missing	Total
HGH	22	32	7	1	**62**
WH	16	15	4		**35**
RH	14	12	2	1	**29**
CDs	15	22	8		**45**
Total	**67**	**81**	**21**	**2**	**171**
Percentage	***39%***	***47%***	***12%***	***1%***	***100%***

Question: To what extent is your department's internal structure fixed and permanent?

Continuity of work during structural changes was viewed as slightly more important at the departmental than the corporate level. Table 6.10 Importance of Continuity – Departmental Responses demonstrates that at the departmental level, 43 percent found continuity to be 'very important' and 32 percent found it to be 'somewhat important'. By contrast, Table 6.11 Importance of Continuity –Corporate Management, indicates that, 39 percent felt corporate management found continuity 'very important' and 36 percent felt management found it 'somewhat important'.

Table 6.10: Importance of Continuity - Departmental Responses

Hospital	Extremely important	Very important	Somewhat important	Not important	Missing	Total
HGH	16	20	21	3	2	**62**
Percentage	*26%*	*32%*	*34%*	*5%*	*3%*	***100%***
WH	4	14	15	2		**35**
Percentage	*11%*	*40%*	*43%*	*6%*	*0%*	***100%***
RH	5	16	4	3	1	**29**
Percentage	*17%*	*55%*	*14%*	*10%*	*3%*	***100%***
CD	4	23	14	3	1	**45**
Percentage	*9%*	*51%*	*31%*	*7%*	*2%*	***100%***
Total	**25**	**73**	**54**	**11**	**4**	**171**
Percentage	***15%***	***43%***	***32%***	***6%***	***2%***	***100%***

Question: When organizational change is introduced into your department, to what extent do you consider that is is important to ensure continuity with past structures and procedures?

Table 6.11 Importance of Continuity – Corporate Management

Hospital	Extremely important	Very important	Somewhat important	Not important	Missing	Total
HGH	12	18	23	6	3	62
Percentage	*19%*	*29%*	*37%*	*10%*	*5%*	*100%*
WH	2	16	12	4	1	35
Percentage	*6%*	*46%*	*34%*	*11%*	*3%*	*100%*
RH	4	14	7	4		29
Percentage	*14%*	*48%*	*24%*	*14%*	*0%*	*100%*
CD	4	19	19	2	1	45
Percentage	*9%*	*42%*	*42%*	*4%*	*2%*	*100%*
Total	**22**	**67**	**61**	**16**	**5**	**171**
Percentage	***13%***	***39%***	***36%***	***9%***	***3%***	***100%***

Question: When organizational change is introduced, to what extent do you consider that management as a whole feels it is important to ensure continuity with past structures and procedures?

Thus, overall, respondents found that their organizational structures were well planned. However, slightly more found their department structure to be well planned (41 percent) then their corporate structure (36 percent). Respondents from the medical, nursing and administrative professions also indicated more confidence in the planning of their department's structure then did other professions. The majorities of respondents found the structures to be somewhat flexible and changing with slightly more finding their corporate structure to be flexible and changing (57 percent) then their department structure (47 percent). Finally, departmental staff viewed continuity of work during structural changes as slightly more important than they perceive senior management viewed it.

As for employee involvement in corporate and departmental structures, the involvement of senior executives in the corporate structure and of general managers and staff in their department structure is explored. Senior executive respondents were asked in interview questions about their involvement in corporate organizational structure changes and managerial and staff level respondents were asked about their involvement in their department's organizational structure.

The majority of the senior executive staff respondents found that they were not involved in the corporation's general organization structure (mentioned 16 times out of 25 responses to this question). A small minority found that they were (mentioned 5 times out of 25) and another group found that they were only informally involved (mentioned 4 times out of 25).

Most of those involved found that they were involved in discussions but that there was no real involvement (mentioned 2 times out of 8 responses to this question). Others were involved in informal discussions, heard about the structural change through gossip, were briefed about it by top management or a committee meeting or requested input about their speciality (each mentioned once out of 8).

The majority of medical staff interviewed found that the corporation has not undergone any structural changes in the last years; that it is still the same structure as in 1982 that had simply expanded.

> *'There is no structure I think, it is just the original one I think.' (56 HGH MED)*
> *'No. It is still the same from 1982, just changed around.' (91 HGH MED)*

Those who did realise there was a structural change that occurred found that it was conducted by two or three people without consulting the rest of the organization.

> *'Decisions are taken by two or three people without consulting.' (81 HGH MED)*

Similarly, administrative staff found that the organizational structure has simply expanded from its original structure.

> *'There has been no structural changes since it is still the original one (structure) of 1981, just expanded.' (33 HMC FIN)*

Some found that their last proper briefing about the organization structure was in the 1980s.

> *'No, we have not seen the first one (structure) but we were informed in early 80s of the first structure and job descriptions. After that we have not been involved or informed.' (65 HMC MTL)*

Nursing staff seem to have been most affected by the organizational change attempt of 1997. Although they were not involved in the actual decision of the structure, they were briefed about it.

'No I haven't seen it until it was completed and decided upon.'(11 HMC NUR)
'The before last, the one of 1997, the Administrative Director came and briefed us on the structure which is quite unusual' (13 RH NUR)

It is interesting to note that although there were two distinct attempts at restructuring the organization and one which was underway as the study was being conducted respondents did not qualify those as structural changes attempts. Respondents attributed this to the frequency of changes over a short period of time.

'The frequent management changes has affected the running of HMC and services. Each person tried to change the structure.' (Administration Director)
'Because of all the changes in management people are sceptical and do not take it seriously or implement. It is because of the quantity of changes over a short period of time. The last proposal, the nurses where very enthusiastic but the doctors there were not interested in being involved, and there were not enough administration to implement it fully' (13 RH NUR)

At the departmental level, the majority of respondents found that they were involved in changes in their departmental structure (mentioned 33 times out of 54 responses to this question). About half as many said they were not involved in changes in their department's structure (mentioned 15 times out of 54) and finally, a small number said that they could not interfere with the structure; that it was fixed (mentioned 5 times out of 54).

Of those that were involved, the most common type of involvement was involvement in discussions about the structure (mentioned 14 times out of 27 responses to this question). Some found that they were involved in the actual structural change decision (mentioned 4 times out of 27) and others had recently made a change in their structure by creating new units (mentioned 5 times out of 27).

When exploring nursing involvement in their structure it is apparent from interview responses that nursing staff were highly involved in their department through the many committees and meetings yet they were not involved in decisions related to departmental structure.

'We are involved in decisions, yes, but not on the organizational structure itself. Most decisions are taken in meetings, for example, modifications, forms, etc.. we modify and review processes and practices all the time but not the actual structure.' (71 HGH NUR)

They found that their department's structure has been fixed for a long time and does not undergo changes.

> *'My superior is more involved and she passes the information to me. Our structure of units is fixed and has been fixed for a long time. People change and rotate but the structure is the same.' (3 WH NUR)*

As for medical staff, their involvement in changes in department's structure was mostly on personal basis.

> *'My involvement was formally and on a personal basis by respect of seniority.' (45 HGH MED)*

Similar to nursing staff, administrative staff found that they were involved in policy changes but not in structural changes. They found that their department's structure has been the same for a long time. Some found that their department's structure needed change yet others found that the structure was adequate and that it was the work processes, and staff quantity and quality that needed improvement.

> *'Sometimes, not always, I am informed of what is happening. Involvement in structure? None. This structure is the structure I found at arrival. We need to add staff for shifts.' (23 RH ADMIN)*
> *'Yes, I have participated in decisions and changes but mostly of policies. Our structure is the same and it can remain. We are trying to change the policies and procedures. That's our main focus now, to improve work processes to facilitate work internally and coordinate with others. The structure is ok; just shortage of staff. The problem is not the structure, but the number of staff, quality of staff and policies and procedures. These are our problems.' (36 HMC ENG)*

Where the Quality Management (QM) team involvement has been found, there was more involvement of staff in redesigning their department's units.

> *'With the involvement of Quality Management (...) we redesigned the unit, structure and work processes, etc.. and now we meet regularly to discuss.' (86 HMC SS)*
> *'We were not involved until recently. Now with QM meetings we are being involved.' (85 HMC SS)*

Thus, to summarize the findings on involvement in structural changes, the majority of senior executives interviewed were not involved in the changes in the corporation's organizational structure. Others were involved through formal or informal discussions, heard about the changes through gossip, were briefed about changes by top management or were requested their input on their speciality.

The majority of medical staff did not realise or denied any changes in structure beyond the original 1981 structure. Similarly, the majority of administrative staff found that the structure just expanded from the original 1981 structure. Nursing staff expressed their surprise in having been briefed about the last restructuring attempt, which was thought of as unusual, even though it was after the structure was completed.

This denial of past structuring attempts could be attributed to resistance or passivity due to the lack of involvement in the restructuring attempts. Or, as the attempts failed leaving only trace reminders of the change and the governance and leadership changed, organizational members preferred to 'forget' about the changes.

Of those who realised that there was a restructuring attempt, they found it to be conducted by two or three people without consultation or involvement of organizational members. It is interesting to note that although there were two distinct attempts at restructuring the organization and one that was underway as the study was conducted respondents did not qualify those as structural changes attempts. This was attributed to the frequency of changes over a short period of time; *'because of all the changes in administration people are sceptical and do not take it seriously or implement. This is because of the quantity of changes over a short period of time.' (13 RH NUR).*

Compared to corporate structure involvement, there were higher levels of organizational member's involvement in departmental structure. The nature of involvement ranged from discussion and participating in the decision making process to having conducted a recent change in the structure.

It is interesting that higher levels of organizational member's involvement coincided with higher confidence in the structure's planning. Interview respondents revealed that involvement in departmental structure was higher then involvement in corporate structure and survey responses revealed a higher confidence of organizational members in the planning of the department's structure than in the planning in the corporate structure.

Although nursing and administrative staff were highly involved in their department's policy decisions, they found that they were not involved in structuring decisions. They both found their structures to be fixed and having not undergone changes in a long time. Some administrative staff found that their department structure needed change whereas others

found that the structure was adequate but the work processes and staffing needed improvement. As for medical staff, their involvement was found to be on a personal basis.

Where the Quality Management team involvement has been found, there was a greater involvement of staff in redesigning their department, something that organizational members appreciated.

6.4.4 Analysis of change management and restructuring attempts

Studying the evolution of HMC's organizational structure revealed a steady growth with incremental structural changes punctuated by two radical change attempts each lasting one year. The distinguishing feature of the periods of growth and incremental change is the stability of governance and leadership. Both radical restructuring attempts were preceded by crisis or organizational problems and complete change in governance and leadership. This confirms research that indicate that structural change generally follows changes in strategy as well as research that suggest that radical change is achieved through leadership (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 198; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984; Minztberg, 1995). Although the change attempts varied in their approaches to planning change, both failed to 'refreeze' or 'integrate', confirming research on the difficulties of implementing radical change in hospital settings (Greenwood and Hinings, 1997; Packwood et al., 1998).

Overall, findings indicate a high level of centralization whereby projects are handled at the top and the bottom is requested to implement. This indicates a top-down decision making style with coercive implementation rather than normative re-education strategies (Joss and Kogan, 1995). Decisions were found to be quickly taken, not fully studied as involvement of organizational members was little, and implementation was requested as quickly. Implementation was generally forward mapped and quick with a rapid decision-making phase, little involvement and rapid implementation (Joss and Kogan, 1995). However, the level of centralization was found to depend on the superior's management style.

Lack of involvement and high turnover of management were found to lead to lack of continuity of projects. This confirms previous researches that stress the importance of involvement and consultation (Burnes, 1992; Hinings and Greenwood, 1988; Huse, 1980). Where there was involvement, it was found to be bottom up with unsuccessful attempts by organizational members to receive feedback on suggestions.

The majority of senior executives interviewed were not involved in the corporation's organizational structure. Compared to corporate structure involvement, there were higher levels of organizational members' involvement in their department's structures. Findings revealed that higher levels of organizational members' involvement coincided with higher confidence in the structure's planning confirming previous research on the importance of involvement in deep interventions (Burns, 1992; Hennings and Greenwood, 1988; Huse, 1980).

In light of the findings on top-down decision-making, forward implementing, low involvement and high leadership turnover at HMC, the two restructuring attempts will be explored. Both attempts involved deep change in working patterns, job structures and introduced a new work group-based culture. Using Bullock and Batten's (1985) four phases of planned change we shall explore the restructuring attempts of 1990 and 1997. Both restructuring attempts went through similar stages and ceased at the same point with minor variations.

In both cases the first phase, *exploration* commenced with a realization that the present conditions could be improved. In 1990 it was the awareness of the structural weaknesses and problems and in 1997 it was the increased coordination problems. In 1990 outside assistance was called for to produce a plan for change but in 1997 the plan was internally constructed using elements of the 1990 experience.

The *planning* phase varied considerably due to the external assistance factor. In 1990 the consultant collected information from the senior staff, set out an action plan that was phased to commenced at the WH and included a program evaluation body (Steering Committee) to oversee the change implementation *(Introduction of Devolved Administrative Proposal for Women's Hospital, 1st February, 1990)*. In 1997 information was collected via extensive documentation of the corporation's current situation e.g. departmental status reports and manuals *(Proposed New Management System, 1997)*. Meetings were conducted with senior staff after which partial refinement of the planned change were made. Politically sensitive issues and job structures were left vague. As with the 1990 attempt, the 1997 plan contained a Steering Committee composed of the Managing Director, Administrative and Medical Directors to oversee implementation.

The third phase, the *action* phase was also the last phase in both attempts. The *integration* phase was never reached. In 1990 implementation started but ceased soon after. Clinical service group were not successful and there was resistance from

stakeholders outside the WH. Similarly, in 1997, the unit groups were unsuccessful and the Hospital Executive Committee of HGH failed to succeed. The failure to refine the change in order to make it succeed indicates a failure in managing the change process and reinforcing the new behaviour. Additionally, in both cases, by the end of the year the leadership changed and the Steering Committee ceased to exist.

The interview responses indicate that generally and during the last restructuring attempt specifically decision-making was top-down with little involvement or communication throughout the change. There was also vagueness around politically sensitive issues, job structures and descriptions. Such conditions have generally been found to lead to failures of change attempts (Burnes, 1992; Hinings and Greenwood, 1988). For organizational structure change to be successful, a more holistic approach that touches all levels of the organization and achieves a cultural change to support the new socio-structure has been found to be more appropriate (Burke et al., 1981; Allaire and Firsirotu, 1984; Handy, 1986; Burnes 1991; Burnes, 1992; Hinings and Greenwood, 1988).

In both restructuring attempts few intervention activities aimed at normative re-education were found. Those that were found were in the form of document distribution and consultative meetings in the second attempt. This indicates that the changes focused on structure neglecting process, people and culture. Additionally, with the highly versatile leadership during that period, organizational members involvement in, and adoption and support of the change would have been vital to its success. The fact that it was steered by the leadership only resulted in it being dropped as soon as the leadership changed. For the change to succeed the leadership would have had to remain and ensure implementation through coercive strategies.

6.4.6 Conclusion on change management

This section studied the patterns of structural change management at HMC by exploring general change management practices at the departmental and organizational levels, patterns of structural changes and the failure of restructuring attempts. This was achieved through understanding the evolution of HMC's organizational structure, and studying questionnaire and interview responses.

An environment of top-down decision-making, forward implementation, low involvement and high leadership turnover was found. Using Bullock and Batten's (1985) four phases of planned change, the radical restructuring attempts of 1990 and 1997 were explored.

Findings revealed information about the different nature of radical and incremental change and (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 198; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984; Minztberg, 1995) confirmed research on the difficulties of implementing radical change in hospital settings (Greenwood and Hinings, 1997; Packwood et al., 1998).

Findings also confirm that low involvement and vagueness around politically sensitive issues, job descriptions and job structures lead to failure in change attempts (Burnes, 1992; Hinings and Greenwood, 1988; Huse, 1980). Findings revealed that higher levels of organizational member's involvement coincided with higher confidence in the structure's planning. This section concluded by subscribing to the point of view that holistic approaches which touch all levels of the organization and achieve a cultural change to support the new socio-structure are more appropriate (Burke et al., 1981; Allaire and Firsirotu, 1984; Handy, 1986; Burnes, 1991; Burnes, 1992; Hinings and Greenwood, 1988).

6.5 Conclusion

Conclusions about the evolution of hospital organizational structures were drawn based on an exploration of the development of HMC's structure from 1979 to 1999. Tracing the evolution of HMC showed that the organization developed from a simple dual-authority bureaucratic structure to a complex divisional structure with each hospital developing its professional bureaucracies. The issues of balance of power, centralization, leadership, multidisciplinary work groups, coordination, and the balance between differentiation integration in hospital structure design were discussed.

The study of the evolution of HMC's structure also revealed interesting information about change management. The organizational structure has steadily grown with incremental structural changes punctuated by two radical change attempts each lasting one year. Conclusions about the nature of radical changes and their success in hospital settings were reached. The effects of leadership, decision-making style, choice of implementation strategies, members' involvement and consultation, communication and normative re-education on the change attempts were explored.

CHAPTER 7 ORGANIZATIONAL DESIGN: STRUCTURE AND PROCESS

7.1 *Introduction*

The previous chapter explored the evolution of HMC's organizational structure. This chapter continues with a more in depth exploration of HMC's organizational design by exploring organizational structure and processes at the time of research. The section on organizational structure explores in more details the corporate, professional, hospital and departmental structures and draws conclusions on HMC's structure and hospital structures in general. The second section focuses on organizing and organizational processes such as centralization, information and communication, planning, coordination and work processes or procedures from which conclusions on HMC's organizational design are drawn.

7.2 *Organizational structure*

7.2.1 Introduction

This section explores HMC's organizational structure. It commences by exploring corporate structure. It then moves to the different professional structures, followed by the hospital structures. Finally it explores the different departmental structures. Through documents and interview responses analysis, this section explores the characteristics, strengths and weaknesses of the different structures and how it was perceived that these could be improved. Conclusions on the different structures and hospital structures in general are then drawn.

7.2.2 Corporate structure

Interview respondents' perceptions on the corporate organizational structure are explored and contrasted to management documents on the structure. First, the perceived strengths and weaknesses of the corporate structure are discussed. Then, the areas and ways in which the corporate structure can be improved are addressed. Finally, the role and importance of governance and leadership are explored.

7.2.2.1 *Strenghts and weaknesses*

The majority of interview respondents found the corporate organizational structure not effective (mentioned 14 times out of 33 responses to this question). An important number were confused about what is the corporate organizational structure (mentioned 7/33 time) and a small number found that the structure was on paper only but not real (mentioned 4/33 times). The confusion seems to stem from the amalgamation of structural changes and directions and the lack of clear communication.

> *'Departments are still working on the spirit of the last matrix structure. The present management is more centralized than before and very action oriented. We have not been spoken to about the structure. We don't know if the present matrix type structure is to be continued or not. So we just maintain aspects of it that we find good loosely.' (6 WH ADMIN)*

> *'There are many structures that have been released in the last years. I don't know what is being followed. I know that there are the administrative and medical sides. I know the problem of HMC is that there is no organization; it needs by-laws and ways of organizing. No one knows what is his job. Also the structure is not clear. There are so many administrators that we don't know which is doing what. HGH is confusing, there are so many assistants and their jobs are not clear. (62 HMC TENDR)*

Eight characteristics were suggested by interview respondents as being the strengths of the present corporation organization structure[59]. Rearranging the eight characteristics by categories leads to the emergence of four categories presented in Table 7.1 below.

Table 7.1 Strengths of Corporate Structure

Characteristics of Top Management *(8 times/ 22 responses to this question)*
Top management is easy to reach, listens, recognizes hard working staff and takes quick decisions
Structural issues with relation to internal environment *(6 times/ 22 responses)*
Clear hierarchy/lines of communication, information flow upwards efficient, and encourages coordination and decentralization
Structural issues with relation to external environment *(5 times/ 22 responses)*
Independence from Civil State Services
Characteristics of Organizational Members *(3 times/22 responses)*
Hard working/disciplined staff

[59] See Annex 28 List of Corporate Structure Strengths.

Thus it becomes apparent that the biggest strength of the corporation, as perceived by organizational members, is the characteristics of top management (mentioned 8 times out of 22 responses to this question), followed by some internal structural issues (mentioned 6 times/22 responses) such as clear hierarchy/lines of communication, upwards information flow, coordination and decentralization. The third most important strength is structural independence from the State Civil Services (mentioned 5 times/ 22 responses). The fourth and last strength mentioned by respondents is the hard working and disciplined character of organizational members (mentioned 3 times/22 responses).

Respondents were asked what they thought were the weaknesses of the present corporate structure. A list of their responses by order of importance was developed[60] then re-arranged by management function. Table 7.2 Corporate Structure Weaknesses below shows the categories that emerged from this process.

Table 7.2 Corporate Structure Weaknesses

Category of Weakness	Times Mentioned	
Planning		
- no planning	10	
- deviated from primary goal (referral hospital)	1	
- individuals/depts forgot corporate mission of patient care	4	Total: 15
Structuring		
Centralization		
- very centralized decision making/management	43	
Lines of Authority/Hierarchy		
- unclear/dual reporting (hospital vs. corporate depts)	5	
- interference from corporate depts in hospital management	3	
- some depts think they can function in isolation	3	
- structure changes to suit individuals in posts	2	
- not decided if wants decentralization	1	
- too much bureaucracy	1	
- too many committees	1	
- aspects of matrix and centralized structure	1	
	(subtotal: 17)	**Total: 60**
Organizing		
Work Processes		
- no clear roles and functions	11	
- weak administrative processes	11	
- discrimination in applying rules and	11	

[60] See Annex 29 List of Corporate Structure Weaknesses

regulations - relies heavily on individual's character - favouritism - no clear documented processes - some heads take advantage of posts for personal benefit - grey areas - no meetings - relies on personal contacts for coordination Information Flow - no communication mechanisms - no computerization	 8 8 7 4 1 1 1 (subtotal: 63) 8 1 (subtotal: 9) **Total: 72**
Controlling - no medical audit - no accountability	 1 1 **Total: 2**
Human Resources Management - demotivated/demoralized/insecure staff - weak salaries - no career development - no training to work within this structure - people misplaced in posts - need new staff - high turnover in administration - weak/inefficient staff	 21 6 6 3 4 2 1 1 **Total: 44**
	Total responses to this question: 193

This clearly shows that the greatest weakness of the corporation as perceived by organizational members is the organization of work processes and the flow of information (mentioned 72 times out of 193 different responses to this question). The second strongest perceived weakness is structuring, more specifically the level of centralization and the lines of authority or hierarchy within the structure (mentioned 60 times/ 193 responses). The third most important weakness is perceived to be human resources management (mentioned 44 times/ 193 responses), followed by planning (mentioned 30 times / 193 responses) and controlling (mentioned twice /193 responses).

These answers are in line with earlier managerial documents where deficiencies in planning, control, rules and regulations, policies and procedures, decision making processes, and roles and responsibilities allocation have been noted to have lead to a fragmentation of the management process:

> 'The deficiencies outlined earlier on planning, budgetary control, rules and regulations, and policies and procedures all contribute to a general confusion as to objectives and responsibilities and lead to poor communications.

Generally, managers at all levels in the organization do not feel part of the decision making process and often are not aware of decisions having been taken, even through these may affect them. In addition, there is confusion over the respective administrative roles of administration, medical and nursing staff (..).The combined effect of all these factors is a fragmentation of the management process, poor coordination and a general lack of monitoring and control.'

(Management Arrangement and Systems, 1989)

It was also apparent to top management that in addition to the lack of strategic planning, thorough policies and procedures, and interface between administrative and medical functions the lack of medical involvement in management has lead to poor monitoring and control of quality and resources.

'lack of strategic planning, lack of policies and procedures, lack of interface and coordination of administrative responsibilities with medical staff ....under the present management arrangements, there is no system of monitoring and controlling the quality of service or use of resources in clinical areas, and this is in part due to the lack of involvement of medical staff in management.'

(Memorandum: On Proposed Organizational Structure, 1989)

A recent SWOT analysis conducted by the corporation in 1997 has indicated that the most important weaknesses of the corporation are related to inefficient human resources practices, underdeveloped policies and procedures, lack of planning, difficulties in space and location management, and keeping up with computerization and technology. See Table 7.3 below for a summary of the SWOT analysis.

TABLE 7.3: SWOT ANALYSIS SUMMARY 1997

Weakness	**Description**
Human Resources Management	- training and international exposure - shortage of highly qualified staff (medical, nursing and technical) - low grades and salaries = weak attraction - nursing- poor skill-mix, multinational - staff shortage
Policies and Procedures	- medical bye laws underdeveloped - personnel policies
Planning	- overload of service due to unnecessary referrals (PHC) - lack of strategic plans
Space and Location	- RH – difficulties to access certain departments - Space
Information Technology	- computerization and technology

Many respondents were of the opinion that the organization needed restructuring and reorganizing;

> *'I think it is (the structure) doing the job right now but I cannot say it is effective. The current structure is old. It needs change. The structure was created when the corporation opened and it just grew and grew. Now so many changes have occurred. It needs to be relooked at.' (33 HMC FIN)*

Finally, respondents were asked how the organization could be better structured. Table 7.4 below summarizes how it was perceived that the corporation could be better structured. The majority found that this could be done by decentralizing (mentioned 14 times / 39 responses) through decentralization of decision making to department heads or separating of hospitals. Equal weight was given to planning, improving work processes and the calibre and ethics of staff (each mentioned 7 times / 39 responses). The least important methods to improve the corporation's structure were perceived to be reducing the size of the corporation or committees in the corporation (mentioned 2 times / 39 responses) and holding staff accountable (mentioned 2 times / 39 responses).

TABLE 7.4 IMPROVING CORPORATE STRUCTURE

Issue	Methods	Number Mentioned	Total Responsess
Decentralization	-decentralize decisions to department heads -separate hospitals/units	9 5	**14**
Planning	-involving staff in planning -focus on HMC objective	5 2	**7**
Work Processes	-clear job descriptions, role and functions -better cooperation -regular multiprofession meetings	5 1 1	**7**
Calibre and Ethics of Staff	-knowledgeable, creative and enthusiastic people in key posts -hard working staff -people who work for public not personal benefit	4 2 1	**7**
Reduce in size	-reduce number of committees -make smaller in size	1 1	**2**
Accountability	-hold staff accountable	**2**	**2**
		39	**39**

7.2.2.2 *Governance and leadership*

In the absence of processes to support the organization structure organizational members saw the characteristics of their top management as a management that listens, is easy to reach and takes rapid and efficient decisions as their most important strength. This implies that leadership is very important during such periods and under such structural conditions.

Frequent changes and instability of leadership have affected the stability of the organization.

> *'There is instability at senior and middle management level. Every time a new top guy comes, he brings his crew with him, and then when he is removed the crew goes off too. Nobody does long term planning because they don't know how long they will stay. That's why HMC is not progressing.' (39 HM LEGAL)*

It is for this reason that organizational members look to the Board of Directors for leadership and direction. However, some respondents indicated disappointment in the lack of information on the activities and vision of the Board

> *'It's a confusing period we are in (...). Now that we finally have a board of directors they exist only on paper. There is no accomplishment. We don't see their meetings. We have no idea what their vision for the corporation is. As a result each department works in their own direction. We are in a sea and each is sailing in the way they want. We are working on crisis management and we don't have a direction. We don't know what we will do. And the structure, we don't know if the board looked at it and studied it.' (11 HMC NUR)*

> *'We have no idea what issues and decisions are taken by the Board. It is made confidential from us. We read about it from the newspaper. There is no communication. Everything is private and confidential. We have no information from Board or from other departments. ... We should know the conclusions of the Board and its minutes. It shouldn't be issued in the newspaper before we know about it.' (49 HMC AUD)*

It is believed that in the past the Board was involved in functional and not governance issues and a new legislation has been issued to define the role and responsibilities of the Board of Directors. However, the board remains less involved in steering the corporation than it should be. Management is taking action in trying to regulate the functions of the board by revising the legislature that defines the roles and functions of HMC Board of Directors.

'The Board should be doing steering, not daily, work. Some executive functions were given to the board in the past, for example, signing of certain contracts and penalties. Now in our new legislature we have removed these executive functions. The present board's meetings are very infrequent, maybe 3 to 4 times a year. They only meet on emergency situations. The board is less involved then it should be. We are revising the legislature presently. We hope that that will regulate their functions better. The minutes of board are circulated but only to those concerned.' (39 HM LEGAL)

HMC management is fully aware that the Board needs support to fulfil their board functions and is planning to assist the board through legislature, defining the Board's terms of reference and ensuring proper information flow to the Board.

'For HMC's board to fully fulfil its leadership role it needs to be properly assisted and supported via:

- Defining in a terms of reference document or mandate document the roles and responsibilities of the board. This will serve as a guide to Board members as well as self-assessment tool.
- Designing proper information formats for the board. Deciding on the content, format, quantity and quality of information to be submitted to the board on a regular basis will enable the board to make prompt and thoroughly studied decision, monitor plans and performance rather than being overloaded with counterproductive information.'

(Memorandum: Administrative Executive Report, 1998)

7.2.2.3 *Conclusion on corporate structure*

The majority of interview respondents were not satisfied by their corporate structure and found it ineffective. An important number of respondents found the corporate structure to be confusing as a result of the amalgamation of successive structural changes and the lack of clear communication. The main strengths were found to be in order of importance; characteristics of top management (easy to access, listens, recognizes hard working staff and quick decision makers), internal structural environment (clear hierarchy and lines of communication, efficient upward information flow, encourages coordination and decentralization), external environment (independence from Civil State Service), and characteristics of organizational members (hardworking, disciplined staff).

The confusion over the organizational structure and the emphasis on leadership at HMC in 1999 are similar to the NHS experience in the 1980s after the introduction of consecutive changes. In 1948 the NHS was a 'loose federation' of separate administrative, nursing and medical hierarchies (Flynn, 1992). In 1974 some 'scientific

management' principles were introduced and the health authorities were created (Flynn, 1992). In 1983 the Griffith Report introduced general management and accountability (Griffiths, 1983). The end result was *'an amalgam of past purposes, some of which conflicted, some of which had become outdated, it was a structure that required strong leadership in the key roles to provide a sense of direction'* (Packwood et al., 1992, p. 69).

Similarly HMC has undergone structural changes in sometimes-conflicting directions switching from bureaucracy to matrix principles and back to bureaucracy again. Hence employees view leadership that is strong and provides a sense of direction as its most important strength.

In Qatar, the weaknesses were perceived as being in order of importance: the weak organization of work processes and poor information flow, the high levels of centralization and the unclear lines of authority/hierarchy, weak human resources calibre and management, the lack of planning and finally the lack of controlling mechanisms. These perceived weaknesses were confirmed by management documents. In addition, documents revealed weaknesses in space allocation and provision, computerization and technology. It was believed that these weaknesses, in addition to the lack of medical involvement in management, have lead to the *'fragmentation of management process'* and *'poor monitoring and control of quality and resources'*.

In light of such process, structure, organizational and human resources weaknesses the importance placed on leadership is understandable. The characteristics of a strong, decisive, and easy to access leadership to hold the organization together and steer it becomes the most important strength of the organization. However, the frequent changes and instability of leadership have affected the stability of the organization. With regards to the role of the Board of Directors, it was believed by the respondents that the Board remains less involved in steering than it should be, involving itself in functional more than governance issues. Additionally, the lack of communication from the Board to organizational members was found to lead to confusion over the organization's direction. HMC management is fully aware that the Board needs support to fulfil their board functions and is planning to assist the Board through legislation, defining Board terms of references and ensuring proper information flow to the Board.

Some of these weaknesses identified are problem areas generally associated with hospitals. High levels of centralization, multiple lines of authority and coordination difficulties have been generally associated to the complex characteristics of hospitals

(Georgopolous and Mann, 1962; Georgopolous, 1972). The other identified weaknesses- weak organization of work processes, poor information flow, weak human resources calibre and management, lack of planning and lack of controlling mechanisms- seem to be organization specific and not directly related to the characteristics of hospital structures.

When evaluating the structure by the two purposes of organization design proposed by Shortell and Kalzuny (1983) we notice already at this stage of the research major shortcomings. The first purpose was effective coordination and integration of tasks and findings indicate lack of coordination and 'fragmentation of the management process'. As for the second purpose, to monitor and respond to the environment via communication, information and control mechanisms, findings indicate poor information flow and lack of monitoring and controlling mechanisms.

Many respondents were of the opinion that the organization needed restructuring and reorganizing. The areas most cited for improvement were; decentralization to hospitals and departments, planning activities, improving work processes, improving the calibre and ethics of staff, reducing the size of the corporation or committees and finally holding staff accountable.

The issues of improving planning activities and work processes will be explored in the section on organization and organizational processes. The desire to decentralise is understandable considering the frequency that centralization has been brought forth by respondents throughout this research. The desire to reduce the size of the organization or committees is understandable considering the findings on the previous chapter on the evolution of the corporation and the amount of committees. The desire to improve the calibre and ethics of staff goes in line with the nature of health work whereby staff skills are vital. Finally, the desire for holding staff accountable is one of the contradictions identified by Georgopolous (1972) whereby there is a need for clarity of accountability versus a desire for work autonomy.

7.2.3 Professional structures

The structures of the medical, nursing and administrative professions are studied and contrasted by exploring documents on their respective structure and responses to interview questions.

7.2.3.1 *Medical organizational structure*

The medical organizational structure is twofold. It is characterized by clinical autonomy where clinical patient management decisions are left to the discretion of the doctor yet it has an administrative hierarchy. Some doctors at HMC felt that the administrative hierarchy is highly centralized.

> *'Clinical patient management is my decision. The other issues are too centralized and should be decentralized. Administrative issues need to be approved by the proper person first. Some of these should be decentralized and done without prior approval.' (44 HGH MED)*

Others felt that this level of centralization is necessary and appropriate.

> *'Decisions that are centralized are those that need inputs. I don't see decisions that are centralized. Its right.' (55 HGH MED)*

Chart 7.1 is a standard medical department's organization structure in the corporation. The chairman is generally supported by four groups or individuals; the assistant chairman, the chief of residents, the committees and the secretariat. The medical staff are then divided into specialities and subspecialties whereby they are organized by units headed by consultants.

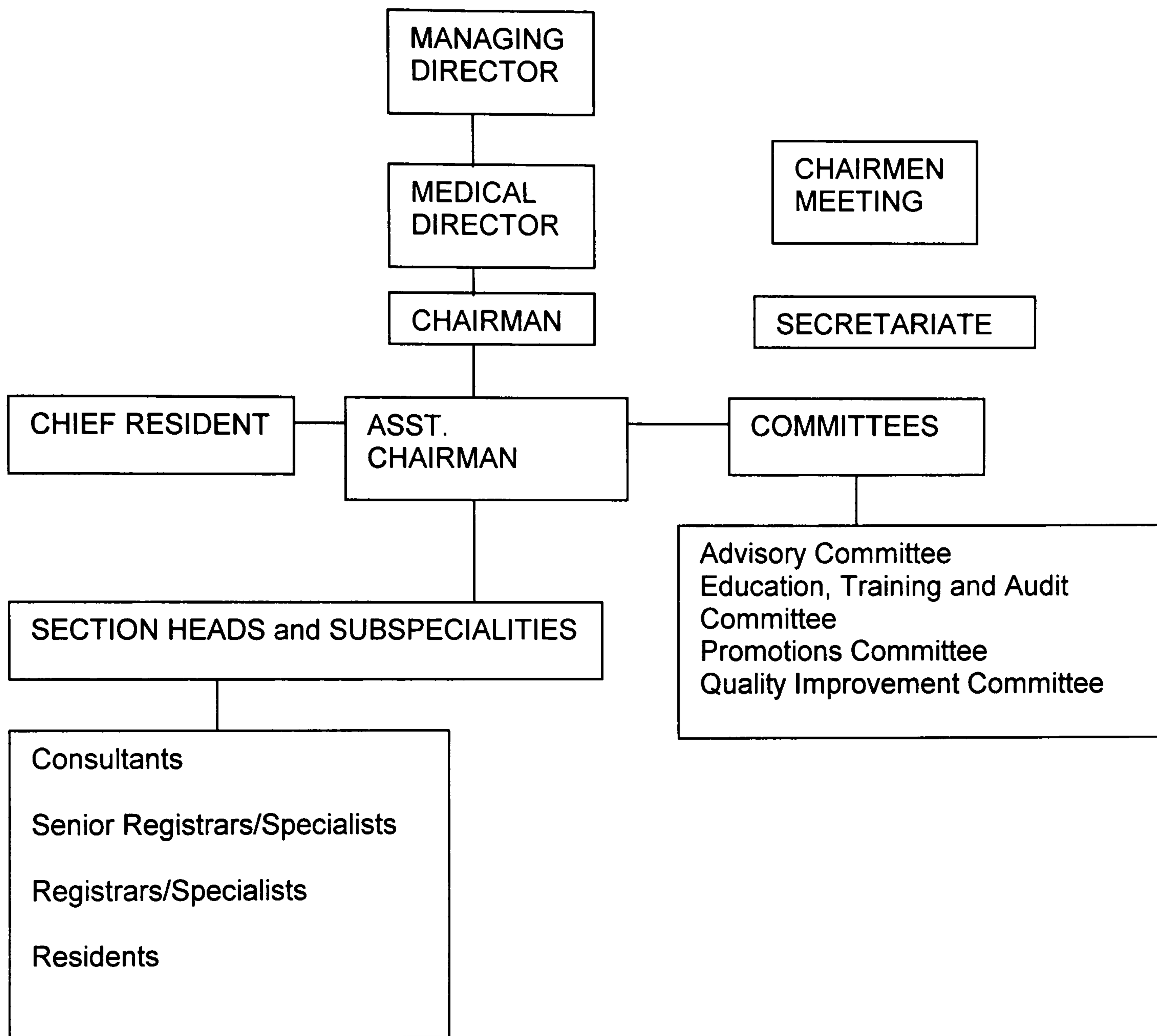
The Chief of Residents handles the organizing of residents and the committees support the department by providing a body for decision making. This results in a duality of decision making structures. One at the specialities and subspecialities and the other , more centralized at the committees level. Some doctors appreciate this centralized decision making body.

> *'Decision making in the department of surgery is a committee decision. Each unit has its committee which looks at staff divisions etc. sending patients abroad, budget approvals and daily events. Things are first approved at the unit committee.' (91 HGH MED)*

Others view the committees as restrictive and would prefer more decision-making freedom.

> *'More freedom to organize my work within the framework of department is needed without having to go back to the committees. Decisions on how to do my work should be decentralized.' (44 HGH MED)*

Chart 7.1Standard Medical Department Structure of HMC, *Illustrating duality of decision-making structures*



Adaptation from Paediatrics, Obstetrics and Gynecology, Surgery, Dentistry, Medicine, Dermatology Department Structures

Most doctors felt that their structure could be improved by having more sections and subspecialties than they do presently but the high workload on the departments is making it difficult to create subspecialties.

'The structure is not yet effective. We are and can still improve it.... We need to create subspecialties and follow up its benefits. We need more sections and subspecialties to work better and provide better care.' (12 WH MED)

Originally there were only three categories of medical staff: consultant, registrar/specialist, and residents. However, as the organization grew and the number of medical staff increased a new post, senior registrar/specialist was created in order to accommodate for the large number of specialists within the limited budget. Most medical staff welcomed this change but a small minority found that this change lengthens the period that a doctor remains registrar unnecessarily.

'From the medical side the structure is effective. But we have four categories of medical staff: consultant, senior specialist, specialist, and registrar. The structure should be: consultant, registrar and resident. Now with senior specialist it creates problems. It makes the period of registrar longer. Should be 3 categories only but for that we need to improve the salary for registrars.' (91 HGH MED)

Most chairmen and senior doctors expressed a concern that the existing department structures do not encourage smooth workflow, rather, that they encourage conflict.

'The present structure causes inconvenience and irritability in budgeting and staffing. The nursing, clerical staff and medical staff are separate. This automatically leads to conflicts' (58 HGH MED)

Some felt that a more constant and permanent administrative presence in the department would be better.

'At each department an administrative advisor for the chairman would be needed. A lot of medical staff don't know the administrative rules in the corporation and make unintentional mistakes.' (53 HGH MED)

Others have recommended that their departments be structured more in the form of a clinical directorate with a chairman, administrator and head nurse responsible for the department.

'We don't have a group running the department. It should be chairman- one administrator– nurse. A committee run by the chairman and weekly meeting should run the department. Presently everyone reports to others, e.g. nurses ask for their

own equipment, I ask for my equipment, etc.. its not organized. A group to run all administrative issues in the department is needed. This would be the ideal structure.' (81 HGH MED).

In conclusion, the medical structure was found to be twofold; an administrative hierarchy together with clinical autonomy. With regards to the administrative hierarchy, many found it to be highly centralized but others felt that this level of centralization was necessary and correct. The standard medical department's structure at HMC is composed of four groups; the chairman supported by the assistant chairman and secretariat, the chief of residents who organize the residents, the decision-making committees and finally, the medical staff organized by units headed by consultants.

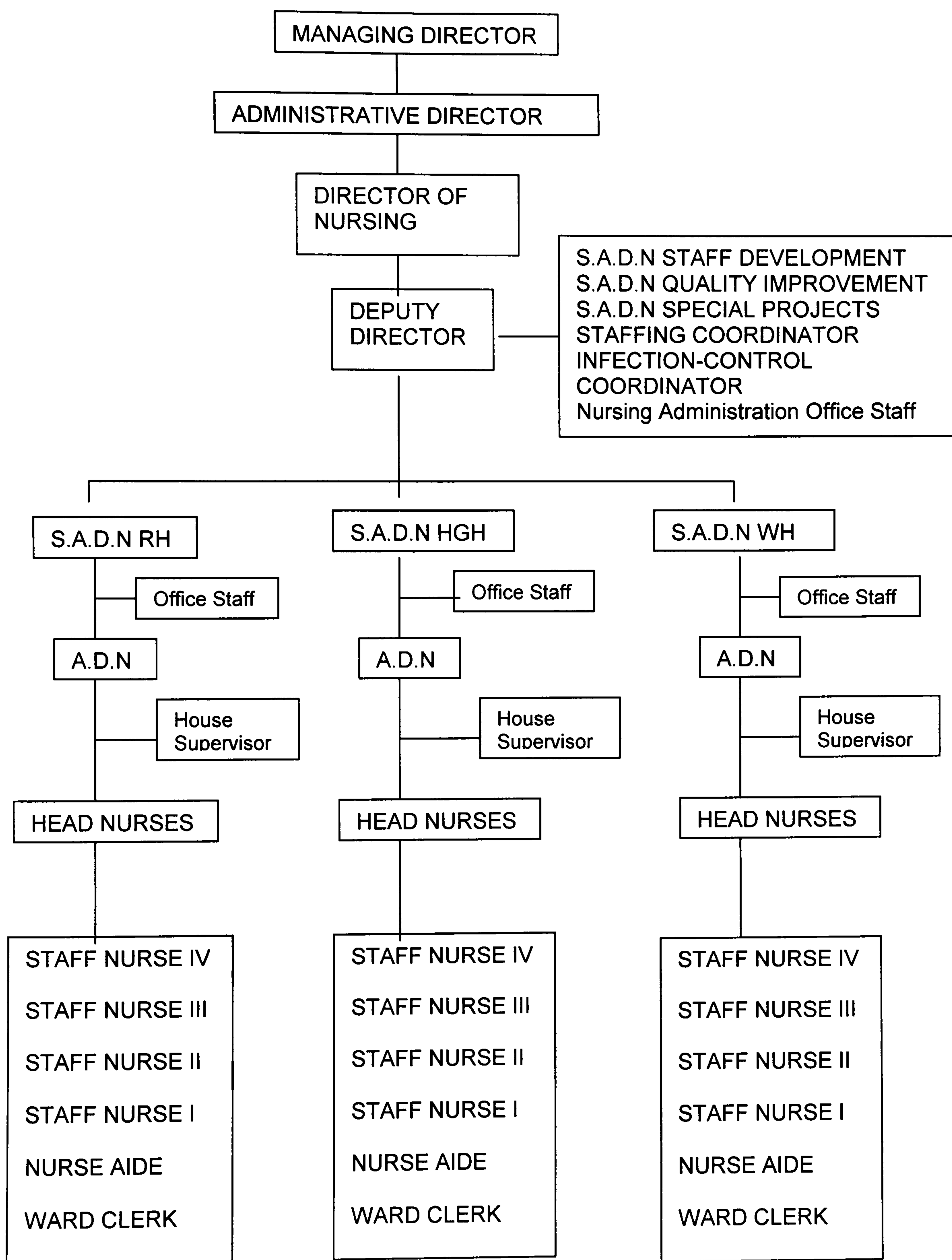
Some doctors appreciated the centralized decision-making through committees. Others found it too restrictive preferring more decision-making freedom. Most doctors felt that their structure could be improved by having more sections and subspecialties. Finally, chairmen expressed the concern that existing department structures, which have separate medical, nursing and administrative hierarchies, encourage conflict. It was believed that permanent administrative presence or a chairman-administration-nursing trio leadership would improve coordination.

Thus it would seem that the medical structure decision making bodies (committees) may facilitate decision making but they also promote centralization, placing medical staff in a position whereby they experience clinical autonomy on one side and restrictive administration on the other. Additionally, there is a simultaneous desire for more specialization at the operational level and multi-professional management and decision-making. This confirms the trend identified in Chapter Six towards a more clinical directorate model of managing departments.

7.2.3.2 *Nursing organizational structure*

Chart 7.2 is the Nursing Department's organizational structure. The Director, Deputy Director and Nursing Administration Office are at the Corporate Level. At the Hospital levels, there are Senior Assistant Directors of Nursing (S.A.D.Ns) for each hospital supported by Assistant Directors of Nursing (A.D.N.s), House Supervisors, and Office Staff. The hospital services are then organized by units headed by the Head Nurse. Similarly to the medical structure, the numerous committees in the nursing department take on a decision-making role.

Chart 7.2 Nursing Organizational Structure, *illustrating bureaucratic hierarchy.*



Main Committees: Nursing Executive Committee, A.D.N Hospital Level committees, Head Nurses committees and Unit committees.

As was noted in Chapter Six when exploring structural change[61], the nursing structure has been described as one that has a fixed and rigid hierarchy.

> *'We have our line of authority. We have very fixed and rigid lines of authority and everyone is expected to follow them.' (19 RH NUR)*

The nursing structure is one that relies heavily on rules, regulations, policies and practices.

> *'We have basic standard practices and policies. We have to work within the guidelines. If the guidelines support me I can take decisions. Otherwise I seek permission.' (74 HGH NUR)*

These policies are used as a means to control.

> *'We control our items and stock properly and within budget. We don't have a say in selection of staff and exit but as far as staff duties and discipline it is very strongly controlled.' (4 WH NUR)*

As these policies and practices are most important for running such a large number of staff, the nursing department is generally well organized in reviewing and upgrading these policies and practices.

> *'Yes we feel very organized. We keep a yearly study of our department where we review our practices and organization. We seek improvement.' (71 HGH NUR)*

As a result of these tight control measures the nursing department has been perceived by other hospital professions as being too bureaucratic.

> *'I don't think that the existing structure of nursing is inefficient, only too much paperwork. This indirectly defects your manpower allocation. Suppose I want to change it I cant as I'm from the medical side. Its their own empire, like they cant interfere in our empire.' (8 WH MED)*

The fixed and rigid hierarchy and the tight control through policies and practices have created a feeling of high centralization among nursing staff.

> *'I feel its very centralized. There are decisions that we need to go back to them (superiors) but need not necessarily to.' (18 RH NUR)*

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[61] See Chapter Six; Section 6.4.3.2, p. 170-171.

'At each hospital, we the S.A.D.N.s, have the full authority of each hospital. It shouldn't be that I have to get approval for everything from the Director Of Nursing. Only the things that she needs to know for her information. If a decision has been taken by the A.D.N.s and S.A.D.N.s why does it have to be approved by the Director of Nursing? If these cant take decisions why are they there.' (9 WH NUR)

The Corporate Nursing Administration is aware of the high centralization and is working on decentralizing decision-making but this involves training the S.A.D.N. and A.D.N. before this can be done.

'I'm working on decentralization of work. The structure is going more towards matrix now. I aim to achieve that people have their specialization and I am leader/supervisor/guidance provider to those people. We started the system but people were not given the opportunity to make decisions. Decisions remained at the top. This year we are working on changing the foundation first so that the corporation does not collapse. S.A.D.N.s are made accountable and responsible for decisions and hiring and firing. Before recruitment and selection was being done at Corporate Nursing Administration. Now the S.A.D.N.s are involved in recruitments and are responsible for recruitment and termination decisions, not the nursing administration.
I'm trying to train S.A.D.N.s in management and leadership skills. The S.A.D.N.s are not trained in this. I'm trying to develop courses. Services are improving, growing in the process, but the staff do not understand the concept of decentralization.' (38 HMC NUR)

As well as decentralization to the S.A.D.N level it is felt that an effort is needed to decentralize to the Head Nurse level.

' The staff at the lower level have no decision making at all or very little. All the decisions are in the hands of the A.D.N. and S.A.D.N., when it is them (the head nurses) who know all the work. Even for the most petty things, the approval of the A.D.N. is needed. Since we allow in her (the head nurse) hand a big amount of budget it is contradictory to control her tiny things like sick leave. And the A.D.N and S.A.D.N. should focus on planning, etc... Day to day work should be left to staff nurse levels. Today A.D.N., S.A.D.N. and all other staff look at day to day.' (11 HMC NUR)

Most senior executive nurses interviewed believed that the categorization of nurses is an inaccurate reflection of reality. The lower staff levels have the same functions and separate categorization at these levels is viewed as unnecessary.

'There are certain things that need to be restructured. For example, the levels/categories of nurses. The chain is too long. I would like to cut it shorter. This will facilitate accuracy and speed of information decision-making. As the lower posts, SN1, 2,3 and, 4, have the same job description separate categorization is not needed. (11 HMC NUR)

Some others find this categorization very organized and good for proper accountability.

'Very organized. Staff nurse level is good. It enables accountability at the right levels.' (24 RH NUR)

In units where working loads are heavy and where high medical, nursing and administrative interaction is needed, nursing staff have expressed a desire for departments to be managed by a doctor, nurse and administrator team, in which the doctor heads the department.

'The department needs restructuring. There should be a medical person in charge with or without an administrator. An administrator is only needed part time. This is an ambulatory care unit and needs medical care supervision with a multi-professional team. It needs a strong medical leader to regulate all the unit's work.... It has not been thought of and well planned. I think its because they don't involve the right people in the planning.' (101 HGH NUR)

'This department should be a team of nursing, administration and medical director.' (38 HMC NUR)

Thus, to summarize, findings indicate that the nursing structure is one of rigid bureaucratic hierarchy. It relies heavily on rules, regulations and policies and practices to control the large workforce. Nursing is also well organized in reviewing and upgrading these policies and procedures. As a result of these tight control measures and rigid hierarchy, nursing is perceived by other hospital professions as being too bureaucratic.

Similarly, internally, there is a feeling of high centralization in the nursing department. Pressure to decentralizes can be witnessed at two levels. First, from top to down by decentralizing to the S.A.D.N., A.D.N. and Head Nurse levels. Second, by reducing the hierarchy. The levelled categorization of staff nurses has been criticized as not reflecting reality and being unnecessary. It was believed that having one staff nurse level would improve communication and decision making speed and accuracy.

Finally, as with the medical staff, in department where high medical, nursing and administrative interaction is needed, nursing expressed a desire for departments to be managed by a doctor, nurse and administrator team headed by a doctor.

7.2.3.3 *Administrative organizational structure*

Chart 7.3 is the Administrative organizational structure at HMC. At the Corporate Level the Administrative Director is supported by the Assistant, the Assistant for Special Projects and the Assistant for Support Services. The seven Corporate Departments also report to the Administrative Director. At the hospital level, each hospital has an Assistant Hospital Director, and at least one Assistant for Administration. Where Corporate Departments have decentralized their sections to the hospitals, the section heads and clerical staff report to the Assistant Hospital Director e.g. Outpatient, Admitting, Public Relation, Emergency.

Two fundamental problems identified by interview respondents are; the unclear role of administration in the organization and the lack of administrative authority. There is an interface between the administrative and medical roles at the corporate level and the hospital level.

> *'Area of interface between medical and administration directors that lead to conflict are; hiring and firing of medical staff, involvement in issues related to medical staff and procurement of equipment' (39 HM LEGAL)*

> *'There is no clear role segregation between administration and medical at hospitals level.' (113 HMC ADMIN)*

Between the different levels of administrators, the Assistant Hospital Director and the Assistant for Administration, there is no clear segregation of roles.

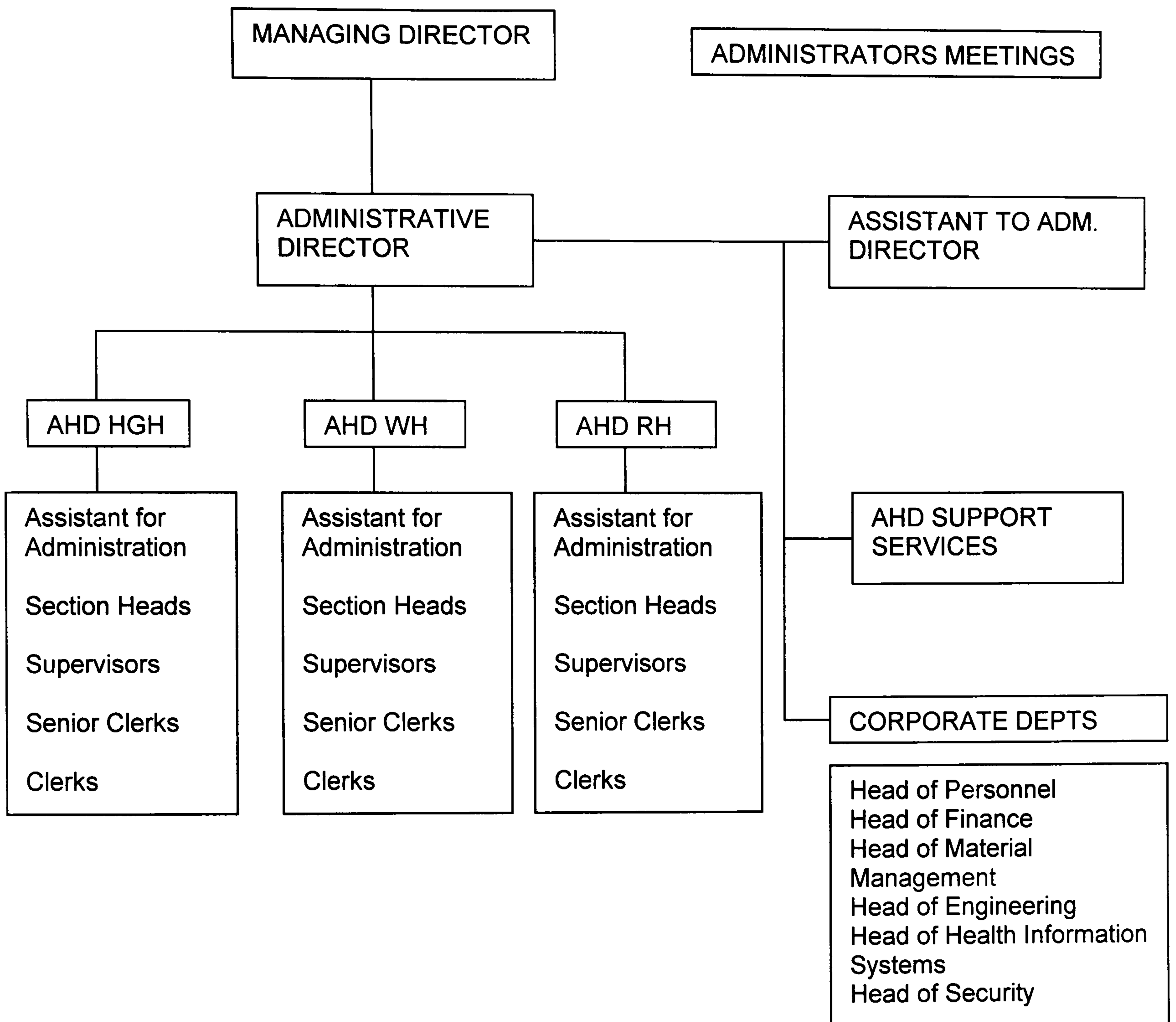
> *'The same job description for the administrator and assistant for administration leads to people doing the same jobs' (113 HMC ADMIN)*

Administrators do not really know what their role and job description are and have been learning based on experience. They are sometimes confused as how work should be conducted.

> *'I came here not knowing my role or job description. We each built up our experiences based on our past. We were not oriented at arrival.' (107 HGH ADMIN)*

> *'Most everything requires approval. It is not clear what are within my decisions and what requires approval. Minor issues could go to Administrative Director. In general we are not authorized to take decisions. Most things require approval of the Administrative Director. There is no clear system on which to work.' (107 HGH ADMIN)*

Chart 7.3 Administrative Organizational Structure



Other professions have a different perception of what the administration's role should be.

> *'There are big conflicts with administration, e.g. on salary grade. Administration has higher grades than doctors although they are less qualified. Some administrators feel they should run the hospital. Their role is to make a proper atmosphere for us, not to run the hospital. They even select equipment. This is not right. Also the concept that quality is costly. The concept for them is containment, not patient care' (81 HGH MED)*

Middle and junior administrators' role and authority in the organization has been described as very weak; the administrator has a more middleman role and real authority is centralized with the Administrative Director.

> *'Too much bureaucracy, so much paperwork. .... Administration is only re-approving, a middleman. Sometimes the word of the medical director is more powerful than the word of the administrator. He cannot really disapprove. This could be because of lack of knowledge on medical equipment. It comes with experience. Now we are doing more the role of the middleman, passing down papers. Administrators are getting more experienced and better but they are still the middle men.'(79 HGH ADMIN)*

> *'I should be involved in meetings and things related to our area. Projects are handled from top and given to us at the end to implement. We should work as a team, we should talk to each other over everything. Now we don't know what is going on. Some departments trespass us and go directly to the Administrative Director or Medical Director and those listen to them. We try to stop them but cannot.' (107 HGH ADMIN)*

The centralization of decision-making and information has left the administrators in a weak position whereby their image has been affected.

> *'We don't get all the information. Some information we get as orders. This is all a result of centralization and lack of planning. We should know everything going on as administrators but we know nothing. This reflects badly on us with other departments. When other departments ask something we say, "we don't know" and they then look down at us that we don't do our job.' (109 HGH ADMIN)*

> *'Administration are there but don't do anything, they don't support. You go to them and they can't help'. (78 HGH NUR)*

Although some administrators found that there was no centralization; *'we are involved in everything related to our unit. We have a lot of decentralization in this area. We take a lot of our own decisions and have freedom,'(102 HGH ADMIN)* the majority found that the administrative structure of the corporation is too centralized.

> *'Our job description is totally different from what we do. The management is unfortunately totally centralized. They did try to decentralize our hospitals before but it is now not working.' (109 HGH ADMIN)*

Finally, many respondents found that it was important to strengthen the administrators position and increase his authority. The medical profession albeit finding that the administrators lacked the depth of knowledge needed to run the corporation, found that it is important to strengthen the administrators position and give him more authority at the hospital level.

> *'If you have an administrator you need to strengthen his position. There is no real authority with administration. We cannot work in harmony, when he and the chairman may not be talking the same language or when the administrator does not have the authority or depth of knowledge. Like you have an administrator responsible for everything in HMC, have one responsible for everything in the WH.' (8 WH MED)*

Hence, when exploring the administrative structure two fundamental issues came out importantly. First, the unclear role of administration. Second, the lack of administrative authority which is linked to the level of centralization.

With regards to the unclear role of administration, interview responses indicated the existence of an interface between the administrative and medical roles at the top and middle levels (corporate and hospital levels). There was no clear distinction between the roles of the middle and junior administrators (Assistant Hospital Directors and Assistants for Administration). Finally, there are no role and job descriptions and administrators have been learning through experience.

With regards to administrative authority, the authority of middle and junior administrators has been described as weak, more of a middleman, with real authority being centralized with the Administrative Director. The centralization of decision-making and information has left the administrators in a weak position whereby their image has been negatively affected. Many respondents, including medical staff, found it important to strengthen the administrator's position and increase his authority, especially at the middle level (hospital administrators).

7.2.3.4 *Professional boundaries*

We will first explore the professional boundaries between the medical, nursing and administrative profession at corporate, hospital, and departmental levels and the reasons behind interfaces of boundaries. We will then compare these interfaces with respondent's perceived appropriate levels of interface. Finally, we will see how the empirical findings relate to Greenwell et al.'s (1994) conceptual models of professional relationships.

As seen in the previous section, there seem to be areas where the boundaries between the medical, nursing and administrative professions blur. This can be noticed at both the corporate, hospital and departmental levels. Respondents found that, at the corporate level, there was confusion between the roles of nursing and administrative staff and the roles of medical and administrative staff. These confusions of roles have resulted in conflicts which it was felt could be resolved by role allocation. *'(...) To reduce conflict, these issues, as well as technical matters of procurement e.g. specifications, should be left to the medical staff. The rest administration should handle, e.g. all financial and personnel issues related...' (39 HM LEGAL).* However, from the interviews there did not seem to be any confusion between the roles of the medical and nursing staff at the corporate level.

At the hospital and departmental level these confusions in professional boundaries seem to escalate. As with the corporate level, there is confusion on the role and boundaries of nursing and administration but these, as some respondents reported, were linked to unclear decentralization of corporate responsibilities to hospital and departmental levels. There was also mention of confusion between the roles and boundaries of the medical and administrative staff.

> *'With administration the lines of responsibilities and authorities are not clear therefore there are arguments and misunderstandings. These can be minimized by clear demarcation of where administration responsibilities begins and mine end.' (56 HGH MED)*

Although no one has mentioned a direct confusion between the nursing and medical staff boundaries, it is implicit at the hospital and departmental level.

> *'Here the conflict is because there is no organization structure within the department. Everyone steps on one another. There is no clear role separation between administration, nursing and medical. This can be minimized by clarifying the roles of each in the organization structure (of the department) and circulating information. (101 HGH NUR)*

The reasons given for these unclear boundaries range from lack of applied job descriptions to lack of clarification of roles and responsibilities.

> *'The absence of proper guidelines and clear boundaries has made it possible for conflicts to arise. Conflicts are mainly related to roles and responsibilities. They can be minimized by having job description, proper delegation of responsibilities and mechanisms to control the way of thinking e.g. code of conduct and ethics to try to control behaviour and attitude of others…' (41 HMC NUR)*

As was noted earlier employees at all levels and professions are not provided with accurate job descriptions or descriptions of roles and responsibilities. They are all employed on contracts that do not specify the work required of them. *(Medical Staffing at HMC, Report, 1994*). In the absence of clear boundaries the professional boundaries seem to shift in favour of the most politically powerful.

> *'The organization structure as it is depends on the power and support the medical or administrative director gets. In the past we had waves in which at one point medical staff had more power and authority and the next the administrative director. It all depended on the strength of each and the support they got from the Managing Director or Minister Of Health. When one was weak the other would take over.' (61 HMC QM)*

Thus it would seem from interview respondents that at the corporate level there was confusion between the roles of medical and administrative staff and nursing and administrative staff but not between medical and nursing staff roles. At the hospital and departmental levels confusions and boundaries interface escalated between all three professions. The reasons for the confusion of boundaries that emerged through empirical work were unclear decentralization of corporate functions to hospitals, lack of applied job descriptions and clarification of roles and responsibilities. Within this context of boundaries and role confusion the organization became ground for a power dominance struggle where the most politically affiliated dominates.

In the questionnaire respondents were asked what they considered should be the professional boundaries between medical, nursing and administration. We first explore the perceived ideal level of medical involvement in management at the corporate level. Table 7.5 Medical Staff Involvement in Corporation's Management indicates that the majority (43 percent) felt that medical staff should be 'involved in particular issues'. The second highest group (30 percent) found that they should be 'highly involved'. However, there were significant differences in responses by profession.

Table 7.5 Medical Staff Involvement in Corporation's Management

Professions	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
Medical Staff	14	7	4			**25**
Percentage	*56%*	*28%*	*16%*			***100%***
Administration	4	4	5			**13**
Percentage	*31%*	*31%*	*38%*			***100%***
Nursing	12	21	37	2	5	**77**
Percentage	*16%*	*27%*	*48%*	*3%*	*6%*	***100%***
Paramedical	2	4	3			**9**
Percentage	*22%*	*44%*	*33%*			***100%***
Therapy	1	3	5			**9**
Percentage	*11%*	*33%*	*56%*			***100%***
Support Services	4	1	5			**10**
Percentage	*40%*	*10%*	*50%*			***100%***
Corporate Departments		11	15	1	1	**28**
Percentage		*39%*	*54%*	*4%*	*4%*	***100%***
Total	**37**	**51**	**74**	**3**	**6**	**171**
Percentage	***22%***	***30%***	***43%***	***2%***	***4%***	***100%***

Question: To what extent do you think medical staff should be involved in the Corporation's Management?

The majority of administration (38 percent), nursing (48 percent), therapy staff (56 percent), support services (50 percent) and corporate department staff (54 percent) found that medical staff should be 'involved in particular issues' of management. The majority of the paramedical staff (44 percent) found medical staff should be 'highly involved'. Finally, the majority of the medical staff (56 percent) found that medical staff should be 'very highly involved' in the corporation's management.

As for medical staff involvement in their department's management, Table 7.6 Medical Staff Involvement in Department's Management indicates that the majority (40 percent) found that they should be 'highly involved' with no significant variations by hospital or profession.

Similarly, the majority (49 percent), Table 7.7 Nursing Staff Involvement in Corporate Management, believed that nursing should be 'involved in particular issues' of corporate management but 'highly involved' (40 percent) in the department's management, Table 7.8 Nursing Staff Involvement in Department's Management.

Table 7.6 Medical Staff Involvement in Department's Management

Hospital	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
HGH	18	27	15		2	**62**
WH	11	12	11		1	**35**
RH	11	9	6	1	2	**29**
CDs	7	20	17		1	**45**
Total	**47**	**68**	**49**	**1**	**6**	**171**
Percentage	***27%***	***40%***	***29%***	***1%***	***4%***	***100%***

Question: To what extent do you think medical staff should be involved in their department's management?

Table 7.7 Nursing Staff Involvement in Corporate Management

Hospital	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
HGH	13	19	24	4	2	**62**
WH	4	9	22			**35**
RH	6	6	14	2	1	**29**
CDs	4	12	24	4	1	**45**
Total	**27**	**46**	**84**	**10**	**4**	**171**
Percentage	***16%***	***27%***	***49%***	***6%***	***2%***	***100%***

Question: To what extent do you think nursing staff should be involved in the Corporation's management?

Table 7.8 Nursing Staff Involvement in Department's Management

Hospital	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
HGH	24	23	13		2	**62**
WH	11	16	8			**35**
RH	11	10	6	1	1	**29**
CDs	10	19	14	1	1	**45**
Total	**56**	**68**	**41**	**2**	**4**	**171**
Percentage	***33%***	***40%***	***24%***	***1%***	***2%***	***100%***

Question: To what extent do you think nursing staff should be involved in their department's management?

As for administration, the majority believed that administration should be 'involved in particular issues' of clinical matters (50 percent), Table 7.9 Administration Involvement in Clinical Matters, and nursing matters (52 percent), Table 7.10 Administration Involvement in Nursing Matters. However, there were significant variations by hospitals in the believed appropriate level of administration involvement in nursing matters. The majority of respondents from HGH (60 percent) and corporate departments (69 percent) believed that administration should be 'involved in particular issues'. However the majorities of WH (49 percent) and RH (38 percent) believed that administration should be 'highly involved' in nursing matters.

Table 7.9 Administration Involvement in Clinical Matters

Hospital	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
HGH	7	17	33	3	2	62
WH	8	10	13	3	1	35
RH	3	7	11	6	2	29
CDs	1	11	29	2	2	45
Total	**19**	**45**	**86**	**14**	**7**	**171**
Percentage	***11%***	***26%***	***50%***	***8%***	***4%***	***100%***

Question: To what extent do you think administration should be involved in clinical matters?

Table 7.10 Administration Involvement in Nursing Matters

Hospital	Very highly involved	Highly involved	Involved in particular issues	Not involved	Missing	Total
HGH	7	15	37		3	62
Percentage	11%	24%	60%		5%	100%
WH	4	17	12	2		35
Percentage	11%	49%	34%	6%		100%
RH	3	11	9	4	2	29
Percentage	10%	38%	31%	14%	7%	100%
CDs	1	10	31	1	2	45
Percentage	2%	22%	69%	2%	4%	100%
Total	15	53	89	7	7	171
Percentage	9%	31%	52%	4%	4%	100%

Question: To what extent do you think administration should be involved in nursing matters?

Overall, questionnaire responses indicate that organization members perceived that at the corporate level nursing and medical staff should be 'involved in particular issues' of the corporation's management. But the paramedical and medical staff perceived that medical involvement in corporate management should be high or very high. At the departmental level a higher level of involvement was expected whereby the majorities believed that medical and nursing staff should be 'highly involved'.

Similarly, administration was aspired to be 'involved in particular issues' of clinical and nursing matters. More administrative involvement was aspired for in nursing matters in the WH and RH. These findings would seem to indicate that a certain level of interface, or common areas was perceived to be good and that this interface increased as one goes down the organization hierarchy.

When relating the findings to Greenwell et al.'s (1994) models of professional relationships one can find relevance to the first and third models. Historically, the organization studied is one where nursing, medicine and administration have their own hierarchical structures and spheres of influence. Restructuring attempts have tried to

horizontally organize multiprofessional teams and shift professional relationships to interdependency in some common areas. Thus shifting from model one to model three.

This shift is one that is welcomed by organizational members as their questionnaire responses indicate that they aspire for certain levels of professional boundaries interface which increases at the operational levels.

However, as the restructuring attempts have not been carried through completely, the shift from one model of relationship to another was not complete. There are unclear instructions on decentralization, no job descriptions and unclear roles and responsibilities. The result is a confusion of professional boundaries and relationships. One that, understandably, becomes more acute at the operational levels.

Greenwell et al. (1994) also note that in the third model the centre of the relationship is a struggle for position and power. This is apparent in the power struggle at HMC between the administrative and medical director for obtaining power and authority through political support from the Minister or Managing Director.

7.2.3.5 *Conclusion on professional structures*

Although there are distinct differences in the structuring of the medical, nursing, and administrative staff, two similarities stand out importantly; the high levels of centralization and the desire to incorporate multi-professional management at the department levels. The high levels of centralization have been mentioned throughout the study and the desire to have multi-professional management was already apparent in the Chapter Six where it was noted that restructuring attempts tried to incorporate multi-professional management.

With regards to the medical structure, the decision making bodies (the committees) were viewed as facilitating decision making by some but, more often, as promoting centralization placing medical staff in a position whereby on one side they experience clinical autonomy and on the other restrictive administration. This confirms the contradiction noted by Georgopolous (1972), the need for clarity of accountability versus the desire to maintain work autonomy by professionals. Existing clinical departments' structures, which have separate medical, nursing and administrative hierarchies, were found to encourage conflicts and there was a desire for multi-professional management and decision-making. This suggests a realization that coordination could be improved by structuring subunits so that activities within that subunit are as homogenous as possible

(Thompson, 1976). Finally, there was a desire for more specialization at the operational level. The desire for higher specialization as well as the coordination problems with the administrative and nursing hierarchies illustrate the difficulties in balancing specialization and differentiation in hospitals.

The nursing structure was found to be one of rigid bureaucratic hierarchy relying heavily on rules, regulations and policies for control. The result of these tight control measures and rigid hierarchy was that nursing was perceived, by other professions, as being too bureaucratic. This confirms research describing the nursing structure as centralized and bureaucratic with tight formal policies and control mechanisms (Greenwell et al., 1993). Internally, pressures to decentralize and reduce the hierarchy (reduce the levels of nurse categories) were underway. Finally, as with the medical staff, there was a desire for departments to be managed by a doctor-nurse-administrator trio headed by a doctor indicating a trend toward clinical directorate models of structuring medical units (Disken et al., 1990; Packwood et al., 1992; Brady and Carpenter, 1986).

The situation differed with the administrative structure where two issues came out importantly. First, the unclear roles of administration. There was no clear distinction between the roles of the administrative and medical top and middle level staff, nor between the roles of the middle and junior administrators. Additionally, there were no role or job description for administration. Unclear distinction of roles is problematic in hospital settings where there are multiple lines of authority and high interdependence of services (Georgopolous and Mann, 1962). In such settings, clear distinction and mutual understanding of roles and functions is important (Georgopolous, 1972).

Second, there was a lack of administrative authority with the middle and junior administrators due to the high centralization levels. This has negatively affected the authority and image of administration within the corporation and many respondents found it important to strengthen the administrator's position and authority.

First with regards to professional boundaries, working on Greenwell et al.'s (1994) model of professional relations, evidence of a shift in professional relationships from separate structures and spheres of influences to interdependency in some common areas was found. This shift has been encouraged by structural changes as well as an aspiration for interface of professional boundaries (through multi-professional teamwork) that increased at operational levels. Findings indicate that unclear definitions of roles and responsibilities of the different professions result in confusion of boundaries and increased conflicts,

which again reinforces Georgoplous's (1972) emphasis on the importance of mutual understanding among organizational members about one another's roles, work problems and needs.. Finally there seems evidence to support the claim advanced by many (Parsons, 1954; Friedson, 1970; Greenwell et al. 1994, Bettner, 1987; Dawson, 1994; Stewart, 1989) that the relationship between the medical and administrative profession is a struggle for power and authority. This supports the argument that the professional-bureacratic conflict is generally a problem of organizational control and coordination (Overtveit, 1988; Flynn, 1992; Davies, 1984; Begun et al., 1990; Dawson, 1994; Benson, 1973; Engel, 1970) that requires the application of power and politics theoretical perspectives rather than theoretical debates around the ideologies of professionalism.

7.2.4 Hospital structure

As the evolution and development of the hospital structures has been studied in Chapter Six, this section explores the hospital structures at the time of research. The study of the evolution of the hospital structures revealed that managerial efforts were underway to reinforce administrative presence in hospitals, define their managerial functions, and decentralise corporate services. However, decentralization of corporate services has proven to be difficult and issues of the problems of centralized corporate services were constantly brought for discussion by the Assistant Hospital Directors at the Administrative Meetings *(Administrative Meetings, January 1998 and March 1998)*.

The Administrative Director is constantly exploring with the Corporate Departments the possibilities of decentralizing corporate services; *'The routine issues and daily supervision will be the responsibility of each hospital director. The system development, training, recruitment, evaluation of offers will be the responsibility of concerned Assistant Hospital Directors.' (HMC, Administrative Monthly Meeting, March 1998).* It seems from interview responses that there are two main power conflicts. The first, between corporate level and hospital level staff and the second, internally for the leadership of the hospitals.

7.2.4.1 Hospital-corporate power conflict

Interview responses reveal the presence of a conflict of interests between corporate staff and hospital staff. Some corporate staff oppose or resent the decentralization of some of their authority to hospital level staff while hospital staff strive to obtain autonomy.

Some corporate level staff felt that decentralization and withdrawal of the corporate administration's involvement in hospital management were some of the reasons for poor coordination and information flow downwards to staff and were thus against decentralization of hospitals

'In the past, the administrative director was very involved. Now with the present hospital devolution structure they are less involved. Management needs to be involved more in the hospitals...' (61 HMC QM)

Others admitted that it is much simpler for their corporate services to remain centralized.

'As for decentralization, it is difficult for us. I prefer not since I have sections in both hospitals and the primary health centres that report to me. It would be too inconvenient to have them report to the Administrator of each hospital. Rather they report to me and I report to one person.' (68 HGH PARA)

Some in Nursing Administration found that the type and level of issues to be decentralized were not clear and that there needs to be a restudy of the roles and functions of nursing administration and administration.

'There is a conflict of role between nursing administrators and administrators. The role of each is not clear. This is due to the lack of clinical knowledge by administrators. They make wrong decisions and it affects patient care. There is an interference with nursing duties at hospital level. On the corporate level, hospital administration want hospital nurses to report to them, they want centralized decisions in the hospitals. They do not understand what is decentralization. They want S.A.D.N.s to report to them and they take decisions, they want everything to go through them, and Corporate Nursing not to be involved in nursing issues at all (...). HMC's structure is not strong because the roles are not clear and this leads to conflicts.'(38 HMC NUR)

'The semi-independence of hospitals is causing conflicts. The Assistant Hospital Director for RH thinks he is everything and is frustrated and angry when the asst DN reports to her director. The same with the WH.' (77 HMC NUR)

However, the majority admit that the organization is too large for centralized management and its time to give autonomy to the hospitals.

'I feel there is some duplication in the corporate administration and hospital administration. Corporate administration encroaches on hospital administration e.g. Maintenance is centralized. The hospital is too big to be centralized e.g. Housekeeping should be at hospital level because of its link with infection control. (39 HM LEGAL)

Hospital level staff find that the hospitals look more decentralized on paper than they are in reality and this gives them a sense of frustration.

> *'It blocks one, does not leave one the freedom for decisions and action. Its very centralized and centralized decisions are selected on personal interests basis not on job description. The structure of HMC is mostly on paper, it looks good on paper but is not really like that. On paper the hospital is a team but in real it is independent one-man shows. And there are interferences from corporate directors all the time. Decisions are taken about my staff and areas and I'm the last person to know.'(9 WH NUR)*

> *'The invisible lines that are between the sections under RH and the main head offices are much stronger than on paper. They are direct and more efficient than the lines that coordinate them with us. Our structure is good on paper only. To make it better you have to be more realistic. Either show the structure as it is, recognise that there is a professional organization and social organization and make the job description for the people that are there and accept it, or decentralize sections to report to administration.' (16 RH ADMIN)*

It seems to hospital staff as though corporate management is not sure if they do want to decentralize.

> *'It is not decided if they want to go through decentralization. We don't know our roles with their departments. We tell them something while their boss tells them something else' (16 RH ADMIN)*

Medical chairmen specially resent that they have no decision-making authority and that decision-making is still centralized by corporate management.

> *'I have no decisions. Corporate management takes the simplest decisions completely. I would like to be involved in the decision-making regarding my sections but I'm not involved.' (14 RH MED)*

> *'The problem is they don't show us or involve us in issues. The chairman is not involved because of the centralization. I think that the structure is not good, there has been no input from the departments. (81 HGH MED)*

Also, dual reporting/orders whereby the department reports to the Assistant Hospital Director and to their Corporate office has been found by respondents as the fourth most important reason for conflicts (mentioned 12 times / 138 responses) at HMC.

7.2.4.2 *Power conflicts for hospital leadership*

The second power conflict is for leadership of the Hospital by the administrative and medical staff. The AHD is having a hard time asserting his authority as Hospital Director within the hospital.

> *'You need to have your superiors recognise you as captain of the ship, but here at RH there is no captain. Everyone is a captain and superiors have been very biased towards them, supporting them.... For example, nursing at RH, I sign their overtime but I have no control over nursing and their budget. I need a plain answer ... is it me who is in charge or not?' (16 RH ADMIN)*

> *'The chronic medical problems. They have two different heads and reportability, they report to us and to medical director. If they go to the Medical Director without our approval we try to avoid problems and if there are problems we go to the Administrative Director as arbitrator. The small departments like dieticians also have that problem. They go for real work to the Medical Director and for the dirty work come to us (...). Our titles are not very influential. If we had a title like hospital director it would be much easier. This would give administration an identity and independence.' (110 HGH ADMIN)*

And in cases of conflicts between nursing and medical they feel they do not have the authority to interfere.

> *'There is always conflicts with nursing and medical. The main problem is that they report to another department, if there are problems we cannot interfere with them. It can be minimized with coordination and trying to understand their roles and duties to overcome these problems.' (102 HGH ADMIN)*

Another important area of conflict identified by respondents is the lack of clear description of roles and functions of administrative, nursing and medical staff at the hospital level.

> *'The roles are not clear between the administration, medical and nursing at RH, sometimes it's a question of style. (13 RH NUR)*

> *'Lines of responsibilities and authorities between medical and administrative staff are not clear therefore there are arguments and misunderstandings. These can be minimized by clear demarcation of where administration responsibilities begin and mine end.' (56 HGH MED)*

> *'There is no clear role segregation between administration and medical at hospitals level.' (113 HMC ADMIN)*

7.2.4.3 *Conclusion on hospital structure*

Interview responses reveal two major power conflicts. The first is a conflict of interest between corporate staff and hospital staff, which could be found in any organization attempting to decentralize. Some corporate staff that have interests in the status quo oppose or resent the decentralization of some of their authority to the hospital level. On the other hand, hospital level staff are frustrated with the centralization of authority and strive to obtain autonomy from corporate departments. This conflict could be inflated by the lack of clarity on the type and level of decentralization and the new roles and functions brought by decentralization.

The second conflict is the struggle for leadership at the hospital level by the medical and administrative staff. This power struggle is more specific to hospital settings whereby the multiple lines of authority require the maintenance of a delicate balance of power (Georgopolous and Mann, 1962). Again here, the ambiguity created by the lack of clear roles descriptions for the medical, nursing and administrative staff at hospital level could be escalating this conflict as each party seeks to the capture the vacuum of authority and enlarge the boundaries of its authority and power within the organization.

7.2.5 Departments structure

Having explored the corporate, hospital and professional structure we now explore departmental structures in general. The weaknesses of departmental structures are first described, then, respondents' opinions on how their departments could be improved are explored.

The majority of respondents found that their department's structure was not efficient (mentioned 50 times / 92 responses). The rest found it to be efficient (38 times / 92 responses) and a small number found that there was no real department structure; that the structure was only on paper (mentioned 4 times / 92 responses). Other respondents found that there was no standardized guide as to what the department structures should be.

> *'No there is no department organization structure. Everyone does his own and no one follows it.' (87 HMC SS)*

Interestingly, the majority of Corporate Departments found their structure not efficient (21 times). The professions most satisfied by their department structure were nursing and administration where the majorities found their department structure to be efficient.

When asked why they felt their department structure was not efficient a variety of responses were given[62], the most common response was that they found the structure to be too centralized (21 times/92 responses). The responses were reorganized, Table 7.11 Department Structure Weaknesses, into categorical areas of weaknesses and resulted in apparent weaknesses in structuring, organizing and staffing.

Table 7.11 Department Structure Weaknesses

Category	Issues	Times Mentioned	Subtotals	Total Responses
Structure	**Hierarchy/lines of authority** -too centralized -staff grades and posts not right -unclear/dual reporting -too many committees -departments build empires	 21 13 5 1 1	**41**	
	Size -department just grew in size with no structure -too big	4 1	**5**	
	Structure Evolution/Change -needs complete restructuring -structure not changed as organization changes -still new/under development	4 3 3	**10**	**56**
Organizing	-work scattered -problem not structure but process -no communication between hospital levels -relies heavily on character of superior -physically far	1 2 2 3 1		**9**
Staffing	-understaffed -turnover in administration thus no continuity	4 2		**6**
Other	-structure not being implemented	2		**2**
Total				**92**

The majority of respondents from each hospital found their structure too centralized. However, by profession, most majorities of each profession found their structure too centralized except for the medical staff whose majorities complained of unclear/dual lines of reporting.

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[62] Annex 30 List of Department Structure Weaknesses.

The most important weaknesses of the departmental structure, as viewed by the respondents, were associated with structure. The main structural weaknesses were related to hierarchy/lines of authority (mentioned 41 times / 92 responses) and the need for structural change (mentioned 10 times / 92 responses).

Respondents found that the structures were too centralized with no sections within the departments.

> *'Presently there is no real organizational chart. We have a director, his assistant and reviewers. There are no subspecialties because of shortage of staff.' (61 HMC QM)*
> *'We have no structure, we did meetings with most staff, who presented their comments. We now made a proposal for a structure that is made of 4 sections. Work comes into the general secretary and then goes to the sections. Then I will do the Job descriptions.' (62 HMC TENDR)*

Many respondents found that their department structure did not change appropriately with the organization and that it was not properly studied.

> *'The present structure is not effective. Actually, there is none in existence now. We have proposed a new structure that balances the work and we are working on the job descriptions. We are working with the staff to understand the department's functions. We are also introducing information systems to better coordinate the work. At present there are a lot of overlaps. The department has evolved rather than being organized. There are no job descriptions, no specific work areas and some people had really large spans of control, too large.' (66 HMC MTL)*

7.2.5.1 *Improving departmental structure*

It was believed by most respondents that their department structure could be improved by changing/adding posts (mentioned 16 times / 74 responses), decentralizing (12 times / 74 responses), changing/adding sections (11 times / 74 responses) and changing grades (9 times / 74 responses). A list of all responses to the question on improving departmental structure was produced[63] then reorganized into categories by function in Table 7.12 Improving Departmental Structure.

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[63] Annex 31 Methods of Improving Departmental Structure.

Table 7.12 Improving Departmental Structure

Method of Improving Department Structure	Times Mentioned/ Total Responses
Structure	
- Changing/Adding posts	16
- Changing/adding sections	11
- Decentralize	12
- Involvement in decision making	1
	Total=40
Human Resources	
- better trained staff	5
- changing grades	9
	Total=14
Organizing	
- changing procedures/business process engineering	5
- better communication between hospital levels	1
- departmental committees/meetings	1
- multiprofession committees/meetings	1
- better problem solving	1
- clear roles/job descriptions/functions	1
	Total=10
Planning	
- focus on HMC objectives (don't detract)	2
	Total=2
Other	
- new medical instead of administrator in charge	1
	Total=1
Total	**Total = 74**

When looking at methods of improving by function, it is clear that the majority of respondents believe that the structure of their department could be improved through structural issues such as changing/adding posts, decentralizing, changing/adding sections or more involvement in decision making.

For decentralization, it was believed that decentralization was needed at two levels. First from the superior to the department head; *'to be smaller and more power of decision making to the dept head.' (12 WH MED)* and second from the department head to the section heads;

> *'departments themselves in addition should be more decentralized in their structures and give more power to their sections.' (47 HMC PER)*

The need to change by merging or adding new sections was mentioned 11 times (out of 74 responses) by respondents.

> *'A proper structure needs to be created. Sections that work together a lot and coordinate together are separate. They should be merged. Also the work should be distributed to the right people.'(43 HMC PERS)*

> *'We are trying to change it. The new proposal is aimed to decentralize. I now have six section heads, we will make three and give them more authority. The other problem is the grades which I am working hard at improving.' (33 HMC FIN)*

Changing/adding new posts was mentioned 16 times / 74 responses but it is directly related to changing grades (mentioned 9 times / 74 responses). Most respondents would like to add new posts but are limited by the salary grades and scales provided for their departments. The two most commonly mentioned posts that respondents found are missing in their departments are assistant heads and supervisors/section heads *(Departmental Executive Reports for Library, Support Services, and Therapy Services 1998).*

> *'No. From the origin it was weak. Especially with the grades and the duties of each staff level. All do the same job. Now the structure is: Head – supervisor – assistantt technical – aide. For it to be ideal it would need to be: Head – assistant head – supervisor – technician – assistant technician – aide' (85 HMC SS)*

Additionally, departments are faced with pressure to adapt to the changing corporate structure of decentralizing hospitals. Some departments have created area specialists or coordinators to help with coordinating this transition but others cannot due to manpower shortage and budgetary limitations of posts *(Executive Reports of Security, Finance and Material Management, 1998).*

Having area specialists has also proven to have its complications that departments are struggling to solve.

> *'Our department is suitable for the administration of the hospital now. We have an area administrator for each hospital. This led to non-standardization of work and a disparity of quality in the different areas depending on who is responsible for the area. Each engineer was possessive of his area. Now we are breaking this barrier by coming together at the centre, opening up communication. We are not going back to the old structure, we like the areas but we are working on improving it.' (48 HMC ENG)*

In addition to structural improvement, respondents replied that they are working on improving the organization and processes of their departments.

'We are improving it. We are trying to introduce quality of services. It's still the same organization structure, QM is trying to help us improve the organization and processes of our work in order to improve quality and productivity.' (83 HMC SS)

Some respondents claimed that they have submitted proposals for improvement of their department's structure but that they have not received feedback or approval from top management and as a result did not go ahead with the proposals.

'No. It should be better. I don't know whether I am a unit, a department or what. Nothing has been done in writing about what we are and what is our structure. We have a proposal for improving and a new structure since two years but no approval was given. Additionally, there is no possibility of self improvement, nor attractive salaries so no one comes, all recruits leave.'(49 HMC AUD)

7.2.5.2 *Conclusion on departmental structure*

The majority of respondents found their departmental structure to be inefficient. Interestingly, the majorities of Corporate Department staff found their structure to be inefficient whereas the majorities of nursing and administrative staff were satisfied with their departmental structures.

The most commonly mentioned departmental structure weakness was high levels of centralization except in the case of the medical staff where the majorities complained of unclear/dual lines of reporting. As mentioned earlier the problem of unclear/dual lines of reporting has been generally associated with the characteristics of hospitals (Georgopolous, 1972; Georgopolous and Mann, 1962).

The most important weaknesses of the departmental structure as viewed by respondents are directly related to structure such as issues of hierarchy/lines of authority (too centralized, inappropriate staff post levels, unclear/dual reporting), large department size, and the need for structural change. Other weaknesses identified by respondents were related to organizing (scattered and weak work processes, no communication) and staffing (understaffing and administration high turnover).

Respondents found their structure to be centralized with no appropriate sections and subsections attributing this to shortage of staff and lack of department structure evolution to match organizational structure changes.

As for improvement, the majority of respondents believe that the structure of department could be improved through changing/adding posts, decentralizing, changing/adding sections and more involvement in decision-making. Other areas of improvement are training and grading staff, organization of work and work processes and planning.

Respondents felt that decentralization was needed first from the superior to the department head and then from the latter to the section heads. New assistant, supervisory and section head posts were found necessary as well as improving work processes. Departments that had the manpower to create area specialists or coordinators to adapt to decentralization of hospital management found this method led to non-standardization of work, a disparity of quality of performance and departmental conflicts. Finally, lack of feedback from management on proposed improvements to department structures have led to departments sticking to the status quo or improving on their own agenda.

7.2.6 Analysis of organizational structure

The corporate structure was found confusing (as a result of the successive structural changes) and inefficient. Structural, processes, organizational and human resources weaknesses, some of which are generally associated with the organization of the hospitals, have led to the '*fragmentation of management process*' and '*poor monitoring and control of quality and resources*'. In such context, strong decisive leadership is needed to provide direction. This explains why respondents viewed the strong characteristics of leadership as its main strength.

This situation echoes the British NHS experience where successive structural changes and direction have resulted in a structure that was '*an amalgamation of past purposes, some of which conflicted, some of which became outdated*' and that '*required strong leadership in the key roles to provide a sense of direction*' (Packwood et al., 1992, p.6).

Although there are distinct differences in the structuring of the medical, nursing and administrative staff two similarities stand out, the high levels of centralization and the desire for multi-professional management at the departmental level. This desire for multiprofessional management at the department level seems to point towards the clinical directorate model of structuring prevalent in the US and UK (Packwood et al., 1992; Disken et al., 1990). The desire for higher specialization, as well as the coordination problems between the different hierarchies, illustrate the well documented difficulties in

balancing specialization and differentiation (Thompson, 1976; Lawrence and Lorsch, 1969; Galbraith, 1973b; March and Simon, 1958; Litterer, 1965; Likert, 1967; Van de Ven et al., 1976; Mintzberg, 1979a; Hughe, 1980; Longest, 1996), particularly in hospitals (Georgopolous, 1972; Georgopolous and Mann, 1962).

The organizing of the medical structure at HMC confirms the contradictory need for clarity of accountability versus the desire to maintain work autonomy by professionals identified by Georgopolous (1972) and Georgopolous and Mann (1962). The nursing structure was found to be one of rigid bureaucratic hierarchy relying heavily on rules, regulations and policies for control; characteristics generally associated to nursing structures (Greenwell et al., 1994). As for the administrative structure, the role of administration was found to be unclear and there was a lack of administrative authority with the middle and junior administrators due to high levels of centralization.

Exploring professional boundaries, findings demonstrate a shift in professional relationships due to structural changes and aspiration for increased interface at operational levels. Findings indicate that unclear definitions of roles and responsibilities of the different professions result in confusion of boundaries and increased conflicts. There also seems evidence to support the claim that the relationship between the medical and administrative profession is a struggle for power and authority (Friedson, 1985; Friedson, 1970; Butler, 1992; Harrison et al., 1990; Moran and Wood, 1993; Harrison, 1988). More about the structuring of the different professions and its effect on their culture and interprofessional relations is explored in Chapter Eight.

With regards to the hospital structures, findings reveal two major power conflicts. The first, a conflict of interest between corporate and hospital staff, is one which could be found in any organization attempting to decentralize. The second, the struggle for leadership at the hospital level by the administrative and medical staff, is more hospital specific whereby the multiple lines of authority require a delicate balance of power reflecting the importance of power theories in understanding organizational interaction (Baldridge, 1971; Pfeffer, 1981; Kanter, 1979; Mintzberg, 1983) in hospitals. These power struggles seem to also support the suggestion by power theorists that power is a structural fact; that specialization and division of labour create independent units with varying degrees of importance in the organization who seek to achieve or maintain dominance.

As with organizational structure, the majority of respondents found their department structure to be inefficient. The most commonly mentioned departmental structure weakness was high levels of centralization except in the case of the medical staff where the majorities complained of unclear/dual lines of reporting. This again, confirms the multiple lines of authority setting of hospitals (Georgopolous and Mann, 1962).

Other important weaknesses were organizational (scattered and weak work processes, no communication) and staffing related (understaffing and high administrative turnover). Finally, the majority of respondents believed that the department could be improved through structural improvements (by changing/adding posts, decentralizing and changing/adding sections) However, they also noted that improvements were needed in training and grading staff, organization of work processes and planning. These last two elements will be explores in the next section: Organization and Organizational Processes.

7.2.7 Conclusion on organizational structure

This section explored HMC's organizational structure in some depth by studying corporate structure, the different professional structures, the different hospital structures and the departmental structures. The exploration of corporate structure's strengths and weaknesses revealed the importance of leadership in conditions of process, structural, organizational and human resource weaknesses.

Although distinct characteristics and differences in professional structures were found, similarities were found in that all three found their structures highly centralized and aspired to multi-professional management at departmental levels. Studying hospital structures revealed power conflicts reinforcing the importance of power theories in understanding organizational interaction in hospitals. Finally, exploring the strengths and weaknesses of departmental structures confirmed the multiple lines of authority of hospitals.

7.3 *Organization and organizational processes*

7.3.1 Introduction

Having discussed organization structure at its corporate, hospital, professional and departmental levels, this section explores some of the organizational design issues that came out importantly when studying structures. Centralization, information and communication, planning, coordination, and work processes and procedures are examined in detail through analysis of interview responses on structural strengths and weaknesses, questionnaire responses and documents. Finally, conclusions on HMC's organizational design are drawn.

7.3.2 Centralization

Centralization is an issue that comes out strongly at all levels within the corporation and is repeatedly mentioned by respondents throughout the study.

A significant number of those interviewed felt that there was no need for their superiors to decentralise decisions to them ('no need' was mentioned 28 times / 79 responses to this question), that there was no centralized decision making. However, many more felt that decision-making was centralized and not participative enough. The most commonly named weakness at the corporation's level was that it had very centralized decision making/management (mentioned 43 times / 193 responses to corporate structure weaknesses question)[64].

> *'Anything related to patient care, for example nursing issues of care, are sent to the corporate office. I find that this is related to my work and should be my decision, not the corporate office. I am responsible for it but what is done is different. They will decide on everything and we will know in the end.' (9 WH NUR)*

> *'We should be involved in everything concerning the department and allowed to decide. Most of the things don't come to me. We should be involved in anything concerning our department. We also should participate in decisions.' (54 HMC HIS)*

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[64] Referring to Table 7.2 Corporate Structure Weaknesses, p.179.

Similarly, at the department level, respondents found that their department was too centralized and that they should be decentralized (mentioned 21 times / 78 responses to department structure weaknesses question)[65].

> *'I am not involved in most decisions except for some issues or problems. They involve only our director who doesn't involve us.'(36 HMC ENG)*

As we saw when describing the medical structure, medical staff had the privilege of clinical autonomy that the other professions did not have and found centralization only in the managerial functions of their duties.

It was apparent from responses that the level of centralization of decisions is not systematic and relies on department's head character and management style. Interview respondents identified that one of the weaknesses of the corporation structure is that it relied heavily on individual's character (8 times / out of 193 responses)[66].

> *'Nothing is clear and systematic. Issues come from different sources and some I have to go through (department head) others not, depends on head and mood. Not clear.' (36 HMC ENG)*

> *'Its not clear what are my decisions and what requires approval. Minor issues could go to Administrative Director. In general we are not authorized to take decisions. Most things requires approval to Administrative Director. There is no clear system on which to work.' (107 HGH ADMIN)*

The most commonly mentioned area in which there was centralized decision making was in planning.

> *'We should be involved more in the future planning of the corporation, future projects and programs.' (29 RH MED)*

As with the medical and nursing departments described earlier, centralization of decision-making was sometimes achieved through decision-making committees.

> *'People are fearful of decisions because they don't want the government to come and inquire with them, so they prefer committee decisions for safety. It would be better and quicker if one man decided (...) make people responsible and give them authority. Committees create more paperwork and procedures. (...) Trust and give decision-making authority to the department head. If he fails, punish him.' (48 HMC ENG)*

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[65] Referring to Table 7.11 Department Structure Weaknesses, p.211.

Additionally the organizational by-laws in some cases promoted centralization.

'It's a problem of our by-laws and not our superiors. The by-laws force people to seek approval of small things. By-laws create a lot of approvals and paperwork etc... it restricts us.' (65 HMC MTL)

When asked whether, in their departments, they were free to structure their own jobs, Table 7.13 Freedom to Structure Own Jobs, Departments shows that survey respondents found that they were somewhat free to structure their own job. 42 percent of respondents found that in their department they were 'somewhat free' to structure their own jobs. 24 percent of these found that they were 'not free at all' and another 24 percent found that they were 'highly free'.

Table 7.13 Freedom to Structure Own Jobs, Departments

Hospital	Completely free	Highly free	Somewhat free	Not free at all	Missing	Total
HGH	4	13	30	15		62
WH	5	7	11	11	1	35
RH	5	7	7	9	1	29
CDs	2	14	23	6		45
Total	**16**	**41**	**71**	**41**	**2**	**171**
Percentage	**9%**	**24%**	**42%**	**24%**	**1%**	**100%**

Question: Within your department, rate the extent to which you consider that individuals have the freedom to structure their own jobs.

Similarly, respondents were asked if individuals in the Corporation had the freedom to structure their own jobs. Table 7.14 Freedom to Structure Own Jobs, Corporation suggests that the majority, 53 percent found that they were 'somewhat free' to structure their own work. The second largest group, 26 percent, found that they were 'not free at all' to structure their work. Thus it seems that although there was restricted freedom in both the Corporation and departments, departmental freedom was slightly higher then corporate level freedom.

Table 7.14 Freedom to Structure Own Jobs, Corporation

Hospital	Completely free	Highly free	Somewhat free	Not free at all	Missing	Total
HGH	4	9	36	13		62
WH	3	6	12	12	2	35
RH		4	13	9	3	29
CDs	1	3	29	10	2	45
Total	**8**	**22**	**90**	**44**	**7**	**171**
Percentage	**5%**	**13%**	**53%**	**26%**	**4%**	**100%**

Question: Within the organization as a whole, rate the extent to which you consider that individual have the freedom to structure their own work.

[66] Referring to Table 7.2 Corporate Structure Weaknesses, p.179.

Some respondents felt that the level of centralization was trespassing into their job description and allocated duties.

'I don't have the right authority. I should have the authority of a head. This is lacking and is very important. Now I'm not authorised to make 80 percent of my work decisions without prior approval of the AHD. 75 percent of these decisions I can do comfortably and smoothly without asking anything. Its bad luck that this authority is not there.' (93 HMC SS)

'Our job description is totally different from what we do. The management is unfortunately totally centralized. They did try to decentralize our hospitals before but it is now not working.' (109 HGH ADMIN)

As we saw when exploring change management practices in Chapter Six, decisions were sometimes quickly taken, not fully studied and with no participation. In some cases such decisions were reversed, as they were not thorough.

'Decisions are taken suddenly and you are given no time. Then another decision is taken, and immediately implemented. We go back and forth without going great distances.'(44 HGH MED)

There is no involvement or very little involvement; *'Not really, its orders, orders, orders and we execute, execute, execute. Its better now though than before.' (10 WH ADMIN).* As we saw in the case of the last structural change in chapter 6, when there was involvement it was mostly consultative or informal and in some cases information about the decision came through gossip where the respondents '*heard gossip about it*'. Lack of involvement together with high management turnover have resulted in no continuity of projects (mentioned 2 times/ 193 responses) and low staff morale.

'The decision is a one man decision, its usually the AHD's decision and final. There are examples where he asks you for your advice but doesn't take it at all. His decision is the last and final.' (9 WH NUR)

'People sometimes are victims of changes. Always reshuffling. By the time you get used to a place and can work they take you out. Specially for managerial jobs'.(76 HGH NUR)

However, centralization does not only carry with it the disadvantages of weak participation and morale. It has one strong advantage of making top management accessible (mentioned 4 times /22 responses to the question on corporate strength) and having information centralized with top management thus enabling them to take prompt decisions.

'Its easy to reach the higher people and that is very helpful when you want to create something new. They listen but you need to make sure that the right information reaches.' (12 WH MED)

Overall, the issue of centralization comes out strongly throughout the study. A significant number of respondents felt that the level of centralization was appropriate but many more, at both the corporate and department level, felt that decisions were centralized and not participative enough. Findings reveal that the level of centralization of decision-making is not systematic or standardized; it relies heavily on the department head's character and management style. It was found that decision-making committees and certain organizational by-laws encouraged centralization.

The most commonly mentioned area in which there was centralization was in planning. Some respondents felt that the level of centralization was trespassing into their job description and allocated duties. With regards to freedom to structure your own work, although both were highly restricted, departmental freedom was slightly higher then corporate freedom.

As we saw in Chapter Six when exploring structural changes, it was found that decisions were quickly taken, with no or very little involvement of organizational members and no thorough study. When there was involvement, it was mostly consultative or informal. Lack of involvement, together with high management turnover have resulted in no continuity of decisions and low staff morale. The one advantage of high centralization was that the top management was accessible and had centralized information enabling them to take quick decisions.

7.3.3 Information and communication

Table 7.15 Information Conveying demonstrates that the majority of respondents to the questionnaire found that information was most times clearly and promptly conveyed (40 percent) or sometimes clearly and promptly conveyed (26 percent). However, there were significant differences in response by profession. The majority of administrative staff found that information was always clearly and promptly conveyed (38 percent). The majorities of medical, nursing, paramedical, and support services found that information was at most times clearly and promptly conveyed (32 percent, 49 percent, 56 percent and 50 percent respectively). The majorities of therapy and corporate department staff found that

information was only sometimes clearly and promptly conveyed (67 and 38 percent respectively).

Table 7.15 Information Conveying

Profession	Always clearly&promptly	Most times cl&pr	Sometimes cl&pr	Rarely cl&pr	Never cl & pr	Missing	Total
Medical	7	8	7	2		1	**25**
Precentage	*28%*	*32%*	*28%*	*8%*		*4%*	***100%***
Administration	5	4	4				**13**
Precentage	*38%*	*31%*	*31%*				***100%***
Nursing	17	38	15	7			**77**
Precentage	*22%*	*49%*	*19%*	*9%*			***100%***
Paramedical	1	5	1	1	1		**9**
Precentage	*11%*	*56%*	*11%*	*11%*	*11%*		***100%***
Therapy		2	6	1			**9**
Precentage		*22%*	*67%*	*11%*			***100%***
Support Services	1	5	1	3			**10**
Precentage	*10%*	*50%*	*10%*	*30%*			***100%***
Corp. Depts	4	7	11	5	1	1	**29**
Precentage	*14%*	*24%*	*38%*	*17%*	*3%*	*3%*	***100%***
Total	**35**	**69**	**45**	**19**	**2**	**1**	**171**
Percentage	***20%***	***40%***	***26%***	***11%***	***1%***	***1%***	***100%***

Question: To what extent is information related to your work clearly and promptly conveyed to you?

Similarly, Table 7.16 Needed Information Obtainable, indicates that the majority found that it was easy to obtain needed information (49 percent) or quite easy to (26 percent). Here too, there were significant variations by profession. The majorities of administration, nursing, paramedical, and corporate departments found that needed information was easily obtainable (69 percent, 58 percent, 56 percent, and 43 percent respectively). The majorities of medical and support services found that needed information was somewhat quite easily obtainable (36 and 60 percents respectively).

Approximately the same amount of respondents interviewed found that they did or did not receive all the information they needed to fulfil their roles properly. Slightly more (mentioned 47 times/ 89 responses to this question) respondents found that they received all the information they needed. The rest found that they did not receive the information they needed (mentioned 42 times / 89 responses to this question).

'No I don't get information. I get simple information but important information I get none, like the future of the hospital. I never get it and if I do finally get it, it's been decided on.' (14 RH MED)

Table 7.16 Needed Information Obtainable

	Extremely easily	Easily	Quite easily	Sometimes difficult	Difficult	Total
Medical	5	5	9	5	1	**25**
Percentage	*20%*	*20%*	*36%*	*20%*	*4%*	***100%***
Administration		9	3	1		**13**
Percentage		*69%*	*23%*	*8%*		***100%***
Nursing	6	45	21	4	1	**77**
Percentage	*8%*	*58%*	*27%*	*5%*	*1%*	***100%***
Paramedical	1	5	1	2		**9**
Percentage	*11%*	*56%*	*11%*	*22%*		***100%***
Therapy		3		6		**9**
Percentage		*33%*		*67%*		***100%***
Support Services		4	6			**10**
Percentage		*40%*	*60%*			***100%***
Corp. Depts	2	12	5	6	3	**28**
Percentage	*7%*	*43%*	*18%*	*21%*	*11%*	***100%***
Total	**14**	**83**	**45**	**24**	**5**	**171**
Percentage	***8%***	***49%***	***26%***	***14%***	***3%***	***100%***

Question: When you need information, to what extent is that information relating to you and your work easily obtainable?

Lack of communication or miscommunication was perceived by respondents as being the most important cause for conflict (mentioned 21 times/ 138 responses to the question on conflict) and increasing communication and having good working relationship as the most important means for minimizing conflict. The lack of a systematic method of receiving information was proposed as a reason for this (no communication mechanism was mentioned 8 times / 193 responses to the question on corporate structure weaknesses).

> *'Management information is missing. There is no system or management type of meeting where we are informed. Nothing regular. So we get no management meeting where we can give our suggestions and reviews and where we get information on what's going on.' (93 HMC SS)*

> *'The information that the chairmen get is not adequate, making their work hard. Management type of information is missing. It's not a continuous and regular process of information. At one point the chairmen get a lot of information and involvement, at others they are kept out. Its not consistent.' (52 HGH MED)*

An administrative report noted the lack of a management information system and generally weak information systems.

> 'Management information system is a system that provides management with timely and accurate information on the whole corporation. We do not have such a system that can be relied upon at HMC.'
>
> 'Memorandum: *Administrative Executive Report*, 1998'

The centralization level was found to also affect information communication.

'We don't get all the information. Some information we get as orders. This is all a result of centralization and lack of planning.' (109 HGH ADMIN)

There was also a sense that long term planning information was not passed on to organizational members.

'Information on long-term planning doesn't get to us. We read it in the newspaper or the Bulletin.' (13 RH NUR)

Respondents felt that a communication gap stemmed from the top, the Board of Directors, and went all the way to departments. Physical distance was found to further increase the communication gap.

'RH invariable gets quite important directives late because simply of location distance and slow mail. By the time the directives are typed, sent to the Mail Room, reach RH, get filtered by Administration, and get looked at its late. Nursing at RH suffers a lot from that. ' (13 RH NUR)

In addition information was inconsistent and unreliable.

'The problem is that information changes all the time. Plans and decisions are reverted. You get your information, even informally, but what's the use of that when it changes all the time. It changes daily.' (45 HGH MED)

'Things are not communicated properly. You hear a lot of things through the grapevine, things that should have been your information. Information is very poor and ineffective. There is conflicting information. One day you hear something and the next day something else (...). Its instability' (101 HGH NUR)

Inconsistency of information was associated with dual orders.

'Sometimes there are things that are not clear, orders that are dual. For example, we may receive an order from medical staff or /administration without the information of our superiors. It leads to confusion. Protocols are not always being followed and that is difficult for us. Sometimes we don't know who has to take the decision and decisions are delayed resulting in patient dissatisfaction.' (5 WH NUR)

Inconsistency and non-clarity of information were also associated with lack of policies.

'Sometimes we don't get full information from personnel, or they don't have fixed policies or standards to follow so they are always changing and we always have to ask.' (17 RH NUR)

When asked through which channel information travelled in their department, Table 7.17 Department Information Travel, the majority of respondents to the questionnaire found that important communication travels mostly through formal channels (48 percent) or completely through formal channels (29 percent). Similarly, Table 7.18 Corporate Information Travel indicates that 51 percent found that important information, in the corporation, travels mostly through formal channels. 35 percent found communication to travel completely through formal channels.

Table 7.17 Department Information Travel

Hospital	Completely formal channels	Mostly formal channels	Mostly informal channels	Always informal channels	Missing	Total
HGH	15	35	9	3		62
WH	13	17	2	2	1	35
RH	10	11	4	3	1	29
CDs	11	19	14	1		45
Total	**49**	**82**	**29**	**9**	**2**	**171**
Percentage	***29%***	***48%***	***17%***	***5%***	***1%***	***100%***

Question: In your department, do you consider important information travels through formal or informal channels?

Table 7.18 Corporate Information Travel

Hospital	Completely formal channels	Mostly formal channels	Mostly informal channels	Always informal channels	Missing	Total
HGH	20	36	3	2	1	62
WH	12	18	2	1	2	35
RH	16	11		2		29
CDs	11	22	8	2	2	45
Total	**59**	**87**	**13**	**7**	**5**	**171**
Percentage	***35%***	***51%***	***8%***	***4%***	***3%***	***100%***

Question: In the corporation, do you consider important communication travels through formal or informal channels?

However, interview findings revealed that in an environment of weak and inconsistent information, informal means such as the grapevine, and personal contacts are important to organizational members.

> *'To some extent, most information is available. It depends on your contacts and how long you have been in the corporation for you to be able to reach it.' (29 RH MED)*

> *'Sometimes we hear rumours of our unit moving from out and not from our superiors. Its disconcerting to hear about a possible change from others.' (20 RH NUR)*

Some respondents were strongly affected by this lack of information, conflicting and changing information and perceived it as a conspiracy.

> *'I find some information missing and information not updated. (...)where they hide information, abuse information and do not keep confidentiality (...). This, yes, I saw a lot of and it leads to confusion.' (41 HMC NUR)*

Thus, questionnaire responses revealed that respondents found that information was most times clearly and promptly conveyed. Administrative staff seem to have clearer and more prompt information conveyed to them and administration, nursing, paramedical and corporate departments staff seem to obtain information more easily.

Approximately the same amount of respondents interviewed found that they did or did not receive all the information they needed to fulfil their roles properly, with slightly more being satisfied by the amount of information received.

Lack of communication or miscommunication was perceived by respondents as being the most important cause for conflict at HMC. Consequently, increasing communication and having good working relationships were perceived as the most important means for minimizing conflict.

Weak information systems, lack of management information system, centralization and lack of planning were found to lead to weak communication. The communication gap was found to stem from the top and go all the way down to departments. Physical distance was also found to increase the communication gap. The inconsistency, unreliability and non-clarity of information were associated to dual orders and lack of policies.

Although questionnaire responses revealed that important communication travels mostly through formal channels interview findings revealed that in an environment of weak and inconsistent information, informal means such as grapevine and personal contacts were important to organizational members.

7.3.4 Planning

Lack of planning was apparent throughout interviews, questionnaire responses and administrative reports. The inexistence of planning activities was considered a major weakness of the corporation (mentioned 10 times / 193 responses)[67]. Questionnaire respondents found objectives to be somewhat clear or vague, and administrative reports on the corporation revealed lack of planning activities.

Respondents found that this lack of planning led to a confusion at departmental level

> *'There is no planning for the next five or ten years. The result is confusion for certain department e.g. Engineering have over running forty projects. Bad planning makes services costly.' (108 HGH ADMIN)*

When asked about the corporation's mission, Table 7.19 HMC Mission Statement indicates that the majority found HMC's mission statement to be somewhat clear (51 percent) while others found it extremely clear (22 percent). However, Table 7.20 HMC Objectives indicates that HMC's objectives were found to be somewhat clear (42 percent) by the majority and vague (22 percent) by others.

Table 7.19 HMC Mission Statement

Hospital	Extremely clear	Somewhat clear	Vague	Very vague	Not existent	Missing	Total
HGH	17	31	8	4		2	**62**
WH	7	21	4	1		2	**35**
RH	8	14	3	3		1	**29**
CDs	6	22	9	6	2		**45**
Total	**38**	**88**	**24**	**14**	**2**	**5**	**171**
Percentage	***22%***	***51%***	***14%***	***8%***	***1%***	***3%***	***100%***

Question: To what extent is the organization's mission statement clear and appropriate?

Table 7.20 HMC Objectives

Hospital	Extremely clear and specified	Somewhat clear and specified	Vague	Very vague	Not existent	Missing	Total
HGH	15	25	15	4	3		**62**
WH	5	22	2	1	3	2	**35**
RH	7	9	8	2	3		**29**
CDs	5	16	13	6	4	1	**45**
Total	**32**	**72**	**38**	**13**	**13**	**3**	**171**
Percentage	***19%***	***42%***	***22%***	***8%***	***8%***	***2%***	***100%***

Question: To what extent are the organization's objectives specified and known to all staff?

[67] Referring to Table 7.2 Corporate Structure Weaknesses, p.179.

Table 7.21 Departmental Objectives indicates that departmental objectives were found, by the majority, to be somewhat clear (48 percent) and to others (36 percent) extremely clear and specified. At the departmental level, there were significant variations in responses by profession. The majorities of medical, nursing, therapy, support services and corporate staff found their departmental objectives to be somewhat clear and specified (44 percent, 51 percent, 44 percent, 67 percent, 60 percent, and 50 percent respectively). However, the majority of administrative staff found their departmental objectives to be extremely clear and specified (62 percent).

Table 7.21 Departmental Objectives

Profession	Extremely clear and specified	Somewhat clear and specified	Vague	Very vague	Non-existent	Total
Medical	8	11	3	1	2	**25**
Percent	*32*	*44*	*12*	*4*	*8*	***100***
Administration	8	2	3			**13**
Percent	*62*	*15*	*23*			***100***
Nursing	32	39	6			**77**
Percent	*42*	*51*	*8*			***100***
Paramedical	3	4	1		1	**9**
Percent	*33*	*44*	*11*		*11*	***100***
Therapy	1	6	2			**9**
Percent	*11*	*67*	*22*			***100***
Support Serv.	4	6				**10**
Percent	*40*	*60*				***100***
Corporate Depts	5	14	4	4	1	**28**
Percent	*18*	*50*	*14*	*14*	*4*	***100***
Total	**61**	**82**	**19**	**5**	**4**	**171**
Percent	***36***	***48***	***11***	***3***	***2***	***100***

Question: to what extent are your department's objectives clear and specified ?

The lack of planning activities has been mentioned various times at different years in corporate reports *(Report on the Proposed Organizational Structure, 1989; Management Arrangement and Systems, 1989; SWOT Analysis 1997; Administrative Executive Report; 1998).*

In 1989 the corporation's long-term planning activities were limited to capital expansions that were not fully supported by studies of service needs and short term budgetary planning.

> 'At present, the Corporation has no formalized or operational planning system. Long-term considerations are basically limited to major capital requirements which are not necessarily fully supported by service needs. The short-term plans tend to be documented only at budget preparation time and these do not

generally contain a full analysis of the service needs which will enable the justification and priority of the new programmes to be assessed.

As a result of this situation, the Corporation has no overall direction for service developments, and many of the budget short term programmes fail to be achieved, since their feasibility, resource requirements and implementation plans have not been properly prepared.'

(Administration: *Management Arrangement and Systems*, 1989)

Over the next ten years, from 1989 to 1998, the planning activities of the corporation had not been developed. In 1998 the planning process was non-existent with no corporate set vision, mission, goals, strategic plans and operations plans.

'The planning process is virtually inexistent at the moment. Departments are conducting day-to-day activities without direction as to where the sum of these activities should lead to. If we were to ask truly if the corporation is effective or efficient it is extremely hard to answer since the actual strategic plans of the corporation are implicit and not defined in measurable terms. The vision, mission, goals, strategic plans and operational plans need to be developed and employees trained to work with such tools.'

(Administration, *Administrative Executive Report*, February 1998)

Thus, survey findings reveal that the mission of the corporation was somewhat clear to organizational members and although both corporate objectives and departmental objectives were somewhat clear, departmental objectives were clearer to respondents than corporate objectives. Of the different professions, the administrative staff found their objectives clearest. The lack of planning activities has been mentioned various times at different years in corporate reports. In 1998 the corporation had no documented set vision, mission, goals, strategic or operational plans. Respondents found that this lack of planning activities and information on future plans has resulted in confusion in some departments.

7.3.5 Coordination

The Corporation suffers from some coordination problems as a result of a number of factors. A managerial report found that the main reason for coordination problems is the organization of operational services by profession.

'The operational services are separately organized for the three main functions of medical, nursing and administration leading in many cases to three management departments for on service department (e.g. A&E). There

are no formalized working arrangements between these functions to deal with administrative matters. This is a major factor in creating the lack of coordination and confusion over respective roles. It also leads to decision making and problem solving being pushed up to the Corporate level since the main cross-over point is only reached at Managing Director, Administrative Director, Medical Director level.'

(HMC; *Management Arrangement and Systems*, 1989)

Interview respondents were asked what they believed were the reasons for interdepartmental conflicts. Eighteen reasons were named. Table 7.22 Reasons for Conflict is a list of the reasons, as perceived by respondents, for conflicts.

Table 7.22 Reasons for conflicts

Reason for conflict	**Number of Times mentioned**
No communication/miscommunication	21
When depts don't conduct their function fully/up to level	19
When depts take own decisions and work own way without coordinating	13
Dual reporting/orders	12
When depts don't have SPs/roles/functions	12
When depts procedures lengthy	10
Bad attitude	8
When depts don't understand our work	8
When depts don't follow SPs/protocoles	6
Shortage of staff in other depts	6
No conflicts	6
Constant change in other depts	4
No discipline in depts	4
When depts trespass into my work	3
Coordination with administration difficult	2
When dept is of different school/education	2
When depts are physically far	1
When depts circumvent my dept	1
Total responses to this question	**138**

The most commonly named reason for conflict was miscommunication (mentioned 21 times/ 138 responses).

'We sometimes have conflicts with (...) with specific sections, with the nursing and physicians there. But it is all based on communication and the approach of people. (64 HGH NUR)

Such miscommunication could be as a result of language barriers as the organizational members were of multinationalities and of different educational backgrounds (mentioned twice / 138 responses).

'Sometimes, because of language barrier, there is miscommunication between staff.' (21 RH NUR)
'Conflicts occur because we are working with different nationalities, with different knowledge bases and they come from different backgrounds. Conflicts occur when others don't accept errors and mistakes. We explain to them then they understand. We have to be tolerant. (71 HGH NUR)

Sometimes miscommunication was due to a difference in professional language,

'We don't know what is going on in Finance. Every time we receive the monthly budget there are always mistakes and its not a clear form, and we don't understand their answers. (17 RH NUR)

Others it would be due to non-communicative attitude or spirit.

'Most of the time, it is due to miscommunication and information not arriving. The way information is communicated can create problems. Medical staff don't respond to pagers and when we page them a lot they get irritable (5 WH NUR)
'Sometimes departments change their structures and processes and we are not informed of it so we end up with problems. Sometimes there is no proper communication with other departments and this could cause problems.' (3 WH NUR)

The second most commonly mentioned reason for conflict was when department didn't conduct their work up to level or required standard (mentioned 19 times / 138 responses)

'(housekeeping's) level of work is not up to level. This is problematic and causes conflicts. They don't understand infection etc... They need procedures and protocols and good supervision. (Catering's) meals are not up to standard too. They need to look at improving the standard of food.' (7 WH NUR)

The third most commonly mentioned reason for conflict is when departments take their own decisions and work their own way without coordinating (mentioned 13 times / 138 responses) hence acting like independent empires.

'Each takes their own decisions and want to work their way. They do not coordinate with us.' (1 WH ADM)
'Every department thinks that they are separate worlds. There is no feeling that we complement each other. If I say something against the nurses they take it personally. They don't listen to you and correct it, they take it as a critique.' (12 WH MED)

An important reason for coordination problems, as mentioned by respondents, is structural problems such as dual reporting (mentioned 12 times / 138 responses) and none clarity of roles and functions.

'There is a lot of miscommunication. You don't know what is the right thing to do. Nursing I don't know whether they should come to me or not. I force myself upon them. There is no system or process by which we work. Its not clear what goes where. Who reports to who is not clear. By personal efforts we force ourselves on them. (...) Nothing is clear.' (107 HGH ADMIN)

'Here, the conflict is because there is no organizational structure within the department. Everyone steps on one another. There is no clear role separation between the administration, nursing and medical. This can be minimized by clarifying the roles of each in the organization structure (...) and circulating information. (101 HGH NUR)

Centralization was found to hinder interdepartmental relations

'There is no inter relations between departments. Each dept works on its own. Structure doesn't encourage good relation and flow of work. It is centralized.' (33 HMC FIN)

The lack of coordinators also makes it difficult to coordinate activities.

'Interdepartmental conflicts are mostly administrative because sometimes people don't stick to protocols and this leads to conflicts. Also there is a lack of coordinators in certain departments e.g. assistant for administration has lots of departments under him so he doesn't give my department enough time to coordinate work.' (55 HGH MED)

As we saw when exploring departmental structure earlier, where there were area specialists or coordinators this lead to the non-standardization of work, disparity in quality of performance and departmental conflicts, issues that also have to be dealt with when coordinators are used.

Again, centralization and lack of participatory decision-making were also mentioned as a cause for conflicts.

'Some coordination problems exist. Conflicts arise when decisions are taken without listening to anyone concerned with the decision. (...)This can be minimized by having more consideration for participation, and encouraging participatory decisions. Decisions are taken suddenly and you are given no time.' (44 HGH MED)

The lack of clear and well documented standard practices, roles and functions in departments (mentioned 12 times / 138 responses) were found to be important causes for the lack of coordination. Sometimes department don't know or understand organizational policies and standard practices.

'We have standard practices so we stick to that. The ones that we have problems with are the units that don't know the standard practices or their duties and rights.' (104 RH THER)

Some do have standard practices but don't follow them.

'Sometimes the unit is not following the standard when we are, this creates problems' (5 WH NUR)

However, many times the policies or standard practices are not clear or not fully developed.

'Unless you know what is expected to be done by having clear work standard practices you cannot interfere. If you have that there should be no problems, because the core is there and the audit of it is there. With this you should not have the conflicts that we have now.' (8 WH MED)

'If there were standard practices conflicts would never arise. Now people get approvals from the top. Everything is handled in a one to one manner.' (43 HMC PERS)

It is believed by some respondents that it is the lack of role defining and job descriptions that lead to conflicts.

'We have a lot of conflicts. Mostly because they don't know what role I play in this hospital. Now the relationship relies on personal relations and how much department heads trust you. There are no clear job descriptions, a lot of problems are because of that. It can be minimized by having clear job descriptions for each departments so that each know the proper communication channels.' (36 HMC ENG)

'The absence of proper guidelines and clear boundaries has made it possible for conflicts to arise. Conflicts are mainly related to roles and responsibilities. These can be minimized by having job descriptions, proper delegation of responsibilities, and mechanisms to control ways of thinking e.g. Code of conduct and ethics to try to control behaviour and attitude of others. We should have a system where the outcome of better coordination and collaboration is by itself a motivator.' (41 HMC NUR)

Lengthy procedures have also been found by many respondents to be reasons for conflicts (mentioned 10 times / 138 responses).

'Our relations with material management are mixed. Sometimes it is good and others bad. Evaluation procedures are too long. We have a lot of miscommunication with them. (...) and the procedure of having to go through them for everything related to maintenance takes long.' (36 HMC ENG)

Many respondents deal with conflict in an immediate informal manner.

'We communicate in an immediate way (when there is conflict). I don't wait for formal communication. I do it now myself, on a person-to-person basis. I take my car and go. By going through proper channels you will get it but it will be delayed. I believe in face-to-face communication. I communicate from bottom to up. Its much better and more successful.' (28 RH NUR)

Interview respondents were asked how they thought conflicts could be minimized and coordination improved. Table 7.23 Minimizing Conflict is a table of their responses.

Table 7.23 Minimizing Conflict

How to Minimize Conflict	**Times Mentioned**
Good working relations and communication	21
Multidisciplinary committees/meetings	15
Defining/redefining roles and responsibilities of depts	11
Clear rules and S.P.s in each depts/committee	9
Additional staff to help coordinate	6
Promote attitude/spirit of coordination	6
Decentralize	4
Involvement in decision taken by other depts that involve us	4
Respect our profession	4
Socializing with other depts	3
Depts doing their jobs properly	2
Administration doing their job correctly	2
Better coordination	2
Computerization	2
Faster response to issues from depts	1
Following up implementation of decisions	1
Procedurizing areas of conflicts	1
Total responses to this question	**93**

Good working relations and communication was the most commonly mentioned method to minimize conflict (mentioned 21 times / 93 responses).

'Proper communication. If the units informed us of issues we can deal with it. Also if each unit had its rules (Standard Practices) we could know how to deal with them but some, like medical staff, do not have protocols to follow so its hard to know what to do or what they will do. Proper communication and coordination. Informing each other of issues. Common meetings to solve our problems together.' (4 WH NUR)

An attitude and spirit of cooperation was found the minimize conflict (mentioned 6 times/ 93 responses).

'We should teach people to think of the importance of coordination. We should teach the department head to change attitude. Not to protect staff only but to improve the department by thinking and looking at other sections also; we are all interlinked. For example, to think of the department and hospital as a whole.' (12 WH MED)

'To listen to one another, talk it out, good relationships, be polite to one another. Know your roles each and each other's roles. Lectures, seminars about communication, attitude, to create an atmosphere.' (75 HGH NUR)

Having clear and documented standard practices and rules has been found to reduce conflict (mentioned 9 times / 93 responses)

'Recently, conflicts have been decreasing dramatically. Before we had many. How we reduced these was by having very strict rules and procedures and enforcing them. This reduced the space for conflict. We put procedures on all conflict areas' (10 WH ADMIN)

Decentralization of corporate services and delegating more authority to the department head was mentioned as ways in reducing conflict.

'I can give you a series of problems, if we have devolution it will solve them. The departments in my hospital report to their corporate offices, and these don't know what is going on. They only get involved to protect their groups and interests.' (6 WH ADMIN)

Multiprofessional committees and meetings were found to be helpful in reducing conflict (mentioned 15 times / 93 responses).

'This can be minimized through teams composed of multiprofessions and even administration.' (51 WH NUR)

'Conflicts with paramedical and medical staff are solved in the same time because we are always in contact. We need also regular meetings with our section heads to solve our problems and not let them accumulate. It will solve all our problems if we have monthly or every 2 months meetings, everything would be solved. What we miss here is good communication between departments.' (63 HGH NUR)

Some respondents believed that direct and immediate communication solves conflict best.

'I use urgent meetings to solve coordination problems. We try to solve it together e.g. with the doctors in clinics. We meet with superiors and solve the problems or conflicts. We solve our problems on the table and implement independently. If people meet with each other over it and face the problems it is better. Not just to keep it under. Ask or call.' (7 WH NUR)

Having clear roles and functions for each department was found to reduce conflict (mentioned 11 times / 93 responses).

> *'Clear instructions. There should always be one department responsible for things. To have the clear roles of departments so that we know who is responsible for what. There are delays to respond to problems we are sending. Response to certain issues should be faster and more immediate.' (5 WH NUR)*

Hence, the coordination problems or conflicts of HMC were perceived by management as being a result of the organization of operational services by profession with no formalized working arrangements between these professions to deal with administrative matters. This structural arrangement has also led, they believe, in decision making and problem solving being pushed up the corporate level. Interview respondents perceived some reasons for conflicts as; miscommunication due to language barriers or non communicative attitude, when departments did not conduct their work up to level or standard, when departments did not follow standard practices, when departments worked in isolation and finally structural problems such as dual reporting, centralization and lack of coordinators. However, having coordinators had its own set of complications, non-standardization of work, disparity of quality of performance and departmental conflict, which were dealt with.

Process-issues such as lack of clear and well documented standard practices, roles and functions in departments, job descriptions and lengthy procedures were perceived as additional triggers of coordination problems. Many respondents dealt with conflicts in an immediate and informal manner and felt this to be more efficient than formal channels.

It was believed by respondents that multiprofesional teams and understanding each other's roles and duties would minimize interprofessional conflicts. Good working relations, communication, an attitude or spirit of cooperation, having clear and documented standard practices and rules, decentralization, multiprofessional committees and meetings and finally having clear roles and functions were perceived to reduce conflicts.

7.3.6 Work processes/procedures

Weak processes and procedures were the most important category of corporate structural weakness mentioned by respondents (mentioned 63 times / 193 responses)[68]. It was also

[68] Referring to Table 7.2 Corporate Structure Weaknesses, p.179

perceived as the second most important element in improving the structure of the corporation (mentioned 7 times / 39 responses)[69].

> 'Many of the Standard Practice have not been reviewed and updated for many years and so are no longer being applied. The majority of them are of a Corporation wide nature and very few departmental Standard Practices have been developed.The absence of up-to-date and comprehensive policies and procedures means that there is uncertainty over procedures (a serious problem in view of the turnover of staff), and many systems are not as efficient as they might be.'
>
> (*Management Arrangement and Systems, 1989)*

> 'There is considerable work to be done in this area. First, the medical, personnel, financial and material management by-laws need to be thoroughly revised and approved. Second, the complete medical and nursing protocols need to be developed and approved. Finally, all administrative procedures must be recorded in Standard Practices form and the present standard practices updated.'
>
> (*Memorandum: Administrative Executive Report, 1998)*

Four questionnaire questions on work processes were asked. The responses to the first, Table 7.24 Work Processes, indicate that the majority of respondents found that work processes sometimes were organized and running smoothly (39 percent). However, an important number found that they were rarely organized and running smoothly (35 percent). Responses to the question on smooth work in times of crisis or change, Table 7.25 Smoothness of Work, indicates that the majority found that work sometimes runs smoothly in crises or when changes in key staff occurs (36 percent) but an important number found that it rarely does run smoothly in crisis or change situation (35 percent).

Table 7.24 Work Processes

Hospital	Always	Mostly	Sometimes	Rarely	Never	Missing	Total
HGH	5	25	24	6	2		**62**
WH	1	17	11	5		1	**35**
RH	5	12	10	1	1		**29**
CDs	2	12	15	13	2	1	**45**
Total	**13**	**66**	**60**	**25**	**5**	**2**	**171**
Percentage	***8%***	***39%***	***35%***	***15%***	***3%***	***1%***	***100%***

Question: To what extent are work processes/operation/activities organized and running smoothly?

[69] Referring to Table 7.4 Improving Corporate Structure, p.182.

Table 7.25 Smoothness of Work

Hospitals	Always	Mostly	Sometimes	Rarely	Never	Total
HGH	4	20	28	7	3	62
WH	1	17	7	7	3	35
RH	4	10	6	6	3	29
CDs		14	19	10	2	45
Total	**9**	**61**	**60**	**30**	**11**	**171**
Percentage	***5%***	***36%***	***35%***	***18%***	***6%***	***100%***

Question: To what extent does the work run smoothly and in an organized manner when there are changes in staff and key persons or crisis?

With regards to departmental policies and procedures, Table 7.26 Departmental Policies and Procedures, indicates that the majority (36 percent) found that there were policies and procedures for almost everything in their department and 28 percent found that some activities were not covered. Similarly, with regards to corporate policies and procedures, Table 7.27 Corporate Policies and Procedures, the majority (35 percent) found that there were policies and procedures to control most everything in the corporation and 27 percent found that some activities were not covered by policies and procedures.

Table 7.26 Departmental Policies and Procedures

Hospital	There are p&p for everything	For most everything	Some activities not covered	Many activities not covered	Missing	Total
HGH	18	19	16	7	2	62
WH	7	13	10	4	1	35
RH	5	12	8	4		29
CDs	5	17	14	8	1	45
Total	**35**	**61**	**48**	**23**	**4**	**171**
Percentage	***20%***	***36%***	***28%***	***13%***	***2%***	***100%***

Question: To what extent are administrative activities controlled by policies and procedures in your department?

Table 7.27 Corporate Policies and Procedures

Hospital	There are p&p for everything	For most everything	Some activities not covered	Many activities not covered	Missing	Total
HGH	14	20	19	5	4	62
WH	11	12	7	4	1	35
RH	5	12	8	2	2	29
CDs	5	15	13	11	1	45
Total	**35**	**59**	**47**	**22**	**8**	**171**
Percentage	***20%***	***35%***	***27%***	***13%***	***5%***	***100%***

Question: To what extent are administrative activities controlled by policies and procedures in general?

Most respondents found that standard practices or work practices were not standardized throughout the corporation.

'Standard practices are weak. They have been implemented and not regularly reviewed. Standardization of services is weak.' (108 HGH ADMIN)

As we saw in the previous section on coordination, lack of policies and procedures in departments has been named as the fourth most important reason for conflict to occur (mentioned 12 times/138 responses)[70]. Defining or redefining roles and responsibilities within departments (mentioned 11 times /93 responses) and having clear roles and standard practices in each department (mentioned 9 times / 93 responses) are viewed by respondents as the third and fourth most important means of minimizing conflicts.

'I need (...) information on my role in the corporation. What type of role do I play in the corporation? It is not clear to me or to the other departments. This leads to misunderstandings. Sometimes I go beyond what my role is. We need clear roles and responsibilities, procedures and policies to make me safe and show me my responsibilities.'(36 HMC ENG)

Respondents found that the lack of clear standard practices, policies, roles, functions and job descriptions have affected their ability to conduct their work and take proper decisions

'We don't have standard practices and policies so you cannot really take decisions.' (43 HMC PERS)

'No policies and procedures, we don't have anything to follow. We are just told what to do by the boss and our job descriptions are not clear.' (46 HMC PERS)

As a result, many respondents built their own work practices and job descriptions based on past experiences[71]. Finally, as we saw in the section on departmental structure, some respondents found that re-organizing work processes and procedures was important in improving their department's structure (mentioned 5 times / 74 responses).

'The problem is not structural but business process engineering.' (6 WH ADMIN)

Overall, weak processes and procedures were the most important category of corporate structural weaknesses mentioned by respondents. They were also perceived as the second most important element in improving the structure of the corporation. The absence

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[70] Referring to Table 7.22 Reasons for Conflict, p. 232.

[71] As seen in Section 7.2.3.3 Administrative Organizational Structure, p.195, where the administrators were not oriented nor given job descriptions at arrival.

of comprehensive policies and procedures has resulted in uncertainty over procedures. Important numbers of questionnaire respondents found that work processes were rarely organized and running smoothly and that work rarely runs smoothly in crisis or change situations. Although the majority found that there were policies and procedures for almost everything in the corporation, a significant number found that some activities were not covered by policies.

Respondents found that the lack of standardization, clear policies, roles, functions and job descriptions has lead to conflicts and affected their ability to conduct their work and to take proper decisions. Finally, many respondents found that re-organizing work processes and procedures was important in improving their department's structure.

7.3.7 Analysis of organization and organizational processes

Shortell and Kalzuny (1983) proposed two purposes of organizational design. The first, effective coordination and integration of tasks. Second, to monitor and respond to the environment via communication, information and control mechanisms. However, these two purposes are interlocked and complete each other as communication, information and control are often used as coordination mechanisms (March and Simon, 1958b; Galbraith, 1973a, 1977; Van de Ven et al., 1976; Huse, 1980; Mintzberg, 1983). After exploring our findings on some organizational design issues at HMC, we assess HMC's organizational design in its ability to meet these two purposes.

Structure has often been cited as one of the mechanisms for ensuring coordination (Galbraith, 1973b, 1977; Litterer, 1965; Thompson, 1967; Mintzberg, 1983; and Long and Longest, 1996). HMC management also seem to perceive that most of its coordination problems are a result of its structural arrangements of operational services whereby there is no formalized working arrangements between the different professions for administrative matters. Interview respondents also found that specific structural weaknesses are promoting conflict such as dual reporting, centralization and the lack of coordinators or integrators.

Centralization has come out very strongly at HMC with centralized decision making and planning. Although, this together with the high management turnover were found to result in no continuity and low staff morale, centralization has the advantage of providing top management rapid information so that they may take rapid decisions.

If the main objective of organizational design is to ensure the efficient flow of information to decision makers as Galbraith (1973b) claims then centralization at HMC is serving that purpose extremely well. However, it is with the flow of information downwards and laterally that HMC seems to suffer. Interview respondents perceived lack of communication or miscommunication as the most important reason for conflict at HMC. The existence of unclear, inconsistent and unreliable information was mostly associated with the dual hierarchy and lack of standardization of policies.

In such an environment informal means such as grapevine and personal contacts are important to ensure communication. Informal and personal activities have often been cited as important coordination mechanisms (Van de Ven et al., 1976; and Litterer, 1965). At HMC, informal means came out strongly not only at information sharing but also as means of dealing with conflicts. Respondents dealt with conflict in an immediate and informal manner. Finally, the informal culture was considered by respondents as important in promoting coordination. Respondents felt that a spirit or attitude of good working relations and collegiality would improve coordination at HMC.

Although planning can be used as a coordinating mechanism (Huse, 1980; Galbraith, 1973) it has not been used at HMC. There were no planning activities and the corporate mission and objectives were unclear. On the other hand, the use of multiprofessional teams, committees, and meetings as coordinating mechanisms (Lawrance and Lorsch, 1967a; Van de Ven et al., 1976; Long and Longest, 1996) has been consistently used throughout the corporation.

Standardization of administrative systems and procedures is a major coordination mechanism (March and Simon, 1958b; Galbraith, 1973a, 1977; Van de Ven et al., 1976; Huse, 1980; Mintzberg, 1983, Litterer, 1965). At HMC, respondents perceived it as its most important weakness. The absence of comprehensive policies and procedures resulted in uncertainty over procedures and work that does not run smoothly, especially in moments of crisis or change. Additionally, the lack of standardization, clear policies, roles, functions and job descriptions has lead to conflicts. Re-organizing work processes and procedures and standardizing them has been found by respondents to be the second most important element in improving the structure. Finally, respondents found that coordination would be improved by understanding each other's roles, functions and duties, something that was stressed by Georgopolous (1972) when discussing the nature of hospital work.

Thus, returning to Shortell and Kalzuny's (1983) purposes of organizational design, findings reveal that HMC's organizational design has shortcoming with regards to coordination, and communication, information and control mechanisms. It relies heavily on structure (i.e. centralization), informal means, and teams and committees as coordinating mechanisms. Other mechanisms such as information, communication, planning and standardization have not been developed.

7.3.8 Conclusion on organization and organizational processes

This section discussed some organizational design issues that had come out strongly when studying the corporate, hospital, professional and departmental structures. It explored centralization, information and communication, planning, coordination and work processes and procedures and evaluated HMC's organizational design by assessing how well it met with Shortell and Kalzuny's (1983) proposed two purposes of organizational design. Findings revealed that HMC's organizational design had shortcoming with regards coordination, communication, information and control mechanisms; relying heavily on structure, informal means and team and committees as coordinating mechanisms.

7.4 *Conclusion*

Having explored the evolution of HMC's organizational structure in Chapter Six, this chapter explored HMC's structure at the time of research by, in the first section, studying in some depth its corporate structure, professional structures, hospital structures and departmental structures. Conclusions on the importance of leadership, the similarities and differences in professional structures, the balance and conflicts of power and the multiple lines of authority in hospital settings were drawn.

The second section was concerned with exploring the organizational design issues that had emerged when studying the structures, namely, centralization, information and communication, planning, coordination and work processes and procedures. It concluded by evaluating HMC's organizational design by assessing how well it met with the purposes of organizational design proposed by Shortell and Kalzuny (1983).

CHAPTER 8 ORGANIZATIONAL CULTURE

8.1 *Introduction*

Having discussed the evolution of HMC's organizational structure, its structures and processes, this chapter addresses the normative structure underpinning its organizational design; the organizational culture. It explores organizational culture by studying cultural strength, professional culture and national culture. The first section attempts to assess the organization's cultural strength by studying homogeneity, intensity and direction of core values of organizational members. The second section looks at the different subcultures by studying professional culture through the study of interprofessional relations. The final part explores the relationship between national culture and organizational culture by studying some characteristics attributed to Arab management culture

8.2 *Organizational culture*

8.2.1 Introduction

In assessing cultural strength this research explores homogeneity of core values, commitment to values (the gap between desired and existent culture) and the direction of culture (Luthans, 1995; Kilman et al., 1985). By direction is meant the extent to which the culture helps the organization achieve its goals, whether it is a positive or negative culture.

The objective of this section is to identify the main organizational values and the commitment of different professions and hospitals to the existing culture. Core values were traced from three questions on organizational culture. The first attempted to identify perceived main stakeholders. The second, modelled on the Hay Group's Culture Modelling organizational assessment tool (Fralicx, R. et al., 1997), attempted to have organizational members describe their organizational culture. The third question, basing itself on Shein's (1992) definition of organizational culture, attempted to explore which cultural assumptions were considered important enough to be transmitted to new entrants[72].

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[72] See Chapter Five, Section 5.3 and especially Table 5.1 Breakdown of Comprehensive Questionnaire, p.109.

Commitment to the existing culture is explored by first requesting respondents to describe the ideal health service organization from a list derived from the Hay Group's Targeted Culture Modelling (Fralicx, R. et al., 1997) organizational assessment tool. The cultural gap between the desired culture and actual culture is then assessed by using responses from Competing Values questionnaire and documents analysis as indicators of actual culture. The cultural gap analysis is then used to draw conclusions on the direction of the existing culture.

8.2.2 Strength of core organizational values

Attempts are first be made to understand the main stakeholders. Organizational values are then explored and traced to the core values to which they most likely relate. Finally, the desired culture is described and the cultural gap between desired and actual culture explored.

8.2.2.1 *Understanding the stakeholders*

The first question, 'Which groups should HMC be most concerned to satisfy?' was aimed at seeing whether there was consensus on who were the major stakeholders. Respondents were given seven options and requested to tick only two. As expected, Table 8.1 Perceived Stakeholders for HMC, indicates that the most important stakeholders were, as perceived by organizational members, the patients. The next three most important stakeholders were the staff, the community and the government. Only a small number found management, the professional associations and the board of directors to be major stakeholders.

Table 8.1 Perceived Stakeholders for HMC

Stakeholders	**Score**
Patients	153
Staff	86
Community	57
Government	18
Management	8
Professional Associations	6
Board of Directors	1
Total:	**329**

When comparing responses by hospital and by profession there were no major variations except for responses from administration and therapy services. Administration respondents did not feel that staff were as important as others did. Table 8.2 Stakeholders as Perceived by Administrative Staff indicates that the most important stakeholders for administration were in order of importance; patients, community, government and finally staff. Interestingly, as seen in Table 8.3 Stakeholders as Perceived by Therapy Staff respondents from therapy found the major stakeholders were, in order of importance; patients, professional associations, community and staff. The only other profession to mention professional associations was the medical staff but as seen in Table 8.4 Stakeholders as Perceived by Medical Staff, in very small number.

Table 8.2 Stakeholders as Perceived by Administration Staff

Table 8.3 Stakeholders as Perceived by Therapy Staff

Stakeholders	Score	Stakeholders	Score
Patients	12	Patients	8
Community	7	Professional Associations	5
Government	3	Community	4
Staff	2	Staff	3
Management	0	Management	0
Professional Associations	0	Government	0
Board of Directors	0	Board of Directors	0
Total:	**24**	**Total:**	**20**

Table 8.4 Stakeholders as Perceived by Medical Staff.

Stakeholders	Score
Patients	20
Staff	13
Community	7
Government	3
Management	1
Professional Associations	1
Board of Directors	1
Total:	**46**

Thus, stakeholders perceived to be most important for HMC to satisfy were: patients, staff, community and government.

8.2.2.2 *Understanding core values*

In order to understand the values prevailing at HMC, organizational members from the three hospitals were asked to select ten of twenty descriptions that would describe their organization. Table 8.5 Descriptions that were found to best Describe HMC, is a list of the descriptions and their respective scores. These value descriptions were taken from the Hay Group's Targeted Culture Modelling organizational assessment tool. The ten most important characteristics that define HMC were found to be, in order of importance; focuses on patient satisfaction, develops new services, focuses on gaining the confidence of patients, values and participates in training and development, encourages the use of limited resources effectively, focuses on improving work processes, checks and focuses on quality in performance, encourages establishing clear, well documents work processes and policies, encourages experimenting new techniques and finally, promotes respecting the chain of command.

Table 8.5 Descriptions that were found to best Describe HMC (ten most important characteristics highlighted)

Description	Score (times selected)
Encourages expression of diverse view points	14
Treats employees fairly and consistently	32
Is organized and encourages organization	32
Attracts top talents	39
Encourages initiative and innovation	47
Rewards superior performance	49
Uses all opportunities	51
Tolerates well-meaning mistakes	54
Encourages loyalty and commitment to the Corp.	65
Encourages teamwork	66
Promotes respecting the chain of command	72
Encourages experimenting new techniques	72
Encourages establishing clear, well documented work processes and policies	72
Checks and focuses on quality in performance	74
Focuses on improving work processes	79
Encourages the use of limited resources effectively	83
Values and participates in training and development	92
Focuses on gaining confidence of patients	104
Develops new services	116
Focuses on patient satisfaction	130
Total:	**1213**

These characteristics are an indication of the values of the organization at the time the research was conducted, as perceived by organizational members. Grouping these ten descriptions by subject led to five main values. Patient satisfaction and gaining patient confidence were the most important value. Second, developing new services and experimenting new techniques. Third, training and development of staff. Fourth, a range of process oriented values such as using limited resources effectively, improving work processes, quality of performance and establishing clear, well documented work processes and policies. Finally, a more functional/structural value: respecting the chain of command. Thus, one could deduce that the main values of HMC, as perceived by its members are:

- Patient satisfaction and confidence
- Developing new services and techniques
- Training and developing of employees
- Improving work processes for quality performance and effective utilization of resources
- Respecting organizational structure/chain of command

All together there are no major variations in perceived main values by hospital or profession. Organizational members seem to agree on the main characteristics. However there are interesting minor variations[73]. In addition to the main characteristics shared with other organization members, respondents from HGH found that the organization encourages teamwork. Similarly, respondents from RH found that the organization encourages loyalty and commitment to the corporation. Respondents from Corporate Departments found that the organization tolerates well-meaning mistakes, encourages loyalty and commitment to the Corporation and uses all opportunities.

By profession, respondents from the medical profession found that the organization rewards superior performance and attracts top talent. Nursing respondents found that the organization encourages teamwork. Both respondents from Administration and Paramedical services found the organization to be tolerant of well meaning mistakes. Therapy staff not only found the organization to be tolerant of well-meaning mistakes but also encourages loyalty and commitment to the corporation. Support services staff found the organization to encourage loyalty and commitment to the corporation as well as

[73] See Annex 32 and 33 for tables of characteristics by hospital and profession.

initiative and innovation. Finally, corporate staff found the organization to use all opportunities available, to tolerate well-meaning mistakes and encourage teamwork.

Working from Schein's (1992, p.9) definition of organizational culture as a pattern of basic assumption *'...that has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think and feel ...'*, organizational values were further explored by asking respondents in an open ended question to name three advices they would give colleagues joining the organization for the first time. This would shed light to the cultural elements that are perceived to be important enough to be told new entrants into the organization. In total thirty-five different responses were given[74].

When comparing these thirty-five advices to the main values in the earlier question some similarities stand out. Respecting the organizational structure/chain of command comes out importantly in this list. So do patient satisfaction and confidence, training and development of staff and to a lesser extent improving work processes for quality performance and effective use of resources. However, other new elements have emerged such as the importance of national culture, of personal characteristics, of understanding the nature of the organization and your work, of work ethics, of the informal structure, of working relationships, of self motivation and managing expectation.

<u>Table 8.6 Categories of Advices Related to Culture</u> on the next page is the rearranged list by category and importance of each category. A total of fourteen categories that are important to this particular organizational culture have emerged.

The values extracted from the questions on describing the organization and advice to new entrants are a combination of near core values and operational consequences of core values. For example, focusing on patient satisfaction depends closely on basic values such as altruism. Also establishing clear, well-documented work processes and policies pronounces feelings of accountability and reliability. Working from the values extracted from these questions an attempt at deducing core values to which these values can be traced resulted in eight basic core values (See <u>Table 8.7</u>): altruism, professional ethical conduct, development of knowledge and skills, quality of performance balanced against effective utilization of resources, structure and discipline, technological and service development, team work, and accountability and reliability.

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[74] Annex 34 is a list of the thirty five different responses and the times each response was given.

Table 8. 6 Categories of Advices Related to Culture

Ethics (64/420) Work professionally Be sincere and loyal towards your job	**Organizational Structure (54/420)** **Communicate through formal channels, respect chain of command** Know and abide by HMC structure, rules and regulations
Process (43/420) Do best to maintain standard of corporation Keep focused on your work at all times Produce good quality work Plan and organize your work to achieve plans Be productive	**Training and Development (31/420)** Develop interpersonal skills Motivate yourself into professional development/unit development
Team work/Relations (32/420) Cooperate and have good working relations with co-workers Participate in team work/work as member of team	**Motivation (30/420)** Motivate yourself Don't get discouraged/demotivated easily; be patient
Understanding Organization and Work (27/420) Know/understand organization/contract before applying/signing. Know your job/job description	**Personality (27/420)** Have a high self-esteem/don't be sensitive Be a fighter Accept correction Don't hesitate to ask questions or advice Be flexible to changes, adaptative, open minded.
Patient satisfaction (23/420) Keep patient centre of your work, focus on patient satisfaction	**Informal Structure (10/420)** Don't listen/believe in rumours and intrigues
Expectation (18/420) Don't listen, believe promises Don't compare yourself to others, don't expect equal/fair remuneration Don't expect recognition/rewards or better remuneration	**Negative (12/420)** Think seriously before joining, don't join, look for another job
New Services (12/420) Be creative/innovative	**National Culture (8/420)** Learn the local language Respect State, its policies and culture
Other (2/420) Use opportunities/facilities available Be alert at all times	

Table 8.7 Core Values Traced From Organizational Values below shows the core values and the organizational values from which they were traced.

Table 8.7 Core Values Traced From Organizational Values

CORE VALUE	ORGANIZATIONAL VALUES
Altruism	Patient satisfaction and confidence, patient found the most important stakeholder
Professional Ethical Conduct	Ethics (be professional and sincere)
Knowledge and Skills Development	Training and development of staff, staff found to be second most important stakeholder.
Quality of Performance	Quality of performance mentioned both at description and new entrants advice
Effective Utilization of Resources	Improving utilization of resources found important description of organization
Structure and Discipline	Respecting organizational structure/chain/rules and regulation, understanding organization and your work, not listening to informal structure.
Technology and Service Development	Developing new services and technology, Encourage initiative and innovation, focus on improving work processes
Team work	Team working and good working relations with organizational members.
Accountability and Reliability	Clear, well-documented work processes and policies

8.2.2.3 *Commitment to existing culture*

A question was asked in order to understand which elements members of the organization perceived as important for success of health service organizations in general and thus better understand how they perceive their own culture in relation to this ideal scenario. Fifteen elements were given and respondents were asked to select five only. The elements suggested to organization members for this question were selected from the Hay Group's Targeted Culture Modelling organizational assessment tool. Table 8.8 Elements Considered Most Important for the Success of Health Services is a list of the elements; the scores for each and the five most important are highlighted. The two most important elements were perceived to be staff calibre and motivation. Then came quality of performance, mission and objectives and organized work processes.

Table 8.8 Elements Considered Most Important for the Success of Health Services

Elements	Score (times mentioned)
Controlling activities through complete policies and procedures	16
Controlling budget	17
Having an impact on the population	26
Being highly productive	36
Investing highly in human resources	37
Being able to adapt quickly to changes in industry/environment	39
Investing highly in equipment and technology	41
Being innovative	46
Having open channels of communication	49
Minimizing unnecessary expenditures	51
Having very organized work processes/operations/activities	**58**
Having clear mission and objectives and achieving them	**86**
Focusing on quality of performance	**96**
Having staff that are satisfied and motivated	**117**
Having highly skilled and knowledgeable staff	**127**
Total	***842***

Using responses from the questionnaire and documents, how organization members rate themselves on these five elements that they consider as most important for the success of health services, is explored. This will test the culture gap i.e. the gap between the desired culture and the actual culture, and give indications of the direction of the culture.

Calibre and Motivation of Staff

Organizational members were asked about the skills and training of medical, nursing, paramedical, therapy, administration, corporate departments and support services staff. Overall, majority of respondents found these to be either good or average[75]. The professions where the majority found their skills and training to be good were medical staff (46 percent), nursing staff (53 percent), and administration staff (37 percent). Professions where the majority found their skills and training to be average were paramedical (40 percent), therapy staff (44 percent), corporate department staff (39 percent) and support services staff (42 percent).

As was seen in Chapter Seven when exploring the weaknesses of the corporation, a SWOT analysis conducted in 1997 identified one of the most important weakness of the corporation as its shortage of highly qualified staff (medical, nursing and technical) and attributed this shortage to the corporation's low salaries and grades which results in weak attraction *(Administration, SWOT Analysis Summary, 1997)*[76].

As for staff morale, questions were asked about the morale of each profession and in each case the majority of respondents found the morale to be average[77]. 51 percent found medical staff to have average morale, 45 percent found nursing staff morale average, 48 percent found paramedical morale to be average, 54 percent found therapy staff morale average, 40 percent found administration morale average, 43 percent found corporate departments morale average and finally 49 percent found support services morale to be average.

Quality of Performance

Respondents were asked to rate their departments' and the corporations' productivity. Table 8.9 Corporate Productivity and Table 8.10 Departmental Productivity indicate that in both cases, majority of respondents found the department (44 percent) or the corporation (44 percent) very productive. The second largest group of respondents found the department (29 percent) and the corporation (37 percent) averagely productive.

Table 8.9 Corporate Productivity

Hospital	Extremely productive	Very productive	Average productivity	Low productivity	Very low productivity	Missing	Total
HGH	11	20	27	3		1	62
WH	3	16	14	1		1	35
RH	2	16	9	1	1		29
CDs	4	23	13	3	1	1	45
Total	**20**	**75**	**63**	**8**	**2**	**3**	**171**
Percent	**12%**	**44%**	**37%**	**5%**	**1%**	**2%**	**100%**

Question : How would you rate the productivity of the organization ?

[75] See Annex 35 for Tables 35.1 to 35.7 for responses to questions on skills and training by profession.
[76] Chapter Seven, Section 7.2.2.1, Table 7.3, p.181.
[77] See Annex 36 for Tables 36.1 to 36.7 on morale by profession.

Table 8.10 Departmental Productivity

Hospital	Extremely productive	Very productive	Average productivity	Low productivity	Very low productivity	Total
HGH	15	25	19	2	1	**62**
WH	8	15	12			**35**
RH	3	16	7	3		**29**
CDs	10	20	12	2	1	**45**
Total	**36**	**76**	**50**	**7**	**2**	**171**
Percentage	***21%***	***44%***	***29%***	***4%***	***1%***	***100%***

Question: How would you rate the productivity of your department?

No question was asked to respondents directly about the quality of the performance of the organization and information on quality of performance is derived mostly from Quality Management reports on patient satisfaction. No other quality reports or activities were found in the organization.

In a patient satisfaction report for HGH conducted in 1998, 57 percent found services at HGH to be excellent or very good and 42.6 percent were unsatisfied. (*Patient Satisfaction Report (HGH), June 1998*) In the WH, a similar report on inpatient satisfaction concluded that 36 percent of patients were satisfied and 64 percent were not satisfied *(Patient Satisfaction Report (WH), April 1998*). A report on outpatient services in RH revealed that 52 percent of patients were satisfied (excellent and very good) and 48 percent were unsatisfied (good, fair or poor)(*Patient Satisfaction Report (Dental Clinic and Dermatology Clinic), February 1999*).

Mission and Objectives

As we saw in our review of organization processes in Chapter Seven there were no organized planning activities at HMC as the corporation had no documented set of visions, mission, goals, strategic and operational plans. Survey findings had revealed that the mission of the corporation was somewhat clear to organizational members and both the corporate and departmental objectives were found to be somewhat clear[78].

Organized Work Processes

The section on work processes of Chapter Seven demonstrated that weak processes and procedures were the most important category of corporate structural weaknesses by respondents. The absence of comprehensive policies and procedures had resulted in

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[78] Refer to Chapter Seven, Section 7.3.4, Tables 7.19 (p. 229) and 7.20 (p. 230)

uncertainty over procedures. An important number of questionnaire respondents found that work processes were rarely organized and running smoothly and that work rarely runs smoothly in crisis or change situations. Although the majority found that there were policies and procedures for most everything in the corporate, a significant number found that some activities were not covered by policies[79].

To recap on how organizational members rate themselves on the five elements they consider most important for the success of health services, skills at HMC were found to be either good or average and morale largely average. Overall patient satisfaction in the three hospitals, as provided by the patient satisfaction reports, was slightly more unsatisfied than satisfied. The corporation and various departments were found to be either very or averagely productive.

HMC mission was somewhat or extremely clear but HMC objectives were less clear and more vague. Departmental objectives were found to be clearer and more specified. Finally, work processes were either sometimes or rarely well organized. Work processes would sometimes or rarely run smoothly in crisis or change situations. There were policies and procedures to control most activities in the corporation and in departments with some activities not covered.

The largest gap as expressed by the gap in perceived characteristic and desired characteristic can be witnessed mostly in work processes and HMC objectives where these were perceived as weak or vague when they had been found to be characteristics highly desired by organizational members. There is also a general weakness in the other characteristics; skills, morale and quality as none had strongly satisfied responses (i.e. highly skilled, high morale and very good quality).

8.2.3 Analysis of organizational culture

This research attempted to explore homogeneity of values, commitment to values and the direction of the organization culture (Luthans, 1995; Kilman et al., 1985). Findings conclude that overall there is a strong homogeneity in values. The most importantly perceived stakeholders were patients, staff, community and government. The main organization's values, as perceived by organization members, were; patient satisfaction and confidence, developing new services and techniques, training and developing

[79] Refer to Chapter Seven, Section 7.3.6, Tables 7.24 (p.239), 7.25 (p.240), and 7.26 (p.240).

employees, improving work processes for quality and effective utilization of resources and respecting organization structure/chain of command. There were minor variations by hospital and profession that indicate the existence of subcultures, which share organization wide values but maintain their own individuality. These findings are in line with studies under the differentiation perspective that portrays subcultures as co-existing in harmony, conflict or indifference to one another (Martin and Mayerson, 1987; Smirichich and Morgan, 1982; Riley, 1983).

Values that were perceived important enough to transmit to new entrants in the organization were; professional, sincere and ethical behaviour, respect for hierarchy, rules and regulations, improving work processes, quality performance and effective utilization of resources, training and development, good working relation and teamwork, importance of self-motivation and strong personality, understanding your organization and work, patient satisfaction and the importance of not listening to the informal structure.

These values, together with the main organizational values were traced to the core values to which they most likely relate. The result indicates that HMC has nine basic core values: altruism, professional ethical conduct, knowledge and skills development, quality of performance, effective utilization of resources, structure and discipline, technological and service development, team work and accountability and reliability.

However, it is in the commitment to the existing culture and cultural direction that findings demonstrate that there is an important gap in desired culture and actual culture. The gap is most important in relation to corporate objectives and work processes but is also existent in staff skills, moral and quality of performance. Thus, with regard to desired culture, the research concludes that the existing culture is somewhat negatively directed in that there is a significant gap between desired and actual culture. Relating this to Luthans' (1995) definition of cultural strength as being a function of homogeneity of core values and commitment to existing culture our findings indicate that HMC's culture is not strong. Although its homogeneity of cultural values is relatively high, it is low in commitment to its existing culture.

This first section of Chapter Eight is mostly integrationist, portraying culture as a monolith characterized by consistency, organization wide consensus and clarity. Its takes the view that these integrating features will lead to improved organizational effectiveness. The variations in findings by hospital and profession lead to the differentiationist perspective,

which is further explored in the next section where the relationships and conflicts between the different professional cultures are explored.

8.2.4 Conclusion on organizational culture

This section attempted to assess organizational cultural strength by studying homogeneity, intensity and direction of core values of organizational members. It concluded that overall there was a strong homogeneity of core values with minor variations by sub-culture. Findings indicated that the existing culture was negatively directed and, using Luthan's (1995) definition of cultural strength, HMC's culture was not strong.

8.3 *Professional culture*

8.3.1 Introduction

Having explored general organizational culture, this section studies the different subcultures by looking at professional culture. In exploring professional culture, it focuses on interprofessional relationships of three professions only; the medical, nursing and administrative professions which entails discussions of components of culture. The decision to focus on these three profession stems from the fact that these three groups constitute the largest groups in the Corporation[80] and that most conflicts are between them. Interview respondents found that the majority of conflicts were with medical staff (mentioned 28 times out of 100 responses to this question), followed by administration (19/100 times) and finally nursing (14/100 times each). While exploring interprofessional relations this section touches on some of the structural elements studied in Chapter Seven, Section 7.2.3, when exploring professional structures and further expands the understanding of professional structures.

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[80] In 1999 of the 5215 total employees 1740 were nursing, 555 medical, 572 administration, 368 paramedical, and the remaining a mix of support services (Statistics Report for Active Staff, Personnel 1999).

8.3.2 Interprofessional relations

8.3.2.1 Medical relations

In understanding the interprofessional relations of medical staff we first explore how the medical staff relate to one another. Secondly, how they relate to nursing staff and administrative staff. Findings are then be interpreted in light of theoretical studies on the medical profession.

All together, survey respondents found that medical staff worked well and had a good relationship with other medical staff. Table 8.11 Medical-Medical Working Together indicates that the majority of respondents (47 percent) found that medical staff worked 'well' with one another with a slight variation by profession and hospital. Similarly Table 8.12 Medical-Medical Relationships indicates that the majority (46 percent) of respondents found that medical staff relation with one another only had 'small insignificant conflicts'

Table 8.11 Medical-Medical Working Together

Hospital	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all	Missing	Total
HGH	3	33	15	9		2	62
WH		15	12	4	1	3	35
RH	4	13	2	9		1	29
CD	2	19	12	2		10	45
Total	**9**	**80**	**41**	**24**	**1**	**16**	**171**
Percent	***5%***	***47%***	***24%***	***14%***	***1%***	***9%***	***100%***

Question: To what extent do medical staff work well with each other, respecting and trusting each other?

Table 8.12 Medical-Medical Relationships

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	2	33	19	3		5	62
WH	3	12	10	3		7	35
RH	2	14	9	1	2	1	29
CD	4	20	10			11	45
Total	**11**	**79**	**48**	**7**	**2**	**24**	**171**
Percent	***6%***	***46%***	***28%***	***4%***	***1%***	***14%***	***100%***

Question: How would you rate the relationship of medical staff with one another?

As we saw in Chapter Seven; Section 7.3.5 on coordination, interview respondents revealed that these conflicts were sometimes due to medical training or specialization differences; *'Some conflicts with our colleagues are due to 'school' of managing patients. It's ok. It's good.'(81 HGH MED)*

The majority of respondents found that medical staff worked well with nursing staff but had a relationship of some conflicts. Table 8.13 Medical-Nursing Working Together indicates that the majority of respondents found that medical staff worked 'well' with one another with minor variations by hospital. The majorities of HGH, RH and Corporate Departments found they worked 'well' but the majority of WH (37 percent) found that they worked 'somewhat well together'. Likewise, Table 8.14 Medical-Nursing Relationship indicates that the majority found that the medical-nursing relationship contained 'some conflicts' with some variations by hospital. The majorities of RH (34 percent) and Corporate Departments (42 percent) found that medical and nursing staff had 'small insignificant conflicts' whereas the majorities of HGH (47 percent) and WH (40 percent) found that medical and nursing staff had 'some conflicts'.

Table 8.13 Medical-Nursing Working Together

Hospital	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all	Missing	Total
HGH	2	34	10	16			**62**
Percent	*3%*	*55%*	*16%*	*26%*			***100%***
WH	3	12	13	4		3	**35**
Percent	*9%*	*34%*	*37%*	*11%*		*9%*	***100%***
RH	5	11	9	2		2	**29**
Percent	*17%*	*38%*	*31%*	*7%*		*7%*	***100%***
CD	3	16	15	2	1	8	**45**
Percent	*7%*	*36%*	*33%*	*4%*	*2%*	*18%*	***100%***
Total	**13**	**73**	**47**	**24**	**1**	**13**	**171**
Percent	***8%***	***43%***	***27%***	***14%***	***1%***	***8%***	***100%***

Question: To what extent do medical and nursing staff work well with each other, respecting and trusting each other?

Table 8.14 Medical-Nursing Relationship

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	4	24	29	3		2	**62**
Percent	*6%*	*39%*	*47%*	*5%*		*3%*	***100%***
WH	1	9	14	3		8	**35**
Percent	*3%*	*26%*	*40%*	*9%*		*23%*	***100%***
RH	4	10	9	5		1	**29**
Percent	*14%*	*34%*	*31%*	*17%*		*3%*	***100%***
CD	3	19	12	1		10	**45**
Percent	*7%*	*42%*	*27%*	*2%*		*22%*	***100%***
Total	**12**	**62**	**64**	**12**	**0**	**21**	**171**
Percent	***7%***	***36%***	***37%***	***7%***	***0%***	***12%***	***100%***

Question: How would you rate the relationship of medical staff with nursing staff?

It appears that there are minor conflicts but nurses process these within a very procedurized manner.

'Nursing are very organized. No conflicts. Its maybe because of hierarchy, they don't argue with us in front of the public. If there is a problem they write incidence reports and complaints. They go through their processes' (52 HGH MED)

As for the medical-administrative relationship Table 8.15 Medical-Administration Working Together indicates that the majority of respondents found that they worked 'well' together (47 percent). Table 8.16 Medical-Administration Relationship indicates that they had only 'small insignificant conflicts' (39 percent). Although the survey indicates a good relationship interviews indicated that the medical staff did not have a high perception of the administrative staff and the majority of conflicts by the medical staff were with administration.

'We have big conflicts with administration, e.g. Salary grade. Administration has higher grades than doctors although they are less qualified. Some administrators feel they should run the hospital. Their role is to make a proper atmosphere for us, not to run the hospital. Even they select equipment. Its not right. Also the concept that quality is costly (is wrong). For them its containment not patient care' (81 HGH MED)

'Yes it's a universal problem, everywhere in the world there are conflicts. Coordination with administration is difficult with newly set up areas like Qatar. It will be increasingly difficult for some time. The reason is because administration comes with non medical background and theories.' (58 HGH MED)

'The corporation is working fine. Except administration in general, I don't believe in it. They don't know what they are doing, they are useless. Delete their jobs, it's a burden on the corporation.' (56 HGH MED)

Table 8.15 Medical-Administration Working Together

Hospital	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all	Missing	Total
HGH	3	34	16	2	1	6	62
WH	5	16	7	3		4	35
RH	7	13	3	4		2	29
CD	5	17	8	5		10	45
Total	**20**	**80**	**34**	**14**	**1**	**22**	**171**
Percent	***12%***	***47%***	***20%***	***8%***	***1%***	***13%***	***100%***

Question: To what extent do medical and administrative staff work well with one another, respecting and trusting each other?

Table 8.16 Medical-Administration Relationship

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	10	25	15	2		10	62
WH	10	10	6	1		8	35
RH	8	14	4	1		2	29
CD	3	17	10	2	1	12	45
Total	**31**	**66**	**35**	**6**	**1**	**32**	**171**
Percent	**18%**	**39%**	**20%**	**4%**	**1%**	**19%**	**100%**

Question: How would you rate the relationship of medical staff with nursing staff?

Thus, findings indicate that medical staff work well with one another with small insignificant conflicts arising from differences in specialization and medical training. Although medical staff worked well with nursing staff there were some conflicts with nursing. Nurses, who respect the hierarchy of superiority of the medical staff, generally handled these conflicts in a very procedurized manner.

Although questionnaire responses indicate that medical and administrative staff work well with one another and have only small insignificant conflicts the interviews indicate that the majority of conflicts by medical staff were with administration. The medical staff seem to carry a negative perception of administrative staff viewing them as useless, not accepting their authority and not recognizing their knowledge base.

8.3.2.1.1 Analysis of medical relations

Our findings confirm the extensive references in literature on the dominance of the medical profession and the importance of a distinct body of knowledge (Parry and Parry, 1976; Friedson, 1970b; Flynn, 1992). Our findings confirm that knowledge or knowledge base is important to the medical profession as most of the conflicts of doctors with other doctors at HMC were due to differences in knowledge base (i.e. differences in medical training and specialization). The medical profession's relationships with administration

revolved around its not recognizing the knowledge base of administration and hence not recognizing the authority or utility of administration within the organization.

Also rejection of managerial knowledge and values could be an attempt at protecting medical professional dominance as accepting managerialism could lead to a cut back in professional power as did happen with the introduction of managerialism in the British NHS (Butler, 1992; Harrison et al., 1990; Moran and Wood, 1993).

As for medical relations with nursing staff, although there are some conflicts, the medical staff is not specially annoyed by this as the nurses handle conflicts in a very procedurised manner, without challenging the dominance of the medical staff by directly arguing the problem with them.

8.3.2.2 *Nursing relations*

This section studies the attempts of HMC nurses at professionalizing nursing. It then explores their relationships with medical staff, with other nurses and with administration. Finally, where relevant, similarities are drawn to the British NHS based studies and findings.

Nursing staff at HMC has been trying to develop more influence in the corporation's management and to professionalize nursing. Influence in management has been attempted through development of senior administrative nurses and shifting alliances from the medical to the administrative. Senior nurses have been encouraged to seek administrative functions but this has backfired in that the clinical specialization of nurses has suffered and the image of the professional nurse has been tarnished.

> *'The career ladder is a problem. It doesn't meet the needs of now. This ladder is weak because everyone has been promoted to Nursing Administration. Nursing is trapped into this system as no one wants to specialize because the ladder doesn't have clinical track. We need an administrative track, a clinical track, and an educational track.' (38 HMC NUR)*

In attempting to gain more independence from medical dominance the nursing department has shifted from reporting to the medical director to reporting to the administrative director. As was discusses in Chapter Seven, 7.2.3.2 Nursing Organizational Structure, recently a strategy to professionize nurses has been formulated in which the Nursing Corporate Department would like to remove the different nursing grades and have just one staff

nurse, empower the hospital nurse and head nurse by decentralizing decision making, train nurses in management and leadership and develop a national certification board for nurses.

Nurses generally perceive that most people do not view them as an important member of the organization.

> *'Its part of people's view of nurses, they don't find nursing important, they tell doctors and administration. It doesn't matter about nursing they will find out sooner or later. We are never involved in planning of changes' (13 RH NUR)*

> *'The way administration, and the whole corporation, look at nurses, the image, is that nurses are low and subordinate and all other professions are higher.' 11 HMC NUR)*

As we saw above the majority of respondents found that medical staff worked 'well' (43 percent) with nursing staff but had a relationship with 'some conflicts' (37 percent)[81]. The majority of nurses interviewed found that most of their conflicts were with doctors.

The section on medical relations with nurses above revealed that medical staff had only minor conflicts with nurses and nurses processed these in a very procedurized manner. However, interviews reveal that there still exists a perception by nurses that the doctors view them as subordinates to them.

> *'In the Nursing department we work very closely with medical staff. Doctors feel and look at nurses as subordinates. This is old thinking. They should look as nurses as their second hand. They ignore the advice and opinion of nurses. They want to keep it as before (...) I think doctors and nurses should change their behaviour and attitude to nursing. Its an attitude problem. They have to see that all disciplines are important and work as a team.' (11 HMC NUR)*

This subordinate view has led to nurses not being involved in issues they feel concern them and to doctors being disrespectful.

> *'Conflicts still exist, for example, medical staff take decisions, e.g. equipment, and don't even inform nursing that such equipment is being ordered. Cooperation and attitude of medical staff is wrong. They call nursing staff by their numbers (i.e. staff nurse 1,2,3,4 or Head Nurse) not their name' (51 WH NUR)*

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[81] Refer to Table 8.13 Medical-Nursing Working Together, p. 260 and Table 8.14 Medical-Nursing Relationships, p.261.

Respondents found that the areas of most direct conflicts with doctors were on day-to-day issues such as paging and requesting doctors to attend the unit. A certain level of medical interferences with nursing functions was also found; *'They sometimes interfere in our work, e.g. in the promotion of staff, where some nurses seek their approval.' (17 RH NUR)*

There was also a feeling by medical staff that more medical involvement would be better.

> *'Nursing is a completely different department and we medical staff don't get a say, for example sometimes nurses of no experience in our speciality are hired. This can be minimized if we are approached before recruiting the paramedical and nursing staff to see their qualification before recruiting them.' (29 RH MED)*

However, not all units had problems with medical staff, many found their relationship with the medical staff to be very good which indicates that the relationship differed from one unit to another.

The majority of respondents found that nursing worked well with other nurses and that their relationship had only small insignificant conflicts. Table 8.17 Nursing-Nursing Working Together indicates that 47 percent of the respondents found that nurses worked 'well' with nurses. Table 8.18 Nursing-Nursing Relationship indicates that 37 percent of respondents found that nurses had 'small insignificant conflicts' with other nurses with minor variations in response by profession.

Table 8.17 Nursing-Nursing Working Together

Hospital	**Extremely well**	**Well**	**Somewhat well**	**Sometimes not well**	**Not well at all**	**Missing**	**Total**
HGH	5	33	11	7	1	5	**62**
WH	4	19	5	4		3	**35**
RH	6	13	6	2		2	**29**
CD	7	16	9	3		10	**45**
Total	**22**	**81**	**31**	**16**	**1**	**20**	**171**
Percent	***13%***	***47%***	***18%***	***9%***	***1%***	***12%***	***100%***

Question: To what extent do nursing staff work well with each other, respecting and trusting each other?

Table 8.18 Nursing-Nursing Relationship

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	8	20	21	3	1	9	**62**
WH	6	15	8	4		2	**35**
RH	4	13	8	2		2	**29**
CD	8	16	8	1		12	**45**
Total	**26**	**64**	**45**	**10**	**1**	**25**	**171**
Percent	***15%***	***37%***	***26%***	***6%***	***1%***	***15%***	***100%***

Question: How would you rate the relationship of nursing staff with one another?

Generally nurses have a view that as nurses *' (we) solve our problems with each other' (7 WH NUR)*. However, they found nursing administration *'poor' (78 HGH NUR)*, too centralized and some nurses were found to rally on the medical side.

> *'... clinical nurses like to work with medical staff and do not like the involvement of nurse's administration. There is an element of that in speciality units, a kind of resistance to acknowledging the proper channels. I must say it has improved. But sometimes its more quick and efficient for them to side track and rally with senior medical staff.' (13 RH NUR)*

Similarly, Table 8.19 Nursing-Administration Working Together indicates that the majority of respondents found nursing staff worked 'well' (55 percent) with administration. Table 8.20 Nursing-Administration Relationship indicates that that they had 'small insignificant conflicts' (38 percent). Some respondents found that their relationship with administration was a *'good relation and supportive' (7 WH NUR)* but more found administration not supportive. *'they are there but don't do anything, they don't support, you go to them and they can't help.' (78 HGH NUR)*

Table 8.19 Nursing-Administration Working Together

Hospital	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all	Missing	Total
HGH	3	40	9	1		9	**62**
WH	3	19	6	2		5	**35**
RH	6	13	5	3		2	**29**
CD	6	22	5	3		9	**45**
Total	**18**	**94**	**25**	**9**	**0**	**25**	**171**
Percent	***11%***	***55%***	***15%***	***5%***	***0%***	***15%***	***100%***

Question: To what extent do nursing staff work well with administrative staff, respecting and trusting each other?

Table 8.20 Nursing-Administration Relationship

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	13	24	12	1		12	**62**
WH	9	11	7			8	**35**
RH	8	11	6	1		3	**29**
CD	7	19	5	1		13	**45**
Total	**37**	**65**	**30**	**3**	**0**	**36**	**171**
Percent	***22%***	***38%***	***18%***	***2%***	***0%***	***21%***	***100%***

Question: How would you rate the relationship of nursing staff with administrative staff?

Some also felt that administration did not involve nursing in decisions and some further explained that the level of involvement depended on the character of the administrator; *'It depends on the characters of the administrators, some are authoritarian and patronizing to SADNs others like to involve and give authority to SADNs and we have had both.' (13 RH NUR)*

Thus, findings on nursing relations indicate that nursing attempted to gain more influence in the corporation's management and to professionalize the nursing profession. Generally, nurses perceived that within the corporation they were viewed as subordinate to all professions and were not important enough to be involved in decisions.

Most nursing conflicts were with doctors where there were many day-to-day conflicts and where nurses perceived that doctors viewed them as subordinates. A certain level of medical interference with nursing functions was found and some medical staff would have liked even more involvement.

Amongst each other, nurses only had small insignificant conflicts but some rallying from nurses with medical staff against the 'poor' and 'centralized' nursing administration was found. Finally there were only small insignificant conflicts with administration but nurses found administration to be unsupportive and do not involve nurses in decisions.

8.3.2.3.1 Analysis of nursing relations

As with nurses worldwide, nurses at HMC are shifting away from the 'Nightingale' tradition of nurses as obedient handmaidens of doctors and have set a professionalization strategy that aims at establishing national registration, codes of conduct and eliminating the different levels of nurses to one staff nurse level. Such professionalization attempts are similar to NHS nurses' professionalization attempts (Greenwell et al., 1994).

Traditionally at HMC, nursing were subordinate hierarchically to medical staff as the Nursing Department reported to the Medical Director. By shifting and reporting to the Administrative Director and ensuring they were no longer hierarchically under the medicine, the nursing profession declared its independence from the medical profession, but is having a hard time shacking off the 'subordinate' label. Nurses perceive that all professions view them as subordinate.

Additionally, nurses themselves often rallied with the medical profession against nursing administration. This confirms Greenwell et al.'s (1994) finding that historically nurses have been found to ally often with the medical side against managerial values.

8.3.2.3 *Administration relations*

This last section expands on the administrative relationships with medical staff, with nursing staff and with one another. Findings are then related to Shortell's (1982) attributes of socialization and other theoretical studies.

There was a general corporate level perception that administrators *'lack that enthusiasm' (65 HMC MTL)* needed to accomplish work successfully, that they are *'weak, have no role, just passing down paper' (33 HMC FIN)* and *'that there are so many administrators that we don't know which is doing what.' (62 HMC TENDR).*

As was seen in the section on medical relations, the majority of respondents found that medical staff and administrative staff worked 'well' (47 percent) together with 'small insignificant conflict' (39 percent)[82]. However, the majority of administrators interviewed found that they had most conflicts with the medical staff. This goes in line with findings on the medical staff relationships where the majority of the doctors' conflicts were with administration and where the medical staff had a low perception of administration.

Many of the medical respondents found that administration did not have knowledge of their work, were not professional and did not have real authority.

> *'If you have an administrator you need to strengthen his position. There is no real authority with administration. We cannot work in harmony, when he and the*

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[82] Refer to Table 8.15 Medical-Administration Working Together (p.262)and Table 8.16 Medical-Administration Relationship (p.262).

chairman may not be talking the same language or when the administrator does not have the authority or depth of knowledge.' (8 WH MED)

'About administration in general, they haven't found their niche in the corporation. They should be sent to a hospital to see what other administrators do. It will help them.' (106 HGH PARA)

Administrators suffer from this subordinate perception by the medical staff.

'We have a lot (of conflicts) especially with heads of departments and chairmen who look at us as inferiors. I suffer a lot from them. We told administration and they said they will talk to them but they remain the same. They feel like we are clerk and treat us like clerks...' (109 HGH ADMIN)

As was noted in Chapter Seven, Section 7.2.3.5 on Professional Boundaries, respondents also mentioned grey areas in the roles of administration and medical staff at the hospital level where most of these conflicts arise. There was *'not a clear role segregation between administration and medical at hospitals level.'(113 HMC ADMIN)*

Some doctors felt that administration was taking a policing role;

'Administration act in a way to make nursing and medical staff fear them. They act like police. At least that's what the doctors feel. Like waiting for them to make a mistake and fire them.' (52 HGH MED)

As noted in the section on nursing relations, nursing and administration were found to work 'well' (55 percent) and have only 'small insignificant conflicts' (38 percent)[83]. Although in the nursing relations section above nurses found administration not supportive and that they don't involve nurses in decision making, generally, administrative respondents found that their relationship with nurses were good with *'no major coordination problems' (110 HGH ADMIN).*

Finally, Table 8.21 Administration-Administration Working Together indicates that the majority of respondents found that administration worked well with other administration staff (42 percent) and Table 8.22 Administration-Administration Relationship by Hospital that they had 'small insignificant conflicts' (30 percent). The level of perceived conflict varied by profession and hospital.

[83] Refer to Table 8.19 Nursing-Administration Working Together (p. 266) and Table 8.20 Nursing-Administration Relationship (p.267).

Table 8.21 Administration-Administration Working Together

Hospital	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all	Missing	Total
HGH	3	25	10	1		23	**62**
WH	4	15	7	1		8	**35**
RH	3	15	5	1		5	**29**
CD	11	15	8	3		8	**45**
Total	**21**	**70**	**30**	**6**	**0**	**44**	**171**
Percent	***12%***	***41%***	***18%***	***4%***	***0%***	***26%***	***100%***

Question: To what extent do administrative staff work well one another, respecting and trusting each other?

Table 8.22 Administration-Administration Relationship by Hospital

Profession	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
Medical	2	11	1	0	0	11	**25**
Percentage	*8%*	*44%*	*4%*	*0%*	*0%*	*44%*	***100%***
Administration	7	3	3	0	0	0	**13**
Percentage	*53%*	*23%*	*23%*	*0%*	*0%*	*0%*	***100%***
Nursing	17	18	13	0	0	26	**74**
Percentage	*23%*	*24%*	*18%*	*0%*	*0%*	*35%*	***100%***
Paramedical	2	3	1	0	0	3	**9**
Percentage	*22%*	*33%*	*11%*	*0%*	*0%*	*33%*	***100%***
Therapy	2	5	1	1	0		**9**
Percentage	*22%*	*56%*	*11%*	*11%*	*0%*	*0%*	***100%***
Support Services	1	4	2	1	0	2	**10**
Percentage	*10%*	*40%*	*20%*	*10%*	*0%*	*20%*	***100%***
Corporate Depts	3	8	8	10	0	2	**31**
Percentage	*10%*	*26%*	*26%*	*32%*	*0%*	*6%*	***100%***
Total	**32**	**52**	**29**	**12**	**0**	**44**	**171**
Percentage	***19%***	***30%***	***17%***	***7%***	***0%***	***26%***	***100%***

Question: How would you rate the relationship of administrative staffwith one another?

By hospital, the majorities of HGH, RH and Corporate Departments found that administration had 'small insignificant conflicts' with one another while the majority of WH (34 percent) found there was 'full unity'. By profession, Table 8.23 Administration-Administration Relationship by Profession indicates that the majorities of medical, nursing, paramedical, therapy and support services found that administration only had 'small insignificant conflicts'. But the majority of administrative staff (53 percent) found that administrative staff with administrative staff had 'full unity' and an equal number of corporate staff found that they had 'small insignificant conflicts' (26 percent) or 'some conflicts' (26 percent).

Table 8.23 Administration-Administration Relationship by Profession

Hospital	Full unity	Small insignificant conflicts	Some conflicts	Frequent conflicts	Always in conflicts	Missing	Total
HGH	9	20	12			21	**62**
	15%	32%	19%			34%	**100%**
WH	12	8	3			12	**35**
	34%	23%	9%			34%	**100%**
RH	9	11	3	1		5	**29**
	31%	38%	10%	3%		17%	**100%**
CD	4	16	13	1		11	**45**
	9%	36%	29%	2%		24%	**100%**
Total	**34**	**55**	**31**	**2**	**0**	**49**	**171**
Percent	***20%***	***32%***	***18%***	***1%***	***0%***	***29%***	***100%***

Question: How would you rate the relationship of administrative staffwith one another?

Administrative respondents found that bureaucracy, lack of knowledge in medical equipment and lack of authority has led to them taking the role of the middle man who passes papers down.

> *'Too much bureaucracy, so much paperwork. ... Administration is only re-approving, the middle man. Sometimes the word of the director is more powerful than the word or the administrator. He cannot really disapprove. This could be because of lack of knowledge of medical equipment. It comes with experience. Now the administrators are doing more the role of the middleman, passing down papers. They are getting more experienced and better but they are still the middle man.' (79 HGH ADMIN)*

In addition respondents found that lack of job descriptions and similar job descriptions for the different administrative levels has added to confusion on the role of administrators. Administrators felt that centralization, lack of information and influential titles have contributed to the negative image of administration and to people over passing administrators[84].

> *'... our titles not very influential. If we had title like hospital director it would be much easier. This would give administration an identity and independence.(110 HGH ADMIN)*

Overall, the general corporate opinion on administration is that they are weak, have no authority, have no clear role within the organization, work as the middle man who just passes down papers and that there are too many of them in the corporation.

Although questionnaire responses indicated that medical staff and administrative staff worked well together and had small insignificant conflicts, interview responses indicted that most administrative conflicts were with medical staff. Medical staff perceived administration as not knowledgeable of their work, not professional, having no real authority and acting as policemen. Consequently administrators suffer that doctors view them as inferiors, mere clerks. Additionally, the grey areas in the roles of administration and medical staff at the hospital level lead to conflicts.

Administrative and nursing staff seem to be working well with small insignificant conflicts and 'no major coordination problems'. Administrative staff worked well with one another but although they perceived their relationship as one of 'full unity' it was the perception of other professions that administrators had 'small insignificant conflicts' or 'some conflicts' amongst themselves.

Administrators saw their role in the corporation as middlemen, passing down papers with no real authority and respect by other professions. They viewed the reasons for this as: lack of knowledge and experience with medical equipment, lack of clear job descriptions, similar job descriptions for different administrative levels, centralization of authority and decision making, lack of information and lack of influential job titles.

8.3.2.3.1 Analysis of administrative relations

Findings are explored in terms of four of Shortell's (1982) six attributes of socialization processes of the three health groups; basis of knowledge, exposure to clients while training, time frame of action and professional identity. First, physicians have a biomedical basis of knowledge, nurses a combination of biomedical and social sciences and administrators a social and management sciences.

Our findings indicate that the medical staff view administrators as not having knowledge of their work or no 'depth of knowledge'. In doing so, the medical staff evaluate administrative knowledge from the standpoint of their own knowledge base; *'we cannot work in harmony when he (administrator) and the chairman may not be talking the same language'. (8 WH MED).* Within this fame of mind, medical staff will continue to view administrators as not knowledgeable.

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[84] Refer to Chapter Seven, Sections 7.2.3.3 (p.195) and 7.2.3.4 (p.199).

Second, of the three professions, administrators are those with least exposure to their clients during academic training. This places them in a weak starting point compared to other professions. Where others have acquired some experience before hand, administrators must build theirs from scratch. Some administrators in this case found that they hold the 'middleman' role because of lack of knowledge in medical equipment, something that comes with exposure and experience.

Third, compared to the medical profession and nursing professions whose time frames for action are short or medium to short, the administrative time frame is generally medium to long term with involvement in planning activities. In this case, administrators at individual levels were tied by centralization of decision-making and information, lack of clear job descriptions, and lack of planning activities.

This has had an adverse effect on the administrators to whom involvement in medium and long term planning is an integral part of their function. But it has a compounded effect on the other professions who are viewing the administrators as failing to achieve in the short term, medium term and long term. As a result they see administrators as '*weak, have no role, just passing down paper*' *(33 HMC FIN)*.

Finally, of all three professions the administrative one is the one with the least cohesive identity. In our case we see that administrators were viewed as non-professionals by doctors and although the administrators perceived their relationships with one another as one of 'full unity' the other professions viewed them as having 'small insignificant conflicts' or 'some conflicts' with one another. Additionally, administrators seek influential titles that they perceive will give administration '*an identity and independence*' *(110 HGH ADMIN)*; and thus through autonomy and dominance help create a professional identity

As with other perceptual studies conducted in the US and UK (Bettner, 1987; Dawson, 1994; Stewart, 1989) our study revealed mistrust and suspicion between doctors and managers. As we saw some doctors felt that administrators were policing them '*waiting for them to make a mistake and fire them*" *(52 HGH MED)*.

This study also revealed that the perceived role, by doctors, of the administrator is that of a subservient facilitator. Subservient because the administrators did not really have the power to limit professional activity and control resources *'he cannot really disapprove' (79 HGH ADMIN)* as in the early British NHS days (Dawson, 1994; Flynn 1992).

8.3.3 Analysis of professional culture

With regards to the medical profession, this study finds evidence on the importance of knowledge (Parry and Parry, 1976; Friedson, 1970b) to the medical profession as its relationship with other professions revolved around its recognition or not of their knowledge base. Conflicts with nursing did not seem to annoy the medical profession, as these did not challenge medical dominance. Managerial knowledge and values were rejected possibly as a defence against cut back in professional power echoing the British NHS experience when managerialism was introduced (Butler, 1985; Harrison et al., 1990; Moran and Wood, 1993).

With regards to nurses, findings indicate that nurses still suffer from the subordinate label but are moving towards professionalization and away from medical dominance using similar steps to the British NHS professionalization attempts (Greenwell et al., 1994). However, as with the British NHS (Greenwell et al., 1994) there was also evidence supporting research findings on nurses rallying with medicine against managerial values. Finally, nurses' perception that they are viewed as subordinate to all professions echoes Friedson's (1970b) observation that para-professionals are not only subordinate to professional experts but also to the authority of the bureaucratic office.

With regards to administration, findings indicate that doctors do not recognize managerial knowledge base and values and that, as in similar perceptual studies carried out in the US and UK (Bettner, 1987; Dawson, 1994; Stewart, 1989; Fitzgerland and Sturt, 1992) there is mistrust and suspicion between doctors and administration. Findings also indicate that the lack of exposure and hence experience during training negatively affects the perceived image of administrators to other professions. Of the three professions, administration was found to have the least cohesive identity but aspired towards creating a professional identity by seeking autonomy and dominance, factors found important in maintaining power and monopolistic positions (Hughe, 1958; McKinlay, 1973; Friedson, 1970a and 1970b; Krause, 1971; Johnson, 1972; Larson, 1977).

Finally, there is evidence that in the absence of the authority to limit professional activity and control resources administrators are regarded, as were administrators in the early NHS years, (Dawson, 1994; Flynn, 1992) as 'subservient facilitators' to the doctors.

8.3.4 Conclusion on professional culture

This section explored professional culture by exploring interprofessional relations of medical, nursing and administrative staff. Evidence of the importance of knowledge and professional dominance to the medical staff was found. So was evidence of nurse staff's perception of their subordination to other professions and their move to professionalization. Of the three professions, administration was found to have the least cohesive identity. Evidence of mistrust and suspicion between doctors and administration was found as well as evidence that lack of exposure and experience results in a negative perception of administration by other professions.

8.4 *Influence of national culture*

8.4.1 Introduction

As HMC was set up on western practices and has had western managers until recently, assessing the effect of national culture on HMC organizational culture is not an important element of this research. However, certain elements of national culture did emerge that are worthwhile exploring.

Working from a list of 'Arab management culture' characteristics interview findings were explored for elements that have been attributed to Arab management culture by researchers. Most elements have been found to exist in the organizations studied. However, attributing these elements to national culture is unlikely.

8.4.2 Arab management culture at HMC

Research on Arab management culture has proposed that bedo-aucracy (or sheickocracy), Islam, Turkish and British colonization and rapid westernisation have created a very particular parodoxal culture (Hickson and Pugh, 1995)[85].

[85] This culture was characterized as containing the following elements: centralization of authority and decision making power; decisions not structured, rely on personal judgements and interests; reactive and crises oriented management where decisions and commitments are renegotiated at a later time; participation is in the form of 'consultation' and informal; loyalty and obedience to formal hierarchy of power; group affiliations and kinship ties are important; organization members are motivated by affiliation and power needs rather then performance objectives; informal means of doing things in organization is predominant; constant change and high levels of uncertainty at work; closed information systems and low levels of disclosure to organization members; a low trust atmosphere and political gamesmanship; punctuality and time constraints of less concern; lack of planning (Al-Faleh, 1987; Attiya, 1992; Muna ;1980). See Chapter Four, Section 4.5.1, p.94.

Although the research found proof of the existence of some of the elements attributed to Arab management culture, the researcher does not find these elements to be national culture specific but organizational specific. It is the opinion of the researcher that centralized decision making, lack of planning, 'consultation' rather then participation, lack of continuity, high uncertainty and the importance of informal communication are due to structural and process weaknesses rather than national influence. These supposedly Arab management characteristics could be found in any organization suffering from structural and process weaknesses, regardless of the national culture.

In Chapter Seven we explored HMC's structural and processes weaknesses and revealed an environment of constant change and uncertainty, centralization, reliance on hierarchy and informal means for coordination, lack of planning, continuity and employees participation, no standardization and low information sharing. In such an environment of weak processes where monitoring and control are difficult (as there is no standardization of activities and norms), work relies very heavily on individuals, on their decisions, personalities, values and contacts. A scenario that would occur regardless of national culture. As a result there can be place for discrimination, favouritism, unstudied decisions, reactive management and pursuing personal interests.

> *'...Leaving it to people as it is, is very dangerous because you rely a lot on the individuals specially that there is no written and clear processes...' (11 HMC NUR)*
> *'...There is no fairness in treatment of staff and issues. Don't leave it as a one-man decision. Since issues are not clear, its become a one man decision'. (107 HGH ADMIN)*

The findings support research on Arab national culture in as much as the characteristics attributed to 'Arab management culture' have been found in the research setting. However, given the structural and process weaknesses of HMC this places doubts on the characteristics appearing because of national culture influence. Given the same structural and process weaknesses these elements would appear in most organizations regardless of what the national culture is. Thus, the research does not endorse the point of view that these characteristics are nation-bound. Rather, it finds more evidence in these characteristics being organization-bound shedding a doubt on the conclusions of studies on 'Arab management culture' by Al-Faleh (1987), Attiya (1992), Muna (1980) and Hickson and Pugh (1995).

8.4.3 Conclusion on national culture

This section explored the existence of characteristics of Arab management culture at HMC and found most elements to exist. It concluded that these characteristics were more likely to be organization- bound than national-bound, as they would appear in any organization, regardless of national boundaries, in conditions of structural and process weaknesses.

8.5 *Conclusion*

This chapter explored HMC's organizational culture by looking at homogeneity of organizational values, commitment to existing culture, cultural direction, professional culture and national culture. The first part attempted to explore homogeneity of organizational values, commitment to these values and the direction of the organization culture (Luthans, 1995; Kilman et al., 1985). Findings conclude that overall there is a strong homogeneity in values with minor variation by hospital and profession indicating the existence of subcultures which share organization wide core values but maintain their own individuality. These homogeneous values were then traced to their most likely core values. These findings are in line with studies under the differentiation perspective that portrays subcultures as co-existing in harmony, conflict or indifference to one another (Martin and Mayerson, 1987; Smirichich and Morgan, 1982; Riley, 1983). The research additionally concludes that the existing culture is somewhat negatively directed in that there is a significant gap between desired and actual culture. Relating this to Luthan's (1995) definition of cultural strength as being a function of homogeneity of values and commitment to the culture, our findings indicate that HMC's culture is not strong. Although its homogeneity to cultural values is relatively high, it is low in commitment to its existing culture in that it was found to have shortcomings in corporate objectives, work processes, staff skills, morale and quality of performance.

The second part explored the different subcultures by studying interprofessional relations. With regards to the medical profession, this study finds evidence on the importance of knowledge to the medical profession as its relationship with other professions revolved around its recognition or not of their knowledge base. With regards to nurses, findings indicate that nurses still suffer from being subordinate to other professions but are moving towards professionalization and away from medical dominance. However, there was also evidence supporting research findings on nurses rallying with medicine against managerial values (Greenwell et al., 1994). With regards to administration, findings

indicate that doctors do not recognize managerial knowledge base and values and that there is mistrust and suspicion between doctors and administration (Bettner, 1987; Dawson, 1994; Stewart, 1989; Fitzgerland and Sturt, 1992). Findings also indicate that the lack of exposure during training the absence of the authority to limit professional activity and control resources have negatively affects the perceived image of administrators. Finally, of the three professions, administration has the least cohesive identity and aspires towards creating a professional identity.

The final part explored the influence of national culture. The findings support research on Arab national culture in as much as the characteristics attributed to 'Arab management culture' have been found in the research setting. However, the research does not endorse the point of view that these characteristics are nation-bound. Rather, more evidence in these characteristics being organization-bound was found shedding a doubt on the conclusions of studies on 'Arab management culture' by Al-Faleh (1987), Attiya (1992), Muna (1980) and Hickson and Pugh (1995).

CHAPTER 9 ORGANIZATIONAL AND TEAM EFFECTIVENESS

9.1 *Introduction*

Previous chapters have considered some characteristics that touch upon organizational effectiveness such as cultural strengths and direction and organizational process. This chapter explores overall organizational effectiveness and team effectiveness. Since, as found in Chapter Six[86], HMC relies heavily on committee and team work for coordination, a study on hospital structure and effectiveness would not be complete without a study on the effectiveness of teams. Organizational effectiveness is explored by applying the Competing Values framework as organizational assessment means and team effectiveness is explored by studying team functioning and performance.

9.2 *Assessing organizational effectiveness*

9.2.1 Introduction

The objective of this section is to explore organizational effectiveness using the documentation available and the Competing Values framework (Quinn and Rohrbaugh, 1981 and 1983). First, findings from application of the Competing Values framework are described. Second, the documentation collected and the organization's internal assessment efforts are studied. Third, where relevant, findings are related to the theoretical material on organizational assessment, effectiveness evaluation of public health services and the competing values framework. Finally, conclusions on organizational effectiveness at HMC and the application of the framework are drawn.

9.2.2 Competing Values framework

The Competing Values (CV) framework gives an overview of the organizational effectiveness values and efforts of an organization. As described in Chapter Three the competing values framework contains four components of organizational effectiveness[87]. The Open System component focuses on flexibility, change and the ability to acquire resources. The Rational Goal component focuses on goals, objectives and productivity and efficiency. The Internal Process component stresses information dissemination, control, stability and order. Finally, the Human Relations component emphasizes

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[86] Section 6.3.5.2 The Reliance on Committees, p. 149.

[87] See Chapter Three, Figure 3.1, p. 63.

cohesiveness and skills of the workforce. Plotting questionnaire results on the competing values framework by hospital and by profession identifies the emphasis placed by the corporation, as perceived by its members, on the four organizational effectiveness components.

A series of questions were asked to organizational members on each component of the framework[88]. Annex 8 describes the main elements of each component and the questions used to explore these components. For example, the Open System component was found to be composed of four main sets of questions; response to the environment and clients, change and decision making, budget and budgeting processes, and manpower attraction. These four sets each contain a number of questions with responses ranging from 1 (highest positive score) to 5 (lowest negative score). The responses to these questions are added and averaged to give one score for each of the four sets of the Open System component. The same process is repeated for the Rational Goal, Internal Process and Human Relations components and the responses plotted on a 'radar graph'.

Figure 9.1 Competing Values by Hospital is the graph for results by hospital. The highest positive score possible is 1 and the worst negative score possible is 5 but, in general, the responses all fell in between scores 2.0 and 3.5 indicating somewhat of a balance between the competing values. No one component of organizational effectiveness was emphasized to the extreme.

However, findings indicate that a higher emphasis was placed on one quadrant, the Human Relations Model, characterized by an internal focus and flexibility. All responses except for staff morale had a high positive score ranging from 2.0 to 2.5. Responses for staff morale were around 3.0.

On the other side, findings indicate that the value sets of the Open System Model quadrant, characterized by external focus and flexibility were the least emphasized by the organization. All responses except for response to environment and clients had a score from around 2.75 to 3.5. The score for responses to environment and clients were around 2.5.

[88] See Chapter Five, Section 5.3.2 Questionnaire on culture, structure and organizational effectiveness.

Figure 9.1: Competing Values by Hospital

Flexibility

HUMAN RELATIONS MODEL

OPEN SYSTEM MODEL

Internal

External

281

INTERNAL PROCESS MODEL

RATIONAL GOAL MODEL

Control

Questions Index

Open System

1. Response to Environ/Change
2. Change and Decisions
3. Budget and Budgeting
4. Manpower Attraction

Rational Goal

5. Mission and Productivity
6. Objectives Achievement
7. Impact on Population
8. Productivity

Internal Process

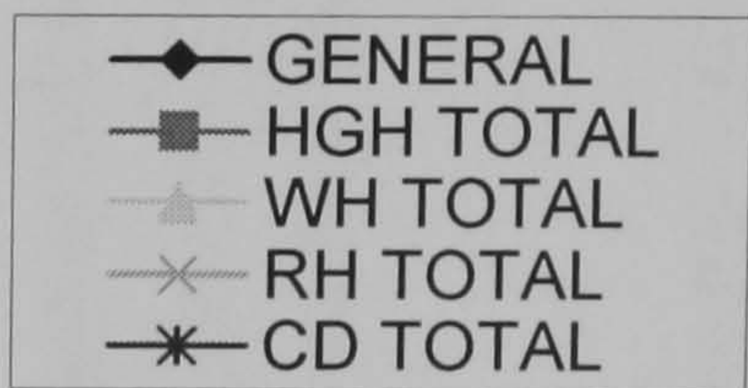
9. Information Flow
10. Employee Awareness of Change
11. Work Processes
12. Policies and Procedures

Human Relation

13. Interprofession Relationships
14. Conflicts
15. Staff Morale
16. Skills and Training

Responses Index

0 Highest Positive Score
3.5 Lowest Negative Score



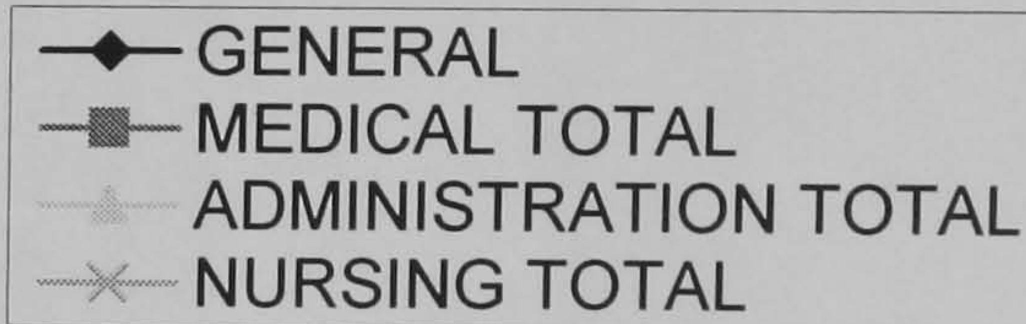
Responses to the Rational Goal and Internal Process quadrants were very similar with slightly higher responses for the Rational Goal model values indicating a slightly higher emphasis on external control than internal control.

Similarly the most noticeable difference between the three hospital and the corporate responses are in these two quadrants, the Rational Goal and Internal Processes Models. This indicates that there are high variations in the perceived emphasis the hospitals place on internal and external control.

Figure 9.2 Competing Values by Profession is the graph for results by profession. Here again results indicate a higher emphasis on the Human Relations Model where all scores except for staff morale were high. The value sets of the Open System Model were the least emphasized. Here too responses to the Rational Goal and Internal Processes quadrants were very similar with slightly higher emphasis on the Rational Goal Model. As in by hospital, the most noticeable differences in perceived effectiveness value emphasis between the different professions was in the rational goal and internal process components.

Findings thus indicate that by hospital and by profession perceived organizational effectiveness values and efforts in the organization were similar. In general, findings indicate the highest emphasis is on the Human Relations component, which emphasizes cohesiveness, skills and morale of the workforce and the least emphasis on the Open System component, which focuses on change, flexibility, and ability to acquire resources. A slightly higher emphasis was placed on the Rational Goal component, i.e. the mission directedness, productivity and efficiency focus, than on the Internal Process component with its information dissemination, control, stability and order emphasis. Additionally, in both hospital and profession results, there were high variations in perceived emphasis on the Rational Goal and Internal Processes components.

Figure 9.2: Competing Values by Profession



Questions Index

Open System

1. Response to Environ/Change
2. Change and Decisions
3. Budget and Budgeting
4. Manpower Attraction

Rational Goal

5. Mission and Productivity
6. Objectives Achievement
7. Impact on Population
8. Productivity

Internal Process

9. Information Flow
10. Employee Awareness of Change
11. Work Processes
12. Policies and Procedures

Human Relation

13. Interprofession Relationships
14. Conflicts
15. Staff Morale
16. Skills and Training

Responses Index

0 Highest Positive Score
3.5 Lowest Negative Score

9.2.3 Internal organizational assessment efforts

Very little information on organizational effectiveness, productivity, performance or efficiency was found. The reason for this is the organization's weakness in capturing and measuring performance indicators:

> 'As it is, HMC collects very poor statistics of work output. General information is captured for the Annual Report but that information is not helpful at analyzing productivity and performance. We need to start in collaboration with Quality Management, HIS, and Finance a program to capture and measure the important elements (medical and administrative indicators) of which the staff and unit's work is composed of that requires regular monitoring and organization..... We need first to define the indicators and introduce simple procedures to record key output of staff and units. This will enable proper study of productivity, proper monitoring of staff output and thus more focused productivity and performance improvement efforts.'
>
> *'Administrative Executive Report, 1998'*

Other than financial expenditure data and visits and deaths statistics the only performance documents available were the quality management reports on patient satisfaction. Even at the job unit level, documentation was lacking. Criticism had been made of the lack of specification of job content and reference to performance in any way in the job contract *(Consultant Report, Medical Recruitment Contracts, 1989).*

The budgeting process is the only managerial activity of performance review and it has been criticised for losing focus and not being linked to organizational objectives;

> 'Budgets that are based on the previous year's expenditures level like that of HMC tend to lose focus and direction as the years go by .....Actual budgeting process needs to be improved and linked to objectives. Presently the budget is done haphazardly with the departments having most influence obtaining larger budgets and those with little influence being left out. Proper prioritisation of overall budget allocation needs to be done ....'
>
> *'Administrative Executive Report, 1998'*

As described in Chapter Eight Organizational Culture[89] when discussing quality of performance, quality patient satisfaction reports indicate that patients were overall, moderately satisfied with services at HMC (57 percent satisfied with HGH; 36 percent satisfied with WH inpatient services; 52 percent satisfied with RH outpatient services).

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[89] Section 8.2.2.3 Committment to Existing Culture, p.252.

Hence, there was also evidence of weak documentation and capturing of performance indicators. Internal organizational review is conducted at budget preparation, a process that has been criticized for its loss of focus and linking to objectives. Internal patient satisfaction reports indicated overall moderately satisfied with HMC services.

9.2.4 Effectiveness of public health services

Klein (1982) noted that the complexity, heterogeneity, uncertainty and ambiguity of the British NHS have made performance evaluation difficult. This was found to be similarly applicable to HMC where there was an absence of clearly documented goals and activities, and a complex, delicate balance of power between the different constituencies.

The absence of clarity and performance assessment activities in HMC could be associated with weak management of the organization but also could be related to the dominance of the health service providing organization on society and on the industry as there are few alternative providers (Klein, 1982). Thus there is no pressure on the organization from society to meet demands as it is the organization itself that prescribes the demand.

Services are generally intangible and hard to measure (Thompson and McEwen, 1958; Newmann and Wallander, 1978). Additionally, the worthiness of a non-profit's activities tends to be assumed, so that its mere existence is seen as indicative of "good works" or "social morale contributions" and there is no need to show returns and results (Kanter and Summers, 1987). This can be implicitly witnessed in our organization in the lack of clear accountability and performance monitoring.

It was found that where nonprofits face little competition, recipients of services tend not to provide feedback (Selby, 1978). This was the case of HMC until the QM department instigated patient satisfaction surveys in the late 90s. Finally, it was found that nonprofits are more likely to focus on input rather than output (service delivered and goals attained) (Kanter and Summers, 1987). This is clear in HMC in the emphasis placed on the budgeting processes compared to the few performance measurement activities conducted.

However, an input-focus risks making effectiveness synonymous with cost management (Burningham, 1990). Elements of this was found in the organization under study where budgeting and staffing received great attention but where output was expressed in terms

of raw statistical data of activities in a manner not helpful at analysing performance and productivity. As indicated by the findings, this focus on input had received criticism for its undirectedness.

In health services, effectiveness is defined in terms of the relationship between outputs and outcomes (Flynn, 1986) and has been equated to quality assurance whose steps are similar (Long, 1992; Donabedian, 1980). A move towards effectiveness was witnessed in the organization under study in the rise of the Quality Management department activities witnessed in Chapter Six[90] on structural change and in the introduction of patient satisfaction studies.

The most commonly used measures to assess the process level are medical audits and patient satisfaction (Roberts, 1990). At HMC, patient satisfaction studies had been conducted and medical audits were underway at the Quality Management department. As outcome measures, statistics of hospital deaths and short-term clinical outcomes were kept but these were not converted into impact, which is important in assessing effectiveness. Flynn (1986) noted that the requirement of professional input in translating output to impact in measuring effectiveness which makes it unpopular among practitioners and researchers (Flynn, 1986; Bourn, 1992; Long, 1992).

In comparing the different criteria of evaluation used to evaluate the NHS, Long (1992, p. 68) found that effectiveness had a low profile with activities associated to effectiveness being patient satisfaction surveys while efficiency was found to be the main criterion dominating NHS evaluation activities. This is quite similar to HMC evaluation activities at the moment the research was conducted. Effectiveness activities were patient satisfaction surveys and efficiency was focused on during the budget processes in terms of cost management.

9.2.5 Analysis of findings

Although social models of organizational assessment are thought to be the least preferred (Thompson, 1967), faced with weak internal documentation and ambiguous standards of desirability, the researcher selected the Competing Values Model, a social model of organizational effectiveness, that would enable assessment of a broad range of effectiveness criteria and values.

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[90] Section 6.4.3.2, p.164

Many of the difficulties in health services effectiveness assessment in the NHS were found in HMC as well such as the ambiguity of goals and performance assessment activities, intangibility of services, dominance of the producers, and assumed worthwhileness of the organization (Klein, 1982; Thompson and McEwen, 1958; Newmann and Wallander, 1978; Kanter and Summers, 1987). Evidence was found to support findings that where nonprofits face little competition, recipients of services tend not to provide feedback (Selby, 1978) as HMC's patient satisfaction surveys only commenced recently. Similarly, our findings on the dominance of the budgeting process support that nonprofits are more likely to focus on input rather than output (Kanter and Summers, 1987) with the risk of an input focus leading to a lose of direction. Also the annual assessment process's focus during budgeting on past performance confirms Thompson's (1967) proposition that organizations assess their components in terms of past efficiency when technologies are perfected and environment stable or buffered.

As in the British NHS (Long, 1992), efficiency was found to be the main criterion at HMC but a move towards effectiveness is witnessed in the rise of the Quality Management department activities at HMC. Exploring effectiveness in terms of Donebedian's (1980) structure-process and outcome model, evidence of structure and process measures activities were found at HMC. Some outcome measures statistics were found but these were not converted to impact. This was associated to the requirement of professional input in translating output to outcome when evidence was found that HMC professional staff found the organization to be more productive and have a higher impact on the population than did non-professional staff (Flynn, 1986; Bourn, 1992; Long, 1992).

Application of the Competing Values framework at HMC revealed that the main emphasis of the organization was on cohesiveness and skilled workforce. This supports findings by another application of the Competing Values framework where a similar emphasis was found in the health industry (Dastmalchain et al., 2000) and indicates how important working relations are in health settings were tasks are codependent on the ability of the different professions to work together.

The second most important emphasis was on plans, goals, productivity and efficiency. This is understandable considering the outcome and impact focus of health services. There were high variations in the responses by profession. On the criteria of productivity and impact on population the medical profession gave the organization the highest score and the administrative staff gave the organization the weakest score. The nursing profession gave an in-between score equal to the general score (See Figure 9.2, Point

Seven). This could be attributed to the fact that professional knowledge and input are required in translating output to impact (Flynn, 1986; Bourn, 1992; Long, 1992). With their professional understanding of the output statistics the medical staff view the organization as having a higher productivity and impact then do the other professions.

The third highest emphasis of HMC organizational effectiveness efforts was on the internal process activities such as information dissemination, control and organization. The significant variations in responses by profession and hospital indicate that it is in this area that the different hospitals and professional groups express their individual management practices and styles. The weakest score of the corporation was on the open system components such as the ability to acquire resources.

It is interesting to note that the three highest emphases of HMC's organizational effectiveness effors are in line with the desired organizational culture. In the findings of Chapter Eight on organizational culture, the application of the Hay Groups' Targetted Culture Model[91] revealed that organizational members aspired for by order of importance, an organization with highly skilled, knowledgeable, satisfied and motivated staff (equivalent to the Human Relations model on the CV framework), an organization which focuses on quality of peformance and has clear missions and objectives which it achieves (equivalent to the Rational Goal model on the CV framework), and finally one which has very organized work processes, operations, and activities (equivalent to the Internal Processes model on the CV framework).

This seems to indicate that the organization is placing emphasis on the areas that organizational members aspire to achieve, as they perceive these elements to be important for the success of health services organizations. It also confirms Thompson's (1967) suggestion that organizations are multidimensional, and that when they cannot show improvement of all dimensions, they seek improvement on those of interest to important elements of the task environment. In a health environment such as HMC where cooperation is important and tasks are codependent on the ability of the different professions to work together, a focus on human relations in the organization is probably the most important element of the task environment.

Exploring findings in light of works on the competing value framework and life-cycle (Quinn and Cameron, 1983; Cameron and Whetton, 1981) findings indicate that HMC has

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[91] Section 8.2.2.3 Commitment to Existing Culture, Table 8.8, p.253.

well exceeded the initial stages of development and is mostly focusing on cohesiveness among members, elements associated to later stages of development. It also exhibits some elements of later and final stages by emphasizing on efficiency, productivity, formal processes of control and structural improvement.

Application of the CV framework revealed that because of its holistic approach to effectiveness the framework is lengthy, time consuming and unpractical for application. First, it is structured in a manner that makes it difficult for all the important constituencies to understand and respond to. Only those working in or closely with the organization would be able to respond to such questions. Second, it does not manage to overcome the limitation of multiple constituencies' approaches (Robbins, 1990) in that is does not help in identifying the expectations that the different constituencies hold for the organization on the different models (i.e., the human relation, open system, rational goal and internal processes models). To overcome this weakness we draw from the findings of the Targeted Culture findings in Chapter Eight that confirm that the organization is placing emphasis on the areas that organizational members view as important for the success of health services organization. Its third weakness lies in it relying solely on perceptual measures. The weak-documentation of productivies and efficiency monitoring in the organization under study did not help in balancing this bias. Future application of the CV framework should seek to address these three weaknesses in order to make the CV framework more valid as a model for evaluating organizational effectiveness.

9.2.5 Conclusion on organizational effectiveness

This section explored health services effectiveness assessment and applied the Competing Values framework (Quinn and Rohrbaugh, 1981 and 1983) exploring findings by hospital and by profession. Findings revealed that HMC suffered from difficulties in health services effectiveness assessment similar to the well-documented British NHS difficulties. Application of the Competing Values framework revealed that the main focus of the organizational efforts was on obtaining cohesiveness and skilled workforce and the second emphasis was on goals, productivity and efficiency. These findings are especially interesting in light of previous findings in Chapter Seven on interprofessional relations where many conflicts were found between the medical, nursing and administrative staff. This indicates that, although there are conflicts between the different professions, it is the human relations focus of the health organization that enables harmony and cohesiveness in the workplace, an environment necessary for the interdisciplinary nature of the work.

9.3 *Evaluation of team effectiveness*

9.3.1 Introduction

In Chapter Six we saw that HMC has over 40 corporate committees as well as hospital teams and committees. In Chapter Seven we found that most departments in all three hospitals had similar departmental committees and that HMC relies heavily on committees and teams to achieve coordination[92]. This section explores team effectiveness in terms of perceived team functioning and team performance. It also sets out to determine whether there are significant differences in perceived effectiveness by hospital or by profession. First, the separate components of team effectiveness (Alexander et al., 1996); team functioning and team performance are each explored in detail. Then, respondents' perception of their team's effectiveness is explored as well as respondents' perceptions on how their team's effectiveness could be improved. These findings are then put together to form an overall indication of team effectiveness at HMC. Finally, finding are analysed in light of theoretical material and conclusions on team effectiveness are drawn.

9.3.2 Team functioning

Team functioning has been broken down into eleven characteristics; clarity of committee objectives, organized meetings, selection of appropriate members, appropriate committee size, members' active participation, members' freedom to express their opinion, serious consideration of opinions, open and trusting communication, careful analysis of issues during disucssions, decisions made timely and appropriately, and finally decisions-making by consensus or majority. For clearer comparisons, the positive responses to each of these characteristics (eg. Committee objectives extremely clear or clear but not the negative responses such as committee objectives not clear or not set) have been presented in number and percentage for each hospital and profession.

When looking at team functioning in HMC as a whole, all characteristics had fairly high response rate. Table 9.1 Team Functioning by Hospital indicates that the characteristics members selection, freedom of expression, open and trusting communication, decision making mode, careful analysis during discussion, and committee objectives got extremely high responses. 97.1 percent of respondents found all or most members to be appropriate, 92.9 percent found that members always or most times have no difficulty in expressing their opinion, 92.9 percent found that communication was either extremely or

generally open and trusting, 91.4 percent found decision making to be either by consensus or majority, 90 percent found that objectives were extremely clear to all or most members and finally, another 90 percent found issues were always or generally carefully analysed during discussions.

Table 9.1 Team Functioning by Hospital

Characteristics	HGH	WH	RH	Corp. Depts.	Total
Committee Objective:					
Extremely clear to all	10 (52.6)*	3 (30)	4 (26.7)	11 (42.3)	28 (40)
Clear to most	8 (42.1)	7 (70)	10 (66.7)	10 (38.5)	35 (50)
subtotal:	**18 (94.7)**	**10 (100)**	**14 (93.4)**	**21 (80.8)**	**63 (90)**
Meetings Organisation:					
Meetings extremely well organized	4 (21.1)	1 (10)	2 (13.3)	12 (46.2)	19 (27.1)
Meetings well organized	11 (57.9)	4 (40)	11 (73.3)	8 (30.8)	34 (48.6)
subtotal:	**15 (79)**	**5 (50)**	**13 (86.3)**	**20 (77)**	**53 (75.7)**
Members Selection:					
All members appropriate to comm. Obj.	13 (68.4)	3 (30)	7 (46.7)	10 (38.5)	33 (47.1)
Most members appropriate	5 (26.3)	7 (70)	8 (53.3)	15 (57.5)	35 (50)
subtotal:	**18 (94.7)**	**10 (100)**	**15 (100)**	**25 (96)**	**68 (97.1)**
Committee Size:					
Very appropriate	**17 (89.5)**	**7 (70)**	**10 (66.7)**	**21 (80.8)**	**55 (78.6)**
Members Participation:					
All are extremely active	6 (31.6)	4 (40)	3 (20)	3 (11.5)	16 (22.9)
Most are active	11 (57.9)	4 (40)	9 (60)	16 (61.5)	40 (57.1)
subtotal:	**17 (89.5)**	**8 (80)**	**12 (80)**	**19 (73)**	**56 (80)**
Freedom to Express Opinion:					
Always have no difficulty	13 (68.4)	5 (50)	7 (46.7)	13 (50)	38 (54.3)
Most time have no difficulty	4 (21.1)	5 (50)	8 (53.3)	10 (38.5)	27 (38.6)
subtotal:	**17 (89.5)**	**10 (100)**	**15 (100)**	**23 (88.5)**	**65 (92.9)**
Opinion Seriously Considered:					
Always seriously considered	11 (57.9)	3 (30)	6 (40)	12 (46.2)	32 (45.7)
Most always seriously considered	7 (36.8)	5 (50)	8 (53.3)	9 (34.7)	29 (41.4)
subtotal:	**18 (94.7)**	**8 (80)**	**14 (93.3)**	**21 (80.9)**	**61 (87.1)**
Open and Trusting Communication:					
Extremely open and trusting	10 (52.7)	2 (20)	4 (26.7)	12 (46.2)	28 (40)
Generally open and trusting	9 (47.4)	8 (80)	10 (66.7)	10 (38.5)	37 (52.9)
subtotal:	**19 (100)**	**10 (100)**	**14 (93.4)**	**22 (84.7)**	**65 (92.9)**
Careful Analysis During Disucssions:					
Always	9 (47.4)	2 (20)	4 (26.7)	7 (26.9)	22 (31.4)
Generally	7 (36.8)	7 (70)	10 (66.7)	17 (65.4)	41 (58.6)
subtotal:	**16 (84.2)**	**9 (90)**	**14 (93.4)**	**24 (92.3)**	**63 (90)**
Decisions Made Appropriately:					
Always	**10 (52.6)**	**4 (40)**	**8 (53.3)**	**13 (50)**	**35 (50)**
Decision Making:					
By concensus	2 (10.5)	4 (40)	2 (13.3)	2 (7.7)	10 (14.3)
By majority	17 (89.5)	5 (50)	11 (73.3)	21 (80.8)	54 (77.1)
subtotal:	**19 (100)**	**9 (90)**	**13 (86.6)**	**23 (88.5)**	**64 (91.4)**

*Figures in ( ) are percentages of the total

The characteristics opinions seriously considered, members' participation, committee size and organization of meetings had fairly high responses as well. 87.1 percent of respondents found that opinions where always or most always seriously considered, 80

[92] Chapter Seven, Section 7.3.5 Coordination, p. 231.

percent found that all or most members were active participants, 78.6 percent found the committee size to be appropriate and 75.7 percent found that meetings were either extremely or well organised. The weakest response came for the characteristics decisions made appropriately where only 50 percent of respondents found decisions were always made appropriately.

When comparing the responses from one hospital to another, it can be noted that the highest variations came in the characteristics meetings organisation and committee size. For organization of meetings the variation between the WH that had the lowest response (50 percent) and RH that had the highest response (86.3 percent) was 36.3 points. For committee size the variation between the lowest response, RH (66.7 percent), and highest response, HGH (89.5 percent), was 22.8 points. The lowest variation can be seen in the characteristics careful analysis during discussion and member's selection. For careful analysis during discussion the variation between the lowest response, HGH (84.2 percent), and the highest response, RH (93.4 percent), was 9.2 points. Finally, for members selection the variation between the lowest response, HGH (94.7 percent), and the highest, WH and RH (100 percent each), was only 5.3 points.

Table 9.2 Team Functioning By Profession indicates that when comparing variations in responses from one profession to another it is interesting to note that the variations were generally wider then the variations in hospital responses. The highest variations can be seen in the responses to characteristics committee objectives, timely and appropriate decisions making, and meetings organization. For committee objectives the difference between the lowest response, administration (58.3 percent), and the highest, paramedical and corporate departments (100 percent each), was 41.7 points. So was the difference in response for appropriate decision-making where the lowest response was paramedical (33.3 percent) and the highest was medical (66.7 percent). Finally, for organization of meetings, the difference between the lowest response, administration (66.7 percent), and the highest response, Corporate Departments (100 percent), was 33.3 points.

The lowest variations can be seen in the characteristic members selection and freedom to express opinion. For members selection the difference between the lowest response, administration (88.3 percent), and all the other profession (100 percent each) was 11.7 points. Finally, for freedom to express opinion the variation between the lowest response, administration (83.3 percent), and the highest response, medical and therapy (100 percent each), was 16.7 points.

Table 9.2 Team Functioning By Profession

Characteristics	Medical	Nursing	Admin	Therapy	Paramed	Corp. Depts	Total
Committee Objective:							
Extremely clear to all	8 (53.3)*	7 (30.4)	4 (33.3)	1 (25)	2 (33.3)	6 (60)	28 (40)
Clear to most	6 (40)	15 (65.2)	3 (25)	3 (75)	4 (66.7)	4 (40)	35 (50)
subtotal:	**14 (93.3)**	**22 (95.6)**	**7 (58.3)**	**4 (100)**	**6 (100)**	**10 (100)**	**63 (90)**
Meetings Organisation:							
Meetings extremely well organized	2 (13.3)	1 (4.3)	5 (41.7)		2 (33.3)	9 (90)	19 (27.1)
Meetings well organized	9 (60)	15 (65.2)	3 (25)	3 (75)	3 (50)	1 (10)	34 (48.6)
subtotal:	**11 (73.3)**	**16 (69.5)**	**8 (66.7)**	**3 (75)**	**5 (88.3)**	**10 (100)**	**53 (75.7)**
Members Selection:							
All members appropriate	8 (53.3)	12 (52.2)	4 (33.3)	2 (50)	3 (50)	4 (40)	33 (47.1)
Most members appropriate	7 (46.7)	11 (47.9)	6 (50)	2 (50)	3 (50)	6 (60)	35 (50)
subtotal:	**15 (100)**	**23 (100)**	**10 (88.3)**	**4 (100)**	**6 (100)**	**10 (100)**	**68 (97.1)**
Committee Size:							
Very appropriate	**9 (60)**	**20 (87)**	**9 (75)**	**3 (75)**	**5 (83.3)**	**9 (90)**	**55 (78.6)**
Members Participation:							
All are extremely active	4 (26.7)	6 (26)	2 (16.7)	1 (25)	1 (16.7)	2 (20)	16 (22.9)
Most are active	8 (53.3)	13 (56.6)	6 (50)	2 (50)	4 (66.7)	7 (70)	40 (57.1)
subtotal:	**12 (80)**	**19 (82.6)**	**8 (66.7)**	**3 (75)**	**5 (83.4)**	**9 (90)**	**56 (80)**
Freedom to Express Opinion:							
Always have no difficulty	12 (80)	13 (56.6)	4 (33.3)	1 (25)	3 (50)	5 (50)	38 (54.3)
Most time have no difficulty	3 (20)	9 (39.1)	6 (50)	3 (75)	2 (33.3)	4 (40)	27 (38.6)
subtotal:	**15 (100)**	**22 (95.7)**	**10 (83.3)**	**4 (100)**	**5 (83.3)**	**9 (90)**	**65 (92.9)**
Opinion Seriously Considered:							
Always seriously considered	6 (40)	12 (52.2)	6 (50)		3 (50)	5 (50)	32 (45.7)
Most always seriously considered	7 (46.7)	10 (43.5)	3 (25)	3 (75)	3 (50)	3 (30)	29 (41.4)
subtotal:	**13 (86.7)**	**22 (95.7)**	**9 (75)**	**3 (75)**	**6 (100)**	**8 (80)**	**61 (87.1)**
Open & Trusting Communication:							
Extremely open and trusting	6 (40)	9 (39.1)	2 (25)	1 (25)	3 (50)	6 (60)	27 (38.6)
Generally open and trusting	9 (60)	13 (56.5)	7 (58.3)	2 (50)	3 (50)	3 (30)	37 (52.9)
subtotal:	**15 (100)**	**22 (95.7)**	**9 (75)**	**3 (75)**	**6 (100)**	**9 (90)**	**64 (91.4)**
Analysis During Disucssions:							
Issues always carefly analyzed	6 (40)	8 (34.8)	2 (16.7)		2 (33.3)	4 (40)	22 (31.4)
Generally well analyzed	7 (46.7)	14 (60.9)	7 (58.3)	4 (100)	3 (50)	6 (60)	41 (58.6)
subtotal:	**13 (86.7)**	**22 (95.7)**	**9 (75)**	**4 (100)**	**5 (83.3)**	**10 (100)**	**63 (90)**
Decisions Made Appropriately:							
Always	**10 (66.7)**	**9 (39.1)**	**5 (41.7)**	**3 (75)**	**2 (33.3)**	6 (60)	35 (50)
Decision Making:							
By consensus	1 (6.7)	6 (23.1)	2 (16.7)	1 (25)			10 (14.3)
By majority	12 (80)	16 (69.6)	8 (66.7)	2 (50)	6 (100)	10 (100)	54 (77.1)
subtotal:	**13 (86.7)**	**22 (95.7)**	**10 (83.3)**	**3 (75)**	**6 (100)**	10 (100)	**64 (91.4)**

*Figures in ( ) are percentages of the total

9.3.3 Team performance

Three characteristics; committee decision implementation, resolution of issues discussed and goals achievement were taken as the characteristics of team performance. Table 9.3 Team Performance by Hospital indicates that in all three characteristics HMC responses were equally high. 81.4 percent of respondents found that committee decisions were always or generally implemented. 82.9 percent of respondents found that issues discussed were generally resolved or only sometimes come back for discussions. Finally, 80 percent found the committee achieved all or most of its goals.

Table 9.3 Team Performance by Hospital

Characteristics	HGH	WH	RH	Corp. Depts.	Total
Committee Decisions Implementation:					
Decisions always implemented	4 (21.1)*	3 (30)	5 (33.3)	7 (27)	19 (27.1)
Generally implemented	12 (63.2)	3 (30)	8 (53.3)	15 (57.7)	38 (54.3)
subtotal:	**16 (84.3)**	**6 (60)**	**13 (86.6)**	**22 (84.7)**	**57 (81.4)**
Resolution of Issues Discussed:					
Resolved and never discussed again		1 (10)		2 (7.7)	3 (4.3)
Sometimes come back	15 (79)	7 (70)	13 (86.7)	20 (77)	55 (78.6)
subtotal:	**15 (79)**	**8 (80)**	**13 (86.6)**	**22 (84.7)**	**58 (82.9)**
Goals Achievement					
Yes	8 (42.1)	1 (20)	4 (26.7)	7 (27)	20 (28.6)
Most of the goals	9 (47.4)	4 (40)	9 (60)	14 (53.8)	36 (51.4)
subtotal:	**17 (89.5)**	**5 (60)**	**13 (86.6)**	**21 (80.8)**	**56 (80)**

*Figures in ( ) are percentages of the total

When comparing the responses from one hospital to another the highest variations can be seen in committee decision implementation and goals achievement and the lowest in resolution of issues. For committee decision implementation the difference between the lowest score, WH (60 percent), and the highest score, RH (86.6 percent), was 26.6 points. Similarly, for goals achievement the difference between the lowest response WH (60 percent) and the highest response HGH (89.5 percent) was 29.5 points. Finally for resolution of issues the difference between the lowest score HGH (79 percent) and the highest (86.6 percent) was only 7.6 points.

When comparing responses by profession in Table 9.4 Team Performance by Profession, it is interesting to note that the variations as a whole are higher than the variations by hospital. As for hospitals, the highest variations were in committee decisions implementation and goals achievement and the lowest in resolution of issues discussed. For committee decisions implementation the difference between the lowest score, medical

(66.6 percent), and the highest, therapy (100 percent), was 33.4 points. For goals achievement the difference between the lowest response, administration (58.3 percent), and the highest response, corporate department staff (100 percent), was 26.7 points. Finally, for resolution of issues the difference between the lowest response, corporate department staff (70 percent) and the highest response, medical (93.3 percent), was 18.3 points.

Table 9.4 Team Performance by Profession

Characteristics	Medical	Nursing	Admin	Therapy	Paramed	Corp. Depts	Total
Comm. Decisions Implementation:							
Decisions always implemented	5 (33.3)*	6 (26.1)	4 (33.3)	1 (25)		3 (30)	19 (27.1)
Generally implemented	5 (33.3)	14 (60.9)	6 (50)	3 (75)	4 (68.7)	6 (60)	38 (54.3)
subtotal:	**10 (66.6)**	**20 (87)**	**10 (88.3)**	**4 (100)**	**4 (68.7)**	**9 (90)**	**57 (81.4)**
Resolution of Issues Discussed:							
Resolved and never discussed again		1 (4.4)				2 (20)	3 (4.3)
Sometimes come back	14 (93.3)	19 (82.7)	9 (75)	3 (75)	5 (83.3)	5 (50)	55 (78.6)
subtotal:	**14 (93.3)**	**20 (87)**	**9 (75)**	**3 (75)**	**5 (83.3)**	**7 (70)**	**58 (82.9)**
Goals Achievement							
Yes	6 (40)	7 (30.4)	1 (8.3)	1 (25)	1 (16.7)	4 (40)	20 (28.6)
Most of the goals	5 (33.3)	13 (56.5)	6 (50)	2 (50)	4 (66.7)	6 (60)	36 (51.4)
subtotal:	**11 (73.3)**	**20 (87)**	**7 (58.3)**	**3 (75)**	**5 (83.3)**	**10 (100)**	**56 (80)**

*Figures in ( ) are percentages of the total

9.3.4 Team effectiveness

Overall in HMC, there was higher perceived team effectiveness than ineffectiveness. Table 9.5 Team Effectiveness by Profession on the next page indicates that 67.2 percent of the total respondents from all areas found the committee/team in which they were participating extremely (8.6 percent) or very effective (58.6 percent). 31.4 percent found that the committee was somewhat effective (24.3 percent) or not effective at all (7.1 percent).

Table 9.5 Team Effectiveness by Profession

Profession	Extremely effective	Very effective	Somewhat effective	Not effective	Missing	Total
Medical	2	7	5		1	**15**
Percentage	*13.3*	*46.7*	*33.3*		*6.7*	***100.0***
Nursing	2	13	6	2		**23**
Percentage	*8.7*	*56.5*	*26.1*	*8.7*		***100.0***
Administrative	1	7	1	3		**12**
Percentage	*8.3*	*58.3*	*8.3*	*25.0*		***100.0***
Therapy		3	1			**4**
Percentage		*75.0*	*25.0*			***100.0***
Paramedical		3	3			**6**
Percentage		*50.0*	*50.0*			***100.0***
Corporate	1	8	1			**10**
Percentage	*10.0*	*80.0*	*10.0*			***100.0***
Total	**6**	**41**	**17**	**5**	**1**	**70**
Percentage	***8.6%***	***58.6%***	***24.3%***	***7.1%***	***1.4%***	***100%***

Question: How effective is this team/committee?

By profession, those that found their committee to be extremely effective were, in order of highest; Corporate Departments (10 percent extremely effective, 80 percent very effective), therapy staff (75 percent very effective), administrative staff (8.3 percent extremely, 58.3 percent very), nursing staff (8.7 percent extremely, 56.5 percent very), medical staff (13.3 percent extremely, 46.7 percent very) and finally paramedical staff where 50 percent found the committee very effective. Interestingly, the only two professions which found their committees not effective at all were the administrative staff (25 percent) and the nursing staff (8.7 percent).

Table 9.6 Team Effectiveness By Hospital indicates that, by hospital, the highest perception of effectiveness was in HGH (21.1 percent extremely, 57.9 percent very), followed by Corporate Departments (7.7 percent extremely, 69.2 percent very), and RH (53 percent very effective). The lowest perception of committee effectiveness was in WH where the majority found the committee to be either somewhat (40 percent) or not at all (20 percent) effective.

Table 9.6 Team Effectiveness By Hospital

Hospital	Extremely effective	Very effective	Somewhat effective	Not effective	Missing	Total
HGH	4	11	3	1		19
Percentage	*21.1*	*57.9*	*15.8*	*5.3*		*100.0*
WH		4	4	2		10
Percentage		*40.0*	*40.0*	*20.0*		*100.0*
RH		8	6		1	15
Percentage		*53.3*	*40.0*		*6.7*	*100.0*
CDs	2	18	4	2		26
Percentage	*7.7*	*69.2*	*15.4*	*7.7*		*100.0*
Total	**6**	**41**	**17**	**5**	**1**	**70**
Percentage	***8.6%***	***58.6%***	***24.3%***	***7.1%***	***1.4%***	***100%***

Question: How effective is this team/committee?

For each hospital the activities that the respondents perceived the chairman and management could do to improve team effectiveness has been coded and quantified. Table 9.7 How Management Can Improve the Committee indicates that, in general, it was perceived that management could improve the effectiveness of the committees mostly through better communication (25 percent), decision-making (23 percent), and better committee procedures and functioning (12 percent). Similarly, for the chairman, it was perceived that he/she could improve the effectiveness of the committee mostly through better communication (24 percent), decision-making (23 percent) and better committee procedures and functioning (17 percent).

Table 9.7: How Management Can Improve the Committee

CODE	HAMAD GEN. HOSP.		WOMENS HOSP.		RUMAILAH HOSP.		CORPORATE DEPTS		HMC TOTAL	
	Total	Percentage	Total	Percentage	Total	Percentage	Total	Percentage	Total	Percentage
MEMBERS-SELECTION	2	4%			2	6%	2	3%	6	4%
MEMBERS- TRAINING	1	2%			2	6%	1	2%	4	3%
sub total:	*3*	*7%*			*4*	*12%*	*3*	*5%*	*10*	*7%*
COMMUNICATION-ORGANIZATION	5	11%					3	5%	8	5%
COMMUNICATION-COMMITTEE	6	13%	2	17%	4	12%	10	17%	22	15%
COMMUNICATION- TOP MGT			2	17%			5	8%	7	5%
sub total:	*11*	*24%*	*4*	*33%*	*4*	*12%*	*18*	*30%*	*37*	*25%*
DECISION- AUTHORITY	2	4%			1	3%			3	2%
DECISION- IMPLEMENTATION	9	20%	2	17%	14	42%	7	12%	32	21%
sub total:	*11*	*24%*	*2*	*17%*	*15*	*45%*	*7*	*12%*	*35*	*23%*
PROCEDURE- AGENDA							2	3%	2	1%
PROCEDURE- FREQUENCY							2	3%	2	1%
PROCEDURE- PUNCTUALITY	1	2%	1	8%			3	5%	5	3%
PROCEDURE- ORGANIZATION			1	8%			7	12%	8	5%
PROCEDURE- OBJECTIVES/ROLES							1	2%	1	1%
sub total:	*1*	*2%*	*2*	*17%*			*15*	*25%*	*18*	*12%*
RESOURCES- FUNDING	6	13%					5	8%	11	7%
RESOURCES-TIME			1	8%					1	1%
RESOURCES- MANPOWER	1	2%	1	8%					2	1%
sub total:	*7*	*15%*	*2*	*17%*			*5*	*8%*	*14*	*9%*
HOSPITAL- RULES/PROCEDURES	1	2%	1	8%	4	12%	2	3%	8	5%
HOSP- STRUCTURE	3	7%			1	3%			4	3%
HOSP -ORGANIZATION	1	2%							1	1%
HOSP-OBJECTIVE									0	0%
sub total:	*5*	*11%*	*1*	*8%*	*5*	*15%*	*2*	*3%*	*13*	*9%*
CHAIRPERSON			*1*	*8%*			*9*	*15%*	*10*	*7%*
EVALUATION	*4*	*9%*			*3*	*9%*			*7*	*5%*
APPRECIATION					*1*	*3%*			*1*	*1%*
SATISFIED	*3*	*7%*					*1*	*2%*	*4*	*3%*
SUPPORT	*1*	*2%*			*1*	*3%*			*2*	*1%*
TOTAL:	46	100%	12	100%	33	100%	60	100%	151	100%

WH respondents believed that management could improve the committee through more communication and decision making activities (mentioned most often at 23 percent each). Second came, at equal weight, better membership selection/training and providing resources (mentioned 15 percent of times). Similarly, respondents in HGH believed that management could improve the effectiveness of the committee through, equally, better communication and decision making (each mention at 24 percent) followed by providing resources at 15 percent.

RH respondents believed that management could improve the committee through better decision making implementation (mentioned most often at 45 percent), improving Hospital rules, policies and structure (mentioned at 15 percent), and finally better membership selection/training and communication with the committee were found equally important (12 percent each). Similarly, respondents in Corporate departments perceived that management could make the committee more effective through more decision authority and implementation (mentioned at 39 percent), better membership selection and training (17 percent) and more communication with the committee and the organisation (13 percent).

Table 9.8 How Chairperson Can Improve the Committee explores how respondent's perceived the chairperson or team leader could improve the effectiveness of the committee or team. In the WH, communication activities were perceived as most important (mentioned 33 percent of times), followed by decision implementation, committee procedures, and obtaining resources (each mentioned 17 percent of times). In RH, again communication activities were perceived as most important (mentioned 33 percent times), followed by committee procedures (26 percent), and decision implementation (22 percent times).

Corporate Departments respondents perceived that communication and committee procedures were most important (30 percent and 25 percent) followed by decision implementation (12 percent). Finally, HGH respondents believed that the chairman could improve the effectiveness through better communication (mentioned at 29 percent) and committee procedures (27 percent).

Table 9.8 How Chairperson Can Improve The Committee

CODE	HAMAD GEN. HOSP.		WOMENS HOSP.		RUMAILAH HOSP.		CORPORATE DEPTS		HMC TOTAL	
	Total	Percentage	Total	Percentage	Total	Percentage	Total	Percentage	Total	Percentage
MEMBERS-SELECTION	2	4%	2	15%			5	11%	9	7%
MEMBERS-TRAINING	1	2%					3	7%	4	3%
sub total:	*3*	*6%*	*2*	*15%*			*8*	*17%*	*13*	*10%*
COMMUNICATION-ORGANIZATION	5	10%	1	8%			2	4%	8	6%
COMMUNICATION-COMMITTEE	5	10%	2	15%	8	30%	4	9%	19	14%
COMMUNICATION-TOP MGT	4	8%			1	4%			5	4%
sub total:	*14*	*29%*	*3*	*23%*	*9*	*33%*	*6*	*13%*	*32*	*24%*
DECISION- AUTHORITY							7	15%	7	5%
DECISION- IMPLEMENTATION	3	6%	3	23%	6	22%	11	24%	23	17%
sub total:	*3*	*6%*	*3*	*23%*	*6*	*22%*	*18*	*39%*	*30*	*23%*
PROCEDURE- AGENDA	3	6%			2	7%	1	2%	6	5%
PROCEDURE- FREQUENCY	3	6%			2	7%	1	2%	6	5%
PROCEDURE-PUNCTUALITY	1	2%			1	4%			2	2%
PROCEDURE-ORGANIZATION	6	13%			1	4%			7	5%
PROCEDURE- OBJECTIVES/ROLES					1	4%	1	2%	2	2%
sub total:	*13*	*27%*			*7*	*26%*	*3*	*7%*	*23*	*17%*
RESOURCES-FUNDING	2	4%	1	8%					3	2%
RESOURCES-TIME							1	2%	1	1%
RESOURCES- MANPOWER			1	8%					1	1%
sub total:	*2*	*4%*	*2*	*15%*			*1*	*2%*	*5*	*4%*
HOSPITAL- RULES/PRACTICES							2	4%	2	2%
HOSPITAL- STRUCTURE			1	8%					1	1%
HOSPITAL -ORGANIZATION									0	0%
HOSPITAL- OBJECTIVE							1	2%	1	1%
sub total:			*1*	*8%*			*3*	*7%*	*4*	*3%*
CHAIRPERSON	*6*	*13%*			*3*	*11%*			*9*	*7%*
EVALUATION	*2*	*4%*	*1*	*8%*	*1*	*4%*	*2*	*4%*	*6*	*5%*
APPRECIATION			*1*	*8%*			*1*	*2%*	*2*	*2%*
SATISFIED	*3*	*6%*			*1*	*4%*			*4*	*3%*
SUPPORT							*4*	*9%*	*4*	*3%*
TOTAL:	48	100%	13	100%	27	100%	46	100%	132	100%

QUESTION: HOW CAN THE CHAIRMAN IMPROVE THE EFFECTIVENESS OF THE TEAM?

9.3.5 Team functioning, performance and effectiveness

Thus to summarize findings, by breaking down effectiveness into characteristics of team functioning and team performance a better understanding of perceived effectiveness was achieved. The scores for team functioning for HMC as a whole ranged from extremely high to high indicating that generally teams were perceived to be functioning well. The average of the responses to all eleven team functioning characteristics was 84 percent, a high score of team functioning. Only one characteristic, decisions made timely and appropriately was perceived as weak (50 percent).

Similarly, for HMC as a whole, the scores for the three characteristics of team performance were high. The average score of the responses was 81 percent indicating that generally teams were perceived to be performing well. Thus, HMC teams were perceived to be well functioning and performing. However, the responses to the direct question of how effective the team was indicated a moderately high perception of effectiveness (67.2 percent) but nonetheless, considerably lower perceived effectiveness than the high scores of team functioning and performance.

When comparing team functioning responses by hospital, one notices that the highest variation (proper organisation of meetings) was 36.3 points of differences from the highest score to the weakest score. The second highest variation was for appropriateness of team size (22.8 points of difference). The lowest variation was for appropriateness of member's selection (5.3 points of difference). However, even the highest variation was not important enough to be detected by the chi square test of significant relationships.

Similarly, the highest variations in team performance answers (29.5 points for goals achievement and 26.6 points for team's decisions implementation) and the 39 points variation in responses to the team effectiveness question were not significant enough to be detected by the chi square test.

A more interesting variation was found in the responses by profession. For team functioning, the highest variations in scores were found in response to the characteristics clarity of objectives (41.7 points), decisions made appropriately (41.7 points) and organisation of meetings (33.3 points). As seen in Chapter Five in the section on the

team questionnaire[93], the variations in responses to clarity of objectives and organisation of meetings were detected by the chi square test of significance and the Cramer's V level's of association indicated a moderate association. Variations in team performance responses, 33.4 points for decisions implementation and 26.7 points for goals achievement, and the team effectiveness question (40 points) although high, were not important enough to be detected by the chi square test.

Respondents in HMC as a whole believed that effectiveness of teams could be improved if management had better communication with the teams, implemented decisions made by the team and improved team's procedures and functions. Similarly, they believed that the chairman/team leader could improve effectiveness also through better communication within the team and with management, by implementing team decisions and by improving team procedures and functioning.

9.3.6 ANALYSIS OF TEAM EFFECTIVENESS

This section set out to evaluate team effectiveness in terms of perceived team functioning and team performance (Alexander and al., 1996) and to determine whether there were significant differences in perceived effectiveness by hospital or by profession. Findings demonstrated that there was a considerably high perception of good team functioning and performance. When using these two components to define effectiveness one would deduce that their was a high perception of team effectiveness. However, the responses to the direct question of team effectiveness, although relatively high, were considerably lower than the combined scores of team functioning and performance. This could simply be due to differences in individual definitions attached to the term effectiveness.

Although some high variations were found in the responses by hospital (proper organization of meetings, appropriateness of team size, goals achievement, implementation of team decisions and team effectiveness) none were picked up by the Chi Square test to be significant. Similarly, some high variations were found in the responses by profession (clarity of team objectives, decisions made timely and appropriately, organization of meetings, decisions implementation, goals achievement and team effectiveness) but only two, clarity of team objectives and organization of meetings passed the Chi square test of significant. Thus, statistically, no significant variation was found in the responses by hospital and in two responses by profession there was a

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[93] Chapter Five, Section 5.3.3 Questionnaire on team structure, functioning and effectiveness, p.114.

significant variation in response reflecting the conclusion drawn in Chapter Five that respondent's profession affected responses more than hospital.

Finally, characteristics and functions that were found to be important in improving team effectiveness in both management and the team leader were good communication with and from team, implementation of team decisions and improving team procedures and functions which confirms Hetherington and Rundell's (1983) findings that leadership affects team effectiveness by providing support, facilitating interaction and work and emphasizing on team goals.

9.3.7 Conclusion on team effectiveness

Considering the heavy reliance of HMC on committees and team to achieve coordination, this section explored team effectiveness by studying team functioning and team performance. Findings indicate that there was an overall high perception of good team functioning, performance and effectiveness. Significant variation in the responses of professional staff was found indicating profession was more likely to affect response than hospital. In Chapters Six and Seven we found that HMC's organizational structure relied on committees and teams as coordinating and information sharing mechanism. The highly perceived effectiveness of committees would indicate that this mechanism is functioning well. Finally, findings confirmed the roles of leadership in providing support, facilitating interaction and emphasizing team goals.

9.4 *Conclusion*

This chapter explored overall organizational effectiveness and team effectiveness. The first section explored health services effectiveness assessment and applied the Competing Values framework (Quinn and Rohrbaugh, 1981 and1983). Findings revealed that HMC suffered from difficulties in health services effectiveness assessment similar to the well-documented NHS difficulties. Application of the Competing Values framework revealed that the main focus of organizational efforts was on obtaining cohesiveness and skilled workforce and the second emphasis was on goals, productivity and efficiency. Findings indicated that although there were conflicts between the different professions, it is the human relations focus of the health organization that enables harmony and cohesiveness in the workplace.

The second section set out to evaluate team effectiveness in terms of perceived team functioning and team performance and to determine whether there were significant differences in perceived effectiveness by hospital or by profession. Findings demonstrated that there was a considerably high perception of good team functioning, performance and effectiveness. Findings also indicated that respondent's profession, rather than hospital, was more likely to influence response. Finally, the role of leadership in communication, support, and goal directedness was discussed.

CHAPTER 10 CONCLUSION

The objectives of this study were to explore the evolution of organization structures as applied to a medical corporation in Qatar, examine the nature of organizational culture and multiprofessional cohesiveness, and to assess organizational effectiveness and a range of models on organizational design and change.

The three original propositions that were addressed and tested are:

1. Health professionals are inherently individualistic, specialist in character; enjoying autonomy yet, when brought together in a hospital setting, work within a generic and systematic framework.
2. An organization structure, which focuses on integration and coordination, will promote harmony and effectiveness in highly complex settings.
3. An effectively designed organization structure is one that is supported by proper processes and systems.

Before discussing the findings of these propositions a summary of the main features, findings and conclusions by theme will be given.

As previously mentioned[94], a specific feature of this study lies in its theoretical and methodological eclecticism. It moves across schools of thought on organization in order to best understand the nature of the organizations under study. This exercise revealed the appropriateness of theoretical eclecticism as theories from various schools of thought, ranging from the classical school to the organization culture and symbolic management perspective, were drawn upon to analyse the findings. This approach may well have the drawbacks of not permitting an in-depth study of one perspective and of being lengthy. However, it has the advantage of being less biased than the narrow vision of a subjectively selected perspective of study and thus, painting a more realistic picture.

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[94] Referring to Chapter One: Introduction, Section 1.2.

10.1 Findings and conclusions of study

1. Evolution of Hospital Organization Structure[95]:

Conclusions about the evolution of hospital organizational structures were drawn based on an exploration of the development of HMC's structure from 1979 to 1999. Tracing the evolution of HMC shows that ***the organization developed from a simple dual-authority bureaucratic structure to a complex divisional structure with each hospital developing its professional bureaucracies.*** The issues of balance of power, centralization, leadership, multidisciplinary work groups, coordination, and the balance between differentiation and integration in hospital structure design were discussed.

Findings indicate that:

a. Bureaucratic forms (from simple dual-authority structure to complex divisional structures) are preferred to more integrated matrix or organic forms. Restructuring attempts that tried to move towards more integration reverted back to the divisional model. This confirms research on the difficulties of applying matrix forms (Kimberly, Leatt and Shortell, 1994; Dixon, 1977), on the merits of bureaucracy in health settings (Jaques, 1990; Mintzberga, 1979) and on the formal, quasi- bureaucratic characteristics of health settings (Georgopolous, 1972). Broadly, it indicates the importance and relevance of Weber's (1946) classical theory of bureaucracy in modern organization and its influence on modern structural research.

b. The organization's life cycle determines its structure. Tracing the evolution of HMC shows that the organization developed from a simple dual-authority bureaucratic structure to a complex divisional structure with each hospital developing its professional bureaucracies. Exploring the differentiation-integration balance of the structure revealed that at this moment in the organization's life cycle the divisional model offers the required balance as restructuring attempts that tried to move towards more integration reverted back to the divisional model. This goes in line with findings from the life-cycle perspective (Van de Ven and Poole, 1995). It also kindles interest in the population ecology perspective of the organization (Hannan and Freeman, 1989) as it demonstrates the organization's ability to adapt and select structural forms that suit its life cycle.

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[95] Referring to Chapter Six: Evolution and Change Management of HMC Organizational Structure.

2. Management of Change in Medical Organizations[96]

The study of the evolution of HMC's structure also revealed information about change management. ***The organizational structure has steadily grown with incremental structural changes punctuated by two radical change attempts each lasting one year.*** Conclusions about the nature of radical changes and their success in hospital settings were drawn. The effects of leadership, decision-making style, choice of implementation strategies, members' involvement and consultation, communication and normative re-education on the change attempts were explored.

Findings on radical change indicate that:

a. Radical restructuring attempts are preceded by crisis/organizational problems and a complete change in governance and leadership. This confirms researches that suggest that radical change is achieved through leadership (Chandler, 1962; Channon, 1973; Dyas and Thanheiser, 1976; Grinyer and Yasai-Ardekani, 1981; Rumelt, 1974; Ansoff, 1991; Hannan and Freeman, 1984) and generally follows changes in strategy.

Findings on incremental change indicate that:

b. Incremental change was more successful at HMC than radical change. These findings confirm research on the difficulties of implementing radical change in hospital settings (Greenwood and Hinings, 1996; Packwood et al., 1998).

c. Periods of growth and incremental change are distinguished by stability of governance and leadership.

Findings on organizational members' involvement in change indicate that:

d. Lack of involvement and high turnover of management were found to lead to lack of continuity of projects. This confirms previous researches that stress the importance of involvement and consultation (Burnes, 1992; Hinings and Greenwood, 1988; Huse, 1980). The narrow focus of the change attempts (focus on structure neglecting process, culture and people) has led to its failure. These findings reflect the important contribution of the organization behavior perspective, which views the organization as being in co-dependent relation with employees.

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[96] Referring to Chapter Six: Evolution and Change Management of HMC Organizational Structure.

e. Higher levels of organizational members' involvement coincided with higher confidence in the structure's planning.

f. In the context of versatile leadership, organizational involvement in, understanding, adoption and support of the change are vital to its success. Interview responses indicate that generally, and during the last restructuring attempt specifically, the decision was top-down with little involvement or communication throughout the change. There was also vagueness around politically sensitive issues and job structures and descriptions. In both restructuring attempts few intervention activities aimed at normative re-education were found. Such conditions have generally been found to lead to failures of change attempts (Burnes, 1992; Hinings and Greenwood, 1988; Joss and Kogan, 1995).

3. Organizational Design in Medical Organization[97]:

Organizational design was explored by studying organizational structure and processes. Although there are distinct differences in the structuring of medical, nursing, and administrative staff, all suffer from high centralization and a desire for multi-professional management at the departmental level.

Findings on the confusion of organization structure and leadership indicate that:

a. In periods of confusion and structural, process, organizational, and human resources weaknesses, strong decisive leadership that provides direction is greatly valued by organizational members. This confirms similar findings from the British NHS experience (Packwood et al., 1992)

b. The successive structural changes resulted in a corporate structure that was found confusing and inefficient. Structural, processes, organizational and human resources weaknesses, some of which are generally associated to hospitals, have led to the 'fragmentation of management process' and 'poor monitoring and control of quality and resources'. In such a context, strong decisive leadership is needed to provide direction. This explains why respondents viewed the strong characteristics of leadership as the organization's main strength.

In general, findings reveal that:

c. HMC's organizational design has shortcoming with regards to coordination, and communication or information dissemination. It relies heavily on structure (i.e. centralization), informal means, and teams and committees as coordinating mechanisms. Other mechanisms such as information, communication, planning and standardization have not been developed.

Findings on the organization of the medical structure at HMC confirm:

d. The contradictory need for clarity of accountability versus the desire to maintain work autonomy by professionals noted by Georgopolous (1972).

Findings on the organization of the nursing structure at HMC reveal that:

e. As with the British NHS nursing structure, the nursing structure at HMC was found to be one of bureaucratic hierarchy relying on rules, regulations and policies for control.

As for the administrative structure, findings reveal that:

f. The role of administration was found to be unclear and there was a lack of administrative authority with the middle and junior administrators due to the high centralization levels.

Findings on the professional boundaries between the medical, nursing and administrative indicates:

g. A shift in professional relationships due to structural changes and aspiration for increased interface at operational levels.

h. Unclear definitions of roles and responsibilities of the different professions result in confusion of boundaries and increased conflicts This confirms the importance of clarity of roles and responsibilities in hospital settings (Georgopolous, 1972).

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[97] Referring to Chapter Seven: Organizational Design: Structure and Process.

4. Coordination[98]

On the subject of coordination, findings indicate that:

a. Coordination mechanisms are preferred to integration mechanisms. During the restructuring attempts of 1990 and 1996, integration mechanisms such as integrating administrative, nursing and paramedical structures were rejected and organizational members adopted coordination mechanisms such as liaison roles, committees and teams. This indicates that the different professional structures would not like to lose their valued autonomy by integrating.

b. Lack of structured coordination mechanisms lead to conflict. The lack of coordination mechanisms between the different hierarchies of divisional hospital administrators and the professional staff has lead to conflicts. Liaison roles and joint committees were initiated to reduce such conflicts. This confirms the importance of coordination in health settings (Georgopolous and Mann, 1962).

c. Balancing differentiation and coordination is especially difficult in hospital settings. The desire for higher specialization as well as the coordination problems between the different hierarchies illustrates this difficulty.

d. In environments where coordination mechanisms such as information, communication, planning and standardization are underdeveloped informal mechanisms become important. In such an environment informal means such as grapevine and personal contacts are important to ensure communication. Informal and personal activities have often been cited as important coordination mechanisms (Van de Ven et al., 1976 and Litterer, 1965). At HMC, informal means came out strongly, not only at information sharing, but also as means of dealing with conflicts. Respondents dealt with conflict in an immediate and informal manner. Respondents also considered the informal culture as important in promoting coordination. This goes in line with the contingency point of view whereby the structure adapts to the environment (Thompson, 1967; Lawrence and Lorsch, 1969, Galbraith, 1973b).

[98] Referring to Chapter Seven: Organizational Design: Structure and Process.

e. In environments where coordination and information management mechanisms are underdeveloped, centralization becomes a coordinating and information providing mechanism. Centralization has come out strongly at HMC with centralized decision making and planning. Although, because of the high management turnover, it was found to result in no continuity and low staff morale, centralization has the advantage of providing top management rapid information so that they may take rapid decisions. It thus satisfies the main objective of organizational design; ensuring the efficient flow of information to decision makers (Galbraith, 1973a and 1973b).

5. The Political Nature of Medical Organizations[99]

With regards to the political nature of organizations, findings reveal that:

a. Hospital settings are a political arena with conflicts of interests similar to all organizations and others specific to its multiple lines of authority structure. Findings reassert the importance of power theories in understanding health service organizations (Baldridge, 1971; Pfeffer, 1981; Kanter, 1989; Mintzberg, 1983).

b. Ambiguity encourages political conflicts. Two major power struggles were found in each hospital. The first is with stakeholders protecting their interests during decentralization attempts. The second is between the multiple lines of authority in hospitals as each attempts to enlarge the boundaries of its authority. This was found to be encouraged by the ambiguous definitions of roles, responsibilities and functions confirming the importance of clarity of roles and functions in hospital settings (Georgopolous, 1972; Georgopolous and Mann, 1962).

6. Organizational Culture[100]

Organizational culture is explored by studying homogeneity of values, commitment to existing culture and the direction of the organization culture (Luthans, 1995; Kilman et al., 1985). Findings conclude that:

[99] Referring to Chapters Six, Seven, and Eight
[100] Referring to Chapter Eight: Organizational Culture

a. There is a strong homogeneity in organizational values with minor variation by hospital and profession indicating the existence of subcultures that share organization wide core values but maintain their own individuality. These findings are in line with studies under the differentiation perspective that portrays subcultures as co-existing in harmony, conflict or indifference to one another (Martin and Mayerson, 1987; Smirchich and Morgan, 1982; Riley, 1983) as well as Georgopolous and Mann's (1962) suggestion that the normative structure formed by professional values underpins the formal rational structure helping in integration and coordination.

b. The existing culture is somewhat negatively directed in that there is a significant gap between desired and actual culture.

c. HMC's culture is not strong. Although homogeneity to organizational values is relatively high it is low in commitment to its existing culture.

In both questionnaires (the comprehensive and team questionnaires) the tests of significant relationships revealed that higher levels of significance were found by profession than by hospital[101]. This indicates that:

d. There were more variations in responses by profession than by hospital suggesting that the respondent's profession was more likely to influence response than respondent's hospital and hinting to stronger professional subcultures than hospital subcultures.

7. Professional Culture[102]

The different subcultures were explored by studying the different professional cultures and their interprofessional relationships.

Findings on the relationship between medical staff and administration reveal that:

a. There seems evidence to support the claim that the relationship between the medical and administrative profession is a struggle for power and authority (Friedson; 1970a and b; Butler, 1992; Harrison et al., 1990; Moran and Wood, 1993; Harrison, 1988a; Georgopolous , 1972).

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[101] Referring to Chapter Five: Research Philosophy and Methodology
[102] Referring to Chapter Eight: Organizational Culture

b. Doctors do not recognize managerial knowledge base and values and that there is mistrust and suspicion between doctors and administration supporting similar studies in the US and UK (Bettner, 1987; Dawson, 1994; Stewart, 1989; Fitzgerland and Sturt, 1992).

With regards to the medical profession, this study finds evidence on:

c. The importance of knowledge to the medical profession as its relationship with other professions revolved around its recognition or not of their knowledge base

With regards to nurses, findings indicate that:

d. Nurses still suffer from being subordinate to other professions but are moving towards professionalization and away from medical dominance.

e. Evidence supports research findings on nurses rallying with medicine against managerial values (Greenwell et al., 1994).

With regards to administration, findings indicate that:

f. The lack of exposure during training and the absence of the authority to limit professional activity and control resources have negatively affected the perceived image of administrators.

g. Of the three professions, administration has the least cohesive identity and aspires towards creating a professional identity.

8. National Culture[103]

The influence of national culture was explored and findings were found to:

a. Support research on Arab national culture in as much as the characteristics attributed to 'Arab management culture' have been found in the research setting.

However, the research does not endorse the point of view that these characteristics are nation-bound. Rather:

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[103] Referring to Chapter Eight: Organizational Culture.

b. More evidence in these characteristics being organization-bound was found shedding a doubt on the conclusions of studies on 'Arab management culture' by Al-Faleh (1987), Attiya (1992), Muna (1980) and Hickson and Pugh (1995).

9. Organizational Effectiveness[104]

Organizational Effectiveness was studied by exploring health services effectiveness assessment and applying the Competing Values framework to HMC.

Findings on health services effectiveness revealed that:

a. HMC suffered from difficulties in health services effectiveness assessment similar to the well-documented British NHS difficulties. There was evidence of an ambiguity of goals, intangibility of services, assumed worthwhileness of the organization, lack of competition and a focus on inputs rather than outputs and on efficiency rather than effectiveness.

Exploring effectiveness in terms of Donabedian's (1980) structure-process-output model revealed:

b. The existence of some structure, process and outcome measures in HMC but the later was not converted to impact (Donabedian, 1980; Flynn, 1986). This was found to be associated to the lack of professional input in the assessment.

Application of the Competing Values framework revealed that:

c. The main focus of the organizational efforts was on obtaining cohesiveness and skilled workforce and the second emphasis was on goals, productivity and efficiency, confirming previous research in this area (Dastmalchian et al., 2000). These findings are especially interesting in light of previous findings on interprofessional relations and boundaries where many conflicts were found between the medical, nursing and administrative staff.

d. Although there are conflicts between the different professions it is the human relations focus of the health organization that is thought to enable harmony and ohesiveness in the workplace, an environment necessary for the interdisciplinary nature of the work.

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[104] Referring to Chapter Nine: Organizational and Team Effectiveness

10. Team Effectiveness[105]

Team effectiveness was evaluated in terms of perceived team functioning and team performance (Alexander et al., 1996) Findings demonstrated that:

a. There was a considerably high perception of good team functioning, performance and effectiveness. Statistically, no significant variation was found in the responses by hospital and in two responses by profession (clarity of objectives and organization of meetings) there was a significant variation in response.

b. Characteristics and functions that were found to be important in improving team effectiveness in both management and the team leader were good communication with and from the team, implementation of team decisions and improving team procedures and functions which confirms the effect of leadership (Hetherington and Rundell, 1983) on team effectiveness.

Returning to our original propositions we now address these in the light of our findings.

10.2 *First proposition*

The first proposition stated that health professionals were individualistic, specialist in character enjoying autonomy yet when brought together in a hospital setting work within a generic and systematic framework. Our study, however, found that organizational subcultures share organization wide generic values, while maintaining their own individuality. Overall, there was a strong homogeneity of values. These shared core values were found to be; patient satisfaction and confidence, developing new services and techniques, training and developing of employees, improving work processes for quality performance and effective utilization or resources and finally respecting organization structure/chain of command. It is these shared core values that pull together the different autonomous professions.

When exploring interprofessional relations and the different professional structures many differences, power struggles and conflicts were found. The medical profession's relationship with other professions was found to revolve around its recognition or not of

[105] Referring to Chapter Nine: Organizational and Team Effectiveness

their knowledge base. The nursing profession was found to suffer from medical dominance and subordinate classification to other professions but is moving towards professionalization. The administrative profession was found to be the one with the least cohesive identity, whose knowledge base is not recognized by the medical staff and whose relationship with medical staff is one of mistrust and suspicion. Distinctive differences in the structuring of the medical, nursing and administrative were found as well as power struggles and conflicts between the multiple lines of authority. Additionally, the unclear definitions of roles and responsibilities of the different profession have resulted in confusion of boundaries and increased conflict.

Considering the distinctions and conflicts between the different professions, having shared values would not seem sufficient to ensure that when brought together in a hospital setting; they work within a generic and systematic framework. The answer was found in the result of the competing values framework analysis. Application of the Competing Values framework revealed that the main focus of the organizational efforts was on obtaining a cohesive and skilled workforce and the second emphasis was on goals, productivity and efficiency. These findings indicate that although there are conflicts between the different professions it is the human relations focus of the organization that enables harmony and cohesiveness in the workplace, an environment necessary for the interdisciplinary nature of hospital work.

10.3 *Second proposition*

The second proposition stated that an organization structure that focuses on integration and coordination would promote harmony and effectiveness in highly complex settings. First we explored how integration and coordination promote harmony and then effectiveness. Findings clearly indicated the importance of coordination mechanisms in reducing conflicts. However, findings also indicated that coordination mechanisms were preferred to integration mechanisms. During restructuring attempts integration mechanisms were rejected by organizational members when coordination mechanisms were adopted. Finally, findings demonstrated that coordination mechanisms such as liaison roles and joint committees were initiated to reduce conflicts.

With regards to effectiveness it is difficult to specify the relationship between integration and coordination and effectiveness because it was difficult to collect health services effectiveness data. Hence a subjective measure of effectiveness that maps the effectiveness values and efforts of the organization was used. The findings of the

Competing Values framework application indicated that of the four set of values internal processes were the third highest valued and focused on elements of the organization. This would seem to point to the conclusion that hospitals seek coordination in order to first improve the elements that it considers most important components of its effectiveness, human relations or harmony among the different professions.

10.4 *Third proposition*

The final proposition states that an effectively designed organizational structure is one that is supported by proper processes and systems. Working from Shortell and Kalzuny (1983), two purposes of organizational design as first to ensure effective coordination and integration of tasks and second to monitor and respond to the environment via communication, information and control mechanisms findings reveal that HMC's organizational design has shortcoming with regards to coordination, communication and information mechanisms. It relies heavily on structure (more specifically centralization), informal means, and teams and committees as coordinating mechanisms. Other mechanisms such as information, communication, planning, and standardization are underdeveloped. Our findings indicate that when organizational design has weaknesses, the organization substitutes through other mechanisms. For example, findings indicated that where coordination mechanisms are underdeveloped informal mechanisms become important. Similarly, findings indicate that in environments where coordination and information management mechanisms are underdeveloped centralization becomes a coordinating and information providing mechanism. Finally, findings also indicate that in a context where organizational design is weak and the organization is fragmented and confused strong decisive leadership, which pulls the organization together and provides direction, becomes important.

The proposition is confimed in as much as the study shows that the organization does not have fully developed processes and systems. Only a study of an organization that does possess such processes and systems could fully confirm that they support effectiveness.

10.5 Limitations and future research

This research has been limited by the time frame of the research, the research methodology selected and the research setting. Although the sections on evolution of organization structure and change management covered periods before the research, exploration was undertaken retrospectively from documentation and interview analysis. The research was interpretative in nature, relying on perceptually based tools for investigation, which has its limitations. The weakly documented performance data of the research setting placed additional strains on the research in the section on organizational assessment.

This research attempted to achieve diversity, which has been recommended for improving theory in the interpretative paradigm by transcending paradigmatic thought (Weick, 1989; Eisenhardt, 1989; Deacon et al. 1998; Hammersley, 1996), through the use of multiple perspectives in organization theory and the use of different research methods to enhance confidence in findings. However, in doing so, the researcher staggered under the volume of data collected from the cases.

Areas for future research emerged from this study that this research could not pursue due to time frame limitations. First, it would be interesting for future research to further explore the link between health organization structure and its life-cycle and organizational effectiveness and life-cycle through large-scale industry wide research. Second, although effectiveness of health services has been extensively studied, there is space for studies on the applicability and practicality of effectiveness measures. Of special interest in this topic is the separation of organizational effectiveness research from program evaluation research, as these two seem to be confused by researchers. Additionally work towards a comprehensive framework that takes into account the complexities of public health organization is needed.

Third, with regards to the Competing Values framework as an organizational effectiveness assessment tool, it would be worthwhile to explore how the framework may be rendered more practical, less time consuming and demanding on respondents and researchers and how the expectations of the different constituencies could be taken into consideration. The addition of simple objective measures that could be used to complement the framework would also improve the reliability of the Competing Values framework as an organizational effectiveness assessment tool.

Fourth, exploration of the nature and different types of power struggles in hospitals would contribute to better understanding of interprofessional relations. Fifth, with regards to organizational structure, two interesting areas of future research arise. One, the success of bureaucratic forms of structuring hospitals versus the success of non-bureaucratic forms. Two, how the differentiation-integration balance is achieved in hospitals.

Sixth, this research shed doubts on existing studies on Arab management culture and studies which would redefine what constitutes Arab national culture and organizational culture would be interesting at this moment in time when globalisation and transfer of knowledge and technology make national cultural boundaries no longer clear cut. Finally, positivistic studies that would confirm or refute the findings of this research such as detailed work analysis to understand levels of differentation, integration, coordination and interprofessional relations would be worthwhile.

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ANNEX 1: THEORIES OF ORGANIZATION

1. **Classical organizational theory**
2. **Neoclassical organization theory**
3. **Modern structural organization theory**
4. **Organizational behavior/human resources theory**
5. **Systems, contingency and population ecology organization theory**
6. **Multiple constituencies/market organization theory**
7. **Power and politics organization theory**
8. **Organizational culture and symbolic management organization theory**
9. **Postmodernism influence**

Ott and Shafritz (1991) presented the different organization theories in a grouping of eight schools; classical organization theory, neoclassic organization theory, organizational behaviour or human resources theory, 'modern' structural organization theory, systems, contingency and population ecology organization theory, multiple constituencies/market organization theory, power and politics organization theory, organizational culture and symbolic management organization theory. Their grouping has been selected for this study for its completeness and holistic approach to the development of different organization perspectives, an aspect found particularly important when studying the application of organization theory in the health care setting.

1. Classical organizational theory

The first generally acknowledged classic influence on organization theory was Adam Smith (1776) who wrote on the efficiencies and rationalities in division of labour in factories. Thereafter classical authors split into two streams, a sociological (Durkheim, Weber and Marx) and a classical management theory (Taylor, Fayol, and Barnard); a tension that can still be found in present organization theories as they struggle with theory and practice (Hatch, 1997).

Karl Marx's (1867) theory of capital is based on the belief that collective work forms the foundation of the social world, that collective work emerges as humans realize labour is needed to satisfy their physical needs and that collectively productivity is higher. The fundamental struggle in capitalism is between the interest of capitalists or owners and those of labourers as capitalists pressure labour to work more efficiently, so as to increase profits, by applying managerial controls and tactics. Since labour is defined as a cost of

production, a potential by-product is managerial exploitation, labour disempowerment and alienation which workers can resist by organizing themselves into unions.

Durkheim (1893) studied the structural shifts that accompanied the industrial revolution and noted an increase in specialization, hierarchy and interdependence of work tasks. Durkheim was also the first to distinguish between the formal and informal aspects of organizations and underline the importance of tending to the social needs of workers, concepts that were built on by organizational behaviour, 'modern' structural, and organizational culture theorists.

Taylor (1916) created the Scientific Management approach to improving the efficiency of manual labour, in which he recommended rationalization, managerial controls and supervision, differential pay for performance, and objective productivity measures; techniques which laid the foundations for modern managerial control systems. Scientific Management's unfavourable reputation stems from the fact that his methods where thought to erode workers solidarity and the concept of trust and cooperation between management and workers.

Fayol (1916) presented some general principles for rational management which included span of control, departmentation, unity of command, and hierarchy; principles which contributed to most of the underlying principles of modern structural theories. His definition of the responsibilities and functions of the manager (planning, organization, command, coordination and control) are still greatly utilized. Fayol also argued for the importance of having 'esprit de corps', unity of sentiment and harmony among organizational members for the smooth running of the organization; concepts later adopted by organizational culture theorists.

Weber (1946) had presented a theory of bureaucracy, which depicted the virtues of bureaucracy as being rational, objective, impersonal and unbiased. In bureaucratic organizations, formal authority is based on precise and generalized rules and procedures, and efficiency is achieved through substantive rationality (desired ends) which influences formal rationality, (techniques of calculation and control). These concepts make Weber one of the founding fathers of modern structural theorists. Nonetheless, he warned against application of formal rationality without a sensible consideration of substantive rationality for this leads to imprisoning and dehumanising of workers; concepts which are close to culture and symbolic management theorists.

Finally, Barnard's (1938) focus on informal organization, integration of work efforts through communication of organizational goals and his attention to worker motivation and sentiments have directly contributed to the fields of organizational behaviour, culture and symbolic management.

2. Neoclassical organization theory

The neo-classics vigorously attacked intellectually derived classical organization theories for minimizing vital issues such as the humanness of organizational members, coordination needs amongst units, internal/external organizational relations and organizational decision-making processes and for assuming that scientific management principles are universally applicable. However, they have not developed a distinct body of theory and are generally regarded as an anti-school which played an important role in the evolution of organizational theory. They revealed the weaknesses of the simplistic mechanistic view of classical theorists, stressed the importance of empirical research, and raised some issues that initiated theories for organizational behaviour, modern structural, systems, power and politics, and organizational culture perspective theorists.

Simon (1946) criticized the general principles of management derived by classical theorists as being inconsistent, conflicting, and inapplicable to many of the administrative situations faced by managers. Dalton (1950 and 1959) focused on the problems of educating and socializing managers as well as the structural frictions between line and staff units and between the main office and geographically dispersed facilities. Interrelations and status differences in the workplace were found to contribute to occupational stress (Whyte, 1948).

These writers also realized that organizations were not self-contained islands but social systems which were influenced by, as well as influenced, their environment and who by accomplishing their objectives where accomplishing the larger goals of society in general (Parson, 1956). Selznick (1948) noted that while it is possible to describe and design organizations in a rational manner, strategies need to be adopted to cope with the nonrational aspects of organizational behaviour.

March and Simon (1958) presented a study which revealed that the efforts to achieve bureaucratic objectives sometimes resulted in unforeseen consequences as individuals respond in personal ways. The thus emphasized the dynamic nature of organization, and how systems impact on individuals and vice versa. Simon (1960) addressed the

processes of decision making and proposed improvement of organizational decision making through quantitative methods, operational research and computer technology. Cyert and March (1963) were among the first to analyse the impact of power and politics on the establishment of organizational goals, to describe the formation of coalitions and negotiations between coalitions, and to notice that organizations tended more towards 'safisficing' than profit maximizing.

3. The organizational behavior/ human resources perspective

Munsterberg (1913) with his studies on the impact of psychological conditions on employee productivity is considered the father of industrial psychology. Applied behavioural scientists of the 1960s, 70s and 80s building on the assumptions that organization exist to serve human needs, that organizations and people need each other (co-dependency), and that when the fit between the two is poor, one or both will suffer in the relationship, focused on answering questions revolving around how organization could promote flexibility and creativity thus encouraging employees to grow and development (Bolman and Deal, 1991).

Common themes of organizational behaviour theorists are motivation, group and intergroup relations, leadership, the person-organization interface, power and dependence, and organizational change (Ott, 1989). The first landmark motivation studies were; the Mayo Team's (1933) Hawthorne experiments that demonstrated how different variables affect employee motivation, Maslow's (1943) hierarchy of needs, McGregor's (1957) Theory X and Theory Y and how managerial assumptions become self fulfilling prophecies by causing employees behaviour, and McClelland's (1966) theory that people have three basic needs (achievement, power and affiliation) which vary in intensity under different circumstances, with achievement motivation being the one that can be raised with training.

Argyris (1970) defined the organizational behaviour approach to change (later organizational development) with its fundamental components; the nature of the change-agent/client relationship, the importance of valid and useable information, and the importance for organizational members to internalise change.

Other influential writers under this perspective were Janis (1971) who first described the negative effects of the 'groupthink' phenomenon, and Follett (1926) who promoted

participatory leadership style and situational management. Although greatly optimistic, the weakness of this humanistic perspective is that they have become highly normative.

4. Modern structural organization theory

'Modern' structural theorists have their roots in classical structuralists but have been influenced by the neoclassicals, human relations and systems theorists. Boleman and Deal (1984) identified the basic assumptions of 'modern' structural school as:

> '1. Organizations are rational institutions whose primary purpose is to accomplish established objectives; rational organizational behaviour is achieved best through systems of defined rules and formal authority. Organizational control and coordination are key for maintaining organizational rationality.
> 2. There is a 'best' structure for any organization – or at least a most appropriate structure – in light of its given objectives, the environmental conditions surrounding it, ... the nature of its products and/or services ..., and the technology of the production processes.....
> 3. Specialization and the division of labour increase the quality and quantity of production – particularly in highly skilled operations and professions.
> 5. Most problems in an organization result from structural flaws and can be solved by changing the structure.'
>
> (Quoted from Ott and Shafritz (1991, pgs. 201-202))

Burns and Stalker (1961b) developed their theory of "mechanistic and organic systems" of organization with either form being appropriate in a particular given situation. Blau and Scott (1962) stressed that, when studying formal organization, it is important to understand the parallel informal organization. And Walker and Lorsch (1968) when deliberating on whether organizations should be structured according to product or function conclude that depending on the nature and environment of the organization, either can be suitable.

Like classical structuralists, most 'modern' structural organizational theorists struggle with differentiation and coordination (or integration) between organizational units. Smith (1976) recommended the division of labour to increase effectiveness. Lawrence and Lorsch (1967a) recognized that balancing between differentiation and integration is the most important problem faced by organizations and advocate a contingency approach to organization theory. The matrix organization structure emerged as a solution to this fundamental problem. However, this form of structure necessitates some preconditions such as matrix system, culture and behavior to succeed and is recommended in large

multi function organizations where tasks are complex and interdependent (Davis and Lawrence, 1977).

Mintzberg (1979a and b) has contributed through his management policy and using Thompson's (1967) concept of 'pooled, sequential, and reciprocal organizational coupling' has created a model of organization with five interdependent parts; the strategic apex, the middle line, the operating core, the techno-structure and the support staff.

Weber's concept of bureaucratic organizational form has a fundamental role in 'modern' structural theory, with persistent and renewed attacks from one side and support from the other. It was predicted that the bureaucratic, hierarchical form was to disappear with the rise of democracy, information technology, and the rapidly changing environment, and will be replaced with flatter, information-based, task and mission focused organizations (Bennis, 1966; Toffler ,1970; Bennis and Slater, 1968; Schien, 1989; Drucker, 1988). Other writers promoted the bureaucratic form for its efficiency, and equitable treatment (Ott and Shatritz, 1992).

However, the most determined defender of the bureaucratic form of organization is Jaques (1990), who states that the bureaucratic structure has, despite its problems, persisted because it is the only appropriate structure especially in large organizations. In his view the problems with bureaucracy are due to misimplementation and not understanding the nature of hierarchy and layering. He gives as example implementation in hospitals which he notes *"function in spite of the system, only because of the enormous professional devotion of their staff."* (Jaques, 1990, p. 257). However, he believes that we should stop looking for other solutions such as group dynamics, which go against the accountability systems of organizations. He concluded by saying that, *"managerial hierarchy or layering is the only effective organizational form for deploying people and tasks at complementary levels, were people can do the tasks assigned to them, where the people in any given layer can add value to the work of those in the layer below them, and finally, where this stratification of management strikes everyone as necessary and welcome"* (Jaques, 1990, p. 262).

5. Systems, contingency and population ecology organization theory

Drawing from Bertlanffy's (1951) General Systems Theory and Wiener's (1948) cybernetics model of organizations as an adaptive self-regulating system, the system's perspective dominated organization theory since Katz and Kahn (1966) first described organizations as open systems and Thompson (1967) adopted a rational systems/ contingency perspective of organization.

Systems theory views organizations as a complex dynamic systems with its inputs, processes, outputs, feedback loops, sub-systems and super systems, a departure from the one-dimensional simplistic classical organization theories. Now organizations were seen as multi-dimensional and in continuous interaction with their environments. Such complex variables require quantitative analytical methods and models which identify cause-and –effect relations and find optimal solutions (Ott, 1989).

Some classical organization theorists such as Taylor (1916) with his focus on quantitative scientific methods and Simon's (1957 and 1960) theories on decision-making provided conceptual foundations for systems theorists. Taken to an extreme, the systems approach has created heated debate over issues such as computer domination, and conflicts between human elements and a technology-based organization. However, works such as Katz and Kahn's (1966) open system model, Thompson's (1967) technology and tasks interface, Galbraith's (1973b) information processing models of organization, and Rosenzweige's (1972) realization that systems and contingency views are already applied unconsciously in organizations, have bridged the gap between classical, neoclassical, human relations, 'modern' structural, and system's perspectives.

Emergent from the system's perspective, the contingent perspectives viewed everything as situational. Galbraith (1973b) is often cited in his information-processing model for having captured the essence of the contingency model. He sees uncertainty as the gap between the amount of information an organization needs and the amount of information it possesses where contingent approaches to planning and decision-making are needed in moments of high uncertainty.

Another extension to the systems and contingency theories is the population ecology perspective that has not yet found a solid place in organization theory (Ott and Shafrtiz, 1991). Drawing on Darwinian theories of evolution, these theories are concerned with the formation, adaptation, competition, selection and survival or death of organizations (Hannan and Freeman, 1977). These theorists propose a higher level of analysis, rather than studying single organizations, they promote studying populations or fields of organizations (Trist, 1977; Hannan and Freeman, 1977).

6. Multiple constituencies/market organization theory

The multiple constituencies' perspective views the organization as simply a legal entity, a means for satisfying the interests of the different internal and external stakeholders (Jensen and Meckling, 1976). It does not have utilitarian rational goals and objectives but rather is a 'market' through which constituencies wish to accomplish their own goals and interests. Given this perspective, negotiated order theorists view organizations as in a constant state of change in which conflicting objectives are brought into equilibrium by negotiations (Strauss et al, 1963; Day and Day, 1977; Jensen and Meckling, 1976).

This relationship between organization and individuals is constantly redefined and when their interests are not met, constituencies retreat or alter the nature of their association with the organization (Williamson, 1975; Jensen and Meckling, 1976; Day and Day, 1977; Connolly et al, 1980; Keeley, 1983). However, theorists disagree on whether individual goals and interests are rational, perceptual (Mitroff, 1983), or emergent (Weick, 1979; White and McSwain, 1983).

Cyert and March (1963) describe organizations as coalitions with different interests whose goal is the goals of the dominant coalition. Thus organizational goals arise and change constantly through bargaining. This concept has set the foundations of the power and politics perspective; a perspective which focuses on the tactics and strategies used by coalitions to gain and maintain power in and around organizations.

Connolly, Conlon and Deutsch (1980) criticize the rational, utilitarian and systems based approaches to evaluating organization and advocate organizational effectiveness measures that reflect the evaluation criteria applied by the various stakeholders. Similarly, Keeley (1983) notes that rational, scientific research wrongly ignored values and that organization theory and research should not be value free. He suggests a multiple

constituencies-contract approach of evaluation and a redefinition of organizational worth and effectiveness to include normative values such as justice and equity.

7. Power and politics organization theory

Building on the contingency perspective, power theories view the organization as a complex system of competing individuals and coalitions, each with their own interests, values, beliefs, and perceptions. Baldridge (1971) found organizations to have conflicting and transitory goals, each taking priority as the balance of power shifts within the organizational coalitions. Since organizational resources are limited, conflict is inevitable making influence, power and politics the means in competition to achieve dominance.

Pfeffer (1981) defines power as the ability to influence others in order to get things done and Kanter (1979) further specifies that it be related to the ability to make other dependent on you. Structuralist tended to define power in terms of authority. However, power theories identified many sources of power. Allen and Porter (1983) note the existence of downward influence, lateral influence and upward influence. Other sources include the power to control scarce resources, accessibility to those with power, an important position in a dominant coalition, credibility, expertise or charisma.

Political theorists have realized that power is a structural fact, that specialization and division of labour create small, interdependent units with varying degrees of importance in the organization. Competing organizational coalitions often form around professions and the competition often does not always revolve around organizational goals, emphasizing that contrary to what structuralists and systems theorists believe, organizations are not rational.

Kanter (1979) stressed the importance of executive and managerial power in achieving organizational goals but notes that it is generally these positions that are powerless in the organization. Or they are more likely to have dominance, control and oppression power, powers which are not productive. Leaders may obtain productive power by empowering others.

Finally, Mintzberg (1983) views organizational behaviour as a power game between the 11 groups of external and internal coalitions that influence the organization. Influential external coalitions are employees associations, associates, the organizations' public, and

the corporate directors. Influential internal coalitions are CEO's, operators, line mangers, analysts, support staff and uniquely, the ideology of the organization.

8. Organizational culture and symbolic management organization theory

From the organizational culture perspective, cultural norms, values, beliefs and assumptions rather than formal rules, authority, and norms of rational behaviour control organizational member's actions. Under this perspective, understanding the organization's basic assumptions is important in understanding organizational behaviour in different circumstances. Kilmann et al. (1985) equate organizational culture to individual personality and suggest that it is culture that provides meaning, direction and motivation in organizations.

Like the multiple constituencies and power perspectives, organizational culture theorists do not believe in the usefulness of quantitative, quasi-experimental, logical positivist research designs and have turned to qualitative research methods (VanMaanen, Dabbs and Faulkner, 1982; Louis, 1983; Ott and Shafritz, 1991).

The earliest studies on culture are found in studies on organizational professional socialization processes, which assumed the existence of organizational and professional culture. However, it was the works of Weick (1979) and Berger and Luckman (1967) that gave cultural studies its present symbolic frame. Weick (1979) introduced the enactment theory, which suggests that individuals construct their own phenomena by speaking and acting in ways that give it tangibility. Berger and Luckman (1967) argued that realities are social constructs, that realities are not real in themselves but that shared history and experiences make us perceive them as realities. Hence reality is not objective but objectified and thus can be changed.

Thus, in organizations, meaning and hence realities are established by the organizational members and can be changed or distorted according to the needs of the members. Ambiguity is managed by using symbols and meaning in order to gain a sense of direction (Bolman and Deal, 1984).

Organizational culture and symbolic management perspective theorists view organizational behaviour and administration as artificial sciences, in which reality and knowledge are constructed by humans and can change. Administration activities are cultural artefacts, and leadership's objective is to link organizational members by

interpreting and enhancing meaning and integrating key cultural aspects (Sergiovanni, 1984).

The first substantial book on symbolic management was written by Pondy, Frost, Morgan and Dandridge (1983) and the first works on organizational culture came with the works of Schein (1985), Sergiovanni and Corbally (1984), Sathe (1985) and Kilman et al. (1985). More recently, TQM with its cultural approach has sustained an interest in organizational culture throughout the 1990s.

9. Postmodernism influence

Hatch (1997), in her classification of organization theory, notes that a postmodern wave originating from Marxist and neo-Marxist revived by poststructural French philosophy made its way into organization theory through the application of linguistic, semiotic and literary theory introduced by symbolic-interpretive theorist's studies on meaning and interpretation.

Postmodernist criticize modernists for their uncontested value for rationality, their attempts to develop integrated, universal theories, their notions of truth, their search for one best way, and of a human civilization progressing towards a mutually desirable future. In their view, knowledge is fragmented, truth can be achieved through other than our senses, and human diversity makes it impossible to define a mutually desirable future. They predict organizations will be more eclectic, participative and loosely coupled then ever where organizational members will face more paradoxes, contradictions and ambiguity.

Postmodernists value deconstruction of truth and power and critiques of theorizing practices. Their view of the organization is that which Morgan (1986) describes with the metaphor of organization as a collage, made of bits of knowledge and understanding, brought together to form a new perspective that has reference to the past.

ANNEX 2: SCHOOLS OF THEORIES OF CHANGE

An interdisciplinary literature review by Van de Ven and Poole (1995) identified four basic schools of thought. They note that a combination of the elements that make up these four ideal types is generally used to explain observed change processes in specific contexts (Van de Ven and Poole, 1995):

1. Life-Cycle Theory

The principles behind the life-cycle theory is that *"change is imminent: that is, the developing entity has within it an underlying form, logic, program, or code that regulates the process of change and moves the entity from a given point of departure toward a subsequent end that is prefigured in the present state."* (Van de Ven and Poole, p.515, 1995).

Van de Ven and Poole identified that within this school of thought is developmentalism (Nisbet, 1970), biogenesis (Peatherman, 1986), ontogenesis (Baltes, Dittman-Kohli and Dixon, 1986), some stage theories of child development (Piaget, 1975), human development (Levinson, 1978), moral development (Kohlberg, 1969), organizational development (Kimberly and Miles, 1980), group decision-making stages (Bales and Strodtbeck, 1951), and new venture development (Burgelman and Sayles, 1986).

2. Teleological Theory

"According to teleology, development of an organizational entity proceeds towards a goal or an end state. It is assumed that the entity is purposeful and adoptive; by itself or in interaction with others, the entity constructs an envisioned end state, takes action to reach it, and monitors the progress." (Van de Ven and Poole, p.516, 1995). Included in this school of thought is functionalism (Merton, 1968), decision making (March and Simon, 1958a), epigenesis (Etzioni, 1963), voluntarism (Parsons, 1951), social construction (Berger and Luckmann, 1967), adaptive learning (March and Olsen, 1976), and most models of strategic planning and goal setting (Chakravarthy and Lorange, 1991).

3. Dialectical Theory

This theory begins with the *"Hegeliam assumption that the organizational entity exists in a pluralistic world of colliding events, forces, or contradictory values that compete with each other for domination and control."* (Van de Ven & Poole, p. 517, 1995). Stability is explained as stability of power between opposing entities and change as opposing values, forces or events gaining sufficient power to confront the status quo.

4. Evolution Theory

Evolution theory explains change *"as a recurrent, cumulative, and probabilistic progression of variation, selection and retention of organizational entities."* (Van de Ven and Poole, p. 518, 1992). Two dominant views dominate this theory, the Darwinian and Lamarckian evolution. *"Organizational scholars who adopt Darwinian evolution (e.g. Hannan and Freeman, 1977, 1989; McKelvey, 1982) argue that traits are inherited through intergenerational processes, whereas those who follow Lamarck (e.g. Boyd and Richerson, 1985; Burgelman, 1991; Singh and Lumsden, 1990; Weick 1979) argue that traits are acquired within a generation through learning and imitation."* (Van de Ven and Poole, p. 519, 1995).

ANNEX 3: EARLY ORGANIZATIONAL EFFECTIVENESS

In the earliest studies of industrial organizations, effectiveness had been viewed in terms of productivity. Georgopolous and Tannenbaum (1957, p. 80) note that Thorndike (1949) recalls that in the past, personnel and industrial psychologists accepted organizational productivity, net profit, the extent to which the organization accomplishes its various missions, and the success of the organization in maintaining or expanding itself, as "ultimate criteria" of organizational success.

Similarly, Katz and Kahn (1966, p. 164) defined organizational effectiveness *"as the maximization of return to the organization, by economic and technical means (efficiency) and by political means".* Controversy over the two dominant assumptions; that organizations maximize or satisfies attainment of purpose (Simon, 1957; March and Simon, 1958; Cyert and March, 1963), held the focus of researchers (Thompson, 1967, p. 84).

Later research defined and evaluated effectiveness in terms of goals achievement. Etzioni (1964) defined goals as being future conditions that the organization attempts to bring about. Georgopoulos and Tannenbaum (1957, p. 82) further stress that defining organizational effectiveness must take into consideration both ends and means.

However, formal goals being too vague the "operative goal" concept was developed (Price, 1968; Hall 1972; Etzioni, 1964; Perrow, 1972). This concept entails observing the objectives the enterprise is trying to accomplish and measuring effectiveness by observation of behaviours in pursuit of these objectives (Carnall, 1982, p. 4). This brought up the issue that an organization may have multiple operative goals that could even be conflicting.

Hall (1972) questioned whether it was even possible to conclude that an organization is effective as a whole and noted that organization pursue more than one goal and that the degree of effectiveness in the attainment of one goal may be inversely related to the degree of attainment of other goals. Through internal choice processes and external pressure organizations prioritise operative goals. To this problem Steers (1975) proposed that operative goals might be weighted according to the effort exhausted in their pursuit.

Yutchman and Seashore (1967, p.892) presented a system-resource model in which effectiveness is defined as *"enterprise bargaining position, as reflected in the ability of the organization, in either absolute or relative terms to exploit its environment in the acquisition of scarce and valuable resources"*. The limitation of this approach is that is assumes that providers of resources engage in some kind of assessment of the worth of the operative goals when providing the resource and thus *"is based on an unrealistic model of the resource acquisition process"* (Carnall, 1982, p. 8).

Based on the notion that enterprises exist, ultimately, for human benefits Barnard (1938), Bass (1952), Kahn (1956) and Cyert and March (1963) approached effectiveness from a participant's satisfaction view. Mishan (1973) notes that interpersonal comparisons of satisfaction are viewed as methodologically illegitimate and that a just distribution of satisfaction cannot be assured in practice. Keeley (1978) discusses the application of the ideas of justice and social good to the assessment of organizational effectiveness.

Katz and Kahn (1966, p. 288) suggest;

> *"three categories of behavior are required to achieve high levels of organizational effectiveness. People must join and remain in the organization; they must perform dependably the roles assigned to them; and they must engage in occasional innovative and cooperative behavior beyond the requirements of role but in the service of organizational objectives."*

Campbell (1973), in a review of various effectiveness measures, identified 19 different variables that had been used in research literature and found the most widely used univariate measures to be: (1) overall performance, measured by employee or supervisory ratings, (2) productivity, measured with output data, (3) employee satisfaction, measured by self-report questionnaires, (4) profit, based on accounting data, (5) withdrawal, based on turnover and absenteeism data.

Steers (1975, p.549) in reviewing seventeen multivariate models of effectiveness found a *"lack of consensus as to what constitutes a useful and valid set of effectiveness measures"*. He concluded by recommending the use of "goal optimisation models" which are capable of accounting for multiple and conflicting evaluation criteria, assigning various weight to evaluation criteria to reflect goal variances as well as accounting for interrelationships such as technological, environmental, structural and human constraints. He noted that, *"If we are ultimately to be able to compare results of evaluations of effectiveness across organizations realistically or meaningfully, then greater effort must be*

directed towards more flexible, tailored approaches and away from value-laden prescriptive evaluation criteria that often appear in research literature" (Steers, 1975, p.556).

Another review of organizational effectiveness research by Campbell (1977) identified 30 different criteria of effectiveness, some of which are even contradictory. Finally, Campbell (1977) concluded that since an organization can be effective or ineffective on a number of different facets that may be relatively independent of one another, organizational effectiveness has no *"operational definition."*

ANNEX 4: GRAETNER AND RAMNARAYAN'S (1983) CHARACTERIZATION OF APPROACHES

Graetner and Ramnarayan (1983) characterized the different definitions and approaches to organizational effectiveness by two major dimensions: focus on definition and intended use of concept. Some definitions focus on measures of terminal outcomes, and others tend to be concerned with organizational processes and structures. Likewise, some approaches tend to be organization-specific and others are intended for generality of organizations. Gaertner and Ramnarayan (1983) cross-classified these two dimensions, which resulted in four distinct types of approaches:

General Output Measures:

This approach encompasses traditional accounting measures (Price, 1968) and the population ecology approach which views organizational health and survival as the ultimate organizational outcome (Aldrich, 1979; Hannan and Freeman, 1978; Mc Kelvey, 1980). The main difficulties of these measures identified by Graetner and Ramnarayan are the multiplicity of outputs produced by organizations and the value to be placed on these outputs by the different constituencies of the organization.

Organization-Specific Output Measures:

These are goal centered approaches championed mostly by Etzioni (1964) and Perrow (1970). This approach conceives organizations primarily as rationally designed instruments for the attainment of specific goals (Gouldner, 1959; Etzioni 1960). Some limitations of this approach identified by (Graetner and Ramnarayan, 1983, p. 179) are:

1. Goals for programs and organizations are dynamic and are likely to change over time, partly as reflections of changing external circumstances and partly due to changes in the political makeup of the organization itself (Bardach, 1977; Kahn, 1977).
2. There is a problem of interpreting the uses of goals in organizations. Organizations may adopt different kinds of goals and for different reasons (Scott, 1977). Some goals are designed not to orient the behavior of organizational members, but rather to provide only symbolic recognition to some constituency (Galbraith, 1967; Hannan and Freeman, 1977). Other times goals are seen as internal messages within the organization of what behavior is hoped for (Granick, 1967).
3. Goals are frequently inventions to suit the already performed, a rationale for the past (Weick, 1979).

Gaertner and Ramnarayan (1983, p.180) identified that the problem with both organization specific and general outcome approaches is that they do not include understanding of the factors associated with the production of outputs and therefore are not useful, nor do they reveal how to make organizations more effective.

Process/Structure General Measures:

Included under this category are the more recent and popular academic literature on management style (Blake and Mouton, 1964; Etzioni, 1964; McGregor, 1960), leadership (Feidler and Chemers, 1974), decision-making (Kepner and Tregoe, 1981) and organizational structure (Chandler, 1976; Galbraith, 1973). The main problem of these theories is that *"they rely on abstract theoretical notions of dubious applicability (and) ...neglect the varied uses and meanings that more generally defined constructs have in particular settings"* (Graetner and Ramnarayan, 1983,p. 180).

Process/Structure Organization-Specific Measures:

These measures encompass process oriented qualitative evaluation approaches that have evolved as a response to the limitations of the outcome-oriented views of effectiveness. Graetner and Ramnarayan note that the features recommending this approach (flexibility, openness to information, adaptability) are the same features that encourage criticism of it as being *"too diffuse, not result oriented and having little prescriptive power"* (Graetner and Ramnarayan, 1983, p.181). They also tend to assume the effectiveness of processes and structures (Gaertner and Ramnarayan, 1983)

Graetner and Ramnarayan (1983, p. 181) comment about this approach that:

> *"The view that there are "effective" structures and processes rest on either extremely mixed and generally tenuous empirical support or on the firm belief that some structures must be effective in some sense. Second and more importantly, these examinations of the efficacy of organizational structure or process implicitly or explicitly assume that there is a "real" measure of effectiveness, measured or not. This belief is far from easy to confirm. Until some understanding of what the dependent variable is or means is reached, the tie of structure or process to it must remain unclear."*

ANNEX 5 REVIEW OF STUDIES ON PROFESSIONALIZATION

1. Early studies on professionalization

The first organized studies on professions came in this century, reflecting the rise of social sciences and changes occurring in the professions themselves (Abott, 1988). Overtveit (1988) noted that the perspectives of early social scientists such as Marx, Weber and Durkheim have influenced later social scientists studying this field. Numerous studies on the rise of professions, their status within society, the economic base of their power, and their liberal and progressive position in society based themselves on Marx, Weber and Durkheim's theoretical perspectives (Overtveit, 1988, p. 200)

The earliest authors attempted to define professionals and their basic characteristics. Flexner (1915) put forth six criteria for identifying a profession; that their activity be intellectual in nature, that it is based on knowledge and not routine thus requiring it to be learned, that it is practical in nature, that its techniques can be taught, that it is very strongly organized, and finally that their motivation is altruistic. Carr-Saunders and Wilson's (1933) study of professions in England proposed traits of professions which became the core of later definitions. They noted that professions were organized bodies of experts applying esoteric knowledge to cases, who had elaborate systems of instruction and training with entry by examination and prerequisites and who possessed and applied a specific code of ethics.

Millerson (1964)'s review of definitional studies revealed that the earlier definitions had somewhat reflected the political concerns of the period. Millerson (1964) avoided this by identifying the general traits and characteristics of professionalism (theoretically based knowledge, training and education, code of ethics, loyalty to occupational organization and altruistic service motivations). Another review by Hickson and Thomas (1974) noted that the most commonly cited elements of professionalism in main studies are; skills based on theoretical knowledge, required education and training, competence tested, organized adherence to code of conduct and altruistic services. Other less commonly elements cited were; applied knowledge to affairs of others, provides indispensable service, licensed community sanction, definite professional-client relationship, fiduciary client relationship, best impartial service given, loyalty to colleagues and definite compensation (fee or fixed charge).

Thereafter studies of professionalization shifted from a typological (trying to identify what is and is not a profession) to naturalistic studies, where professionalization is a natural process that comes in stages. Caplow (1964) identified four stages; establishing professional associations, changing their names in order to dissociate themselves with their pasts, setting up a code of ethics and obtaining legal and political recognition. Wilensky (1964) studied first events in occupations in America and demonstrated that historically they go through, with minor deviations, six stages; first training school, first university school, first local association, first national association, first state licensing law, and first code of ethics. Moore (1970) defined a profession as; a full time occupation with a calling, a formalized occupational organization, specialized education, a service orientation and personal and collective organization.

Abbot (1988, p. 5) summarized the research in this period by noting that:

> *"Early work on professionalization had rested on the functional assumptions characteristic of postwar sociology. It attributed the collegial organization of professionals to their positions as experts. The "asymmetry of expertise" required the client to trust the professional and the professional to respect both client and colleagues."* (Abbot, 1988, p.5)

In reviewing studies on the traits of professionals, Overtveit (1988) noted that there seems to be a disagreement as to what differentiates a real professional from other occupations. He found existing studies arbitrary, depending on which profession is regarded as having professional status. Nonetheless he noted that the basic characteristics of the ideal type of profession seem to be a knowledge base, a service ideal and autonomy or public trust. Abbot (1988) in response to the numerous characteristics proposed a very loose definition that *"professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases."* (Abbot, 1988, p. 8)

2. Interactionist and power perspectives

The interactionist and power literature of the 1960s revealed the critical stance of social scientists and the general public toward professionals and exposed the ideological nature of earlier works (Overtveit, 1988; Abbott, 1988). Now rather than studying traits and functions literature focused on how professional associations advanced and maintained their interests to gain monopolistic positions (Overtveit, 1988).

Interactionalists studied the negotiations and interactions between practitioners and clients. Becker (1977) proposed that professions should be viewed as symbol and studied as "collective honorific symbol" or "folk concept". He noted that professions are merely occupations that were considered honorific at that time and that the public's opinion of which occupations are professions changes over time (Overtveit, 1988). And with this honorific symbol came autonomy because only professionals could judge the quality of their own work.

Researchers also looked into the source of professional authority and autonomy. Hughes (1958) noted that community trust in the professional's claim to expertise is fundamental to allowing professionals independence from community or organizational evaluation and control and that community trust was based on willingness of the community to license the professional to quarry into personal affairs of others. In studying the professional-client relationship, McKinlay (1973) stressed the importance for the professional to have client trust, and one way of establishing and maintaining this trust is through the promise of confidentiality. Overveit (1988) noted that there are two main reasons for establishing trust. First, confidentiality protects professionals from evaluation and gives them autonomy. Second, by holding confidential information the professional has gained power over the client and created a dependency relationship.

Friedson (1970a and b) took professional autonomy and dominance as the fundamental aspects of professionals and laid the grounds for the power perspective studies which were adopted by Friedson (1970b), Klaus (1971), Johnson (1972), and Larson (1977) who studied the how occupations acquired and maintained power. Friedson (1970a) proposed that autonomy was at the centre of professional attributes and characteristics. Self-direction was obtained via the acquisition of legal privileges protecting its work from other occupations as well as control over the application of knowledge and skill in their work restricting evaluation to be from other members only. Friedson (1970a) also offered a definition of a profession in terms of hierarchy of dominance. In the health field, he viewed that the only truly autonomous and dominant profession is the medical profession. In a study of health professionals in the UK, Overtveit (1988) draws out some weaknesses in Friedson's theory. First, the central concepts, autonomy, dominance and control are not defined and in his research Overtveit (1988) found that professional autonomy was complex, involving different types of autonomy, different elements and levels. Second, that Friedson (1970b) due to his lack of clear definition seems to confuse authority with autonomy and dominance.

Krause (1971) noted that all occupations have central skills, code of ethics, group culture, occupational authority, and permission to practice on the part of the community. Professions, he suggested, distinguish themselves by having all the above in to a high degree, being functionally powerful (with all the prestige and political power that comes with it) and providing basic needs without which a social crisis would occur.

Johnson (1972) viewed professionalization as a form of control in which professions imposed both definition of needs and manner of service on consumers. Larson (1977) viewed professions as market organizations attempting to dominate certain areas of social concern through their intellectual and organizational arrangements. Larson (1977) overlooked weaker professions and bases herself on American medicine and law as the best examples of professionalism.

BenDavid (1958) in addition to recognizing the status, power and money involved in professionalization, look at the function of professionalism in protecting the professionals from structured, rigid employment and capitalism.

In reviewing the existing literature Abbott (1988) identified 4 categories of approaches to professionalism; the functionalist approach (Carr-Saunders & Wilson, 1933; Parson, 1954), the structuralist approach (Millerson, 1964; Wilensky, 1964; Caplow, 1954), the monopoly approach (Larson, 1977; Friedson, 1970a and b) and the cultural authority approach. He summarized these views in what he proposes as a general concept of professionalization:

> *"Expert, white-collar occupations evolve towards a particular structure and cultural form of occupational control. The structure form is called profession and consists of a series of organizations for association, for control and for work. (In its strong form, the professionalization concept argues that these organizations develop in a certain order.) Culturally, professions legitimate their control by attaching their expertise to values with general cultural legitimacy, increasingly the values of rationality, efficiency and science."* (Abbot, 1988, p.16)

Abbot (1988) proposed that a new approach to studying professions needs to be adopted and proposed one that shifts the focus from organizational structure of professions to focus on the content of their work which, as history has demonstrated, continuously changes. Studying their work would expose the areas of conflict with other professions and demonstrate how they are interdependent.

3. The deprofessionalization debate

Recent studies on professionalism have suggested that the introduction of corporate capitalism, management science, increased focus on productivity and control, will have a negative effect of professions (Overtveit, 1988; Greenwell et al., 1994). Haug's (1973) noted that computerization of academic knowledge, relatively easy accessibility to expert knowledge, the erosion of professional autonomy through client review have and will lead to increased power of clients to criticize professionals and hold them accountable thus resulting in 'deprofessionalization'.

Oppenheimer (1973) noted that increased bureaucracy and rationalization of work, methods for measuring professional output and quantitative criteria to replace qualitative criteria, high unemployment and reductions in income have created the shift towards "proletarianized" professional work where professionals are inclined to joining trade unions or professional associations inclined to assume trade-union type of activities. Similarly, Braverman (1974) proposed that scientific management skills and management rationalization will lead to "de-skilling" in which work is fragmented and the worker losing autonomy and control becomes more of an executioner.

Overtveit (1988) does not agree with such expectations, and notes that;

> *"managerial rationalization does not necessarily lead to work fragmentation and de-skilling for professionals (and consequently union opposition); indeed it may enhance professions' status by encouraging professions to delegate "menial work" to assistants to make most effective use of their skills and training"* (Overveit, 1988, p. 199).

4. The professional-bureaucratic conflict

Much has been written on the professional-bureaucratic conflict. Parsons (1964) was the first to note, based on an abstract notion of Weber's theory of bureaucracy, that authority of expertise conflicted with the bureaucratic organization (Davies, 1985). Thereafter many studies theorized on the incompatibility of bureaucratic legal-rational authority and obedience to superiors with esoteric expertise, collegiality, and professional autonomy (Flynn, 1992).

In a review of early studies Overtveit (1988) noted that most studies traced the source of conflicts as being the different types of authority of professionals and bureaucrats. Bureaucrats drew their authority from the formal structure, policies and organizational goals, while professions drew theirs on expert knowledge, sometimes taking decisions that are not in line with organizational policies and goals. These conflicts were noted through resistance to bureaucratic rules, standards, and supervision, and the bureaucratic demand for unconditional loyalty (Scott, 1965). But most importantly it was noted in resistance to routine review and evaluation of work applied as control mechanisms in bureaucracies (Overveit, 1988).

Overtveit (1988), Flynn (1992), Davies (1985), Begun et al.(1990), Dawson (1994), Benson (1973), Engel (1970) noted that the professional-bureaucrat conflict is more a theoretical debate around the ideologies of professionalism and particular aspects of Weberian ideal type bureaucracy , than an empirical reality and that the conflicts in the relationships are merely general problems of organizational control and coordination Overtveit (1988) attributes this realization to the application of theoretical perspectives such as symbolic interactionism and power and politics to health settings.

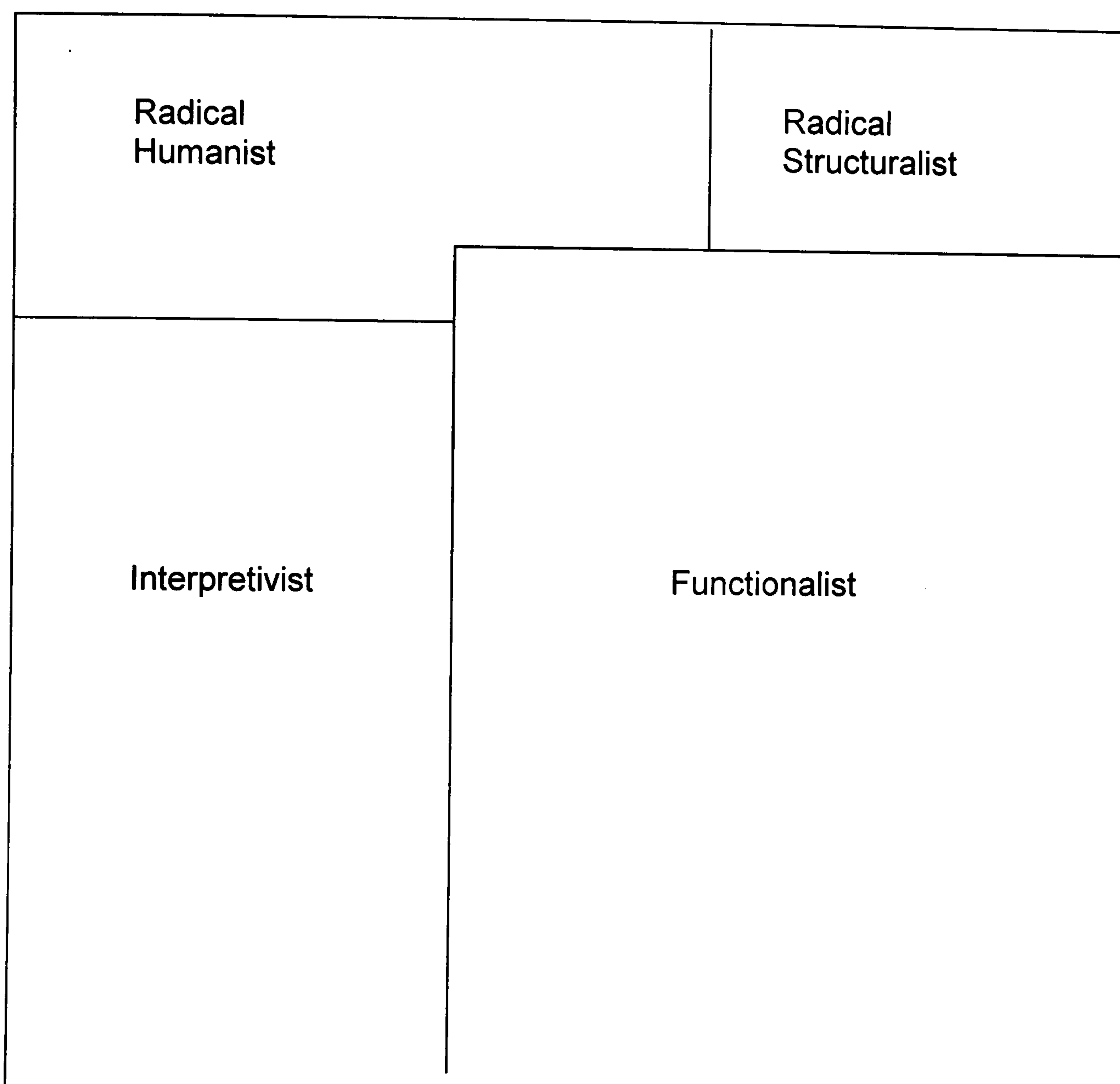
Benson (1973) found proof of the compatibility of professionalization and bureaucracy in showing empirically; first that the two exist together in the same organization, second that the much analyzed incompatibilities are accommodated for in organizations, and third the existence of the professional-manager who holds both roles successfully. Flynn (1992) also notes that professionalization and bureaucratization were historically mutually reinforced and most professionals are salaried employees, thus making both the bureaucratic-professional conflict and the deprofessionalization debate empirically doubtful.

Similarly, recent studies have focused on the ways in which structures have been accommodated to minimize conflicts. Such adaptations were found to be the differentiated reward systems, dual career ladders, committee control systems, involvement of the professions in decision making, creating of the professional-administrator/manager role to supervise professions, matrix organization, task forces, multidisciplinary teams (Overtveit, 1988). Nonetheless, it may be worthwhile noting that similar adaptations in the bureaucratic structure have occurred in most industries and may not necessarily be a result of the professional-bureaucratic conflict thesis.

ANNEX 6: HOFSTEDE'S (1980) CLASSIFICATION OF CULTURES BY THE DIMENSIONS

I more developed Latin High power distance High uncertainty avoidance High individualism Medium masculinity *Belgium* *France* *Argentina* *Brazil* *Spain*	**II less developed Latin** High power distance High uncertainty avoidance High individualism Whole range on masculinity *Colombia* *Mexico* *Venezuala* *Chile* *Peru* *Portugal* *Yogoslavia*
III more developed Asian Medium power distance High uncertainty avoidance Medium individualism High masculinity *Japan*	**IV less developed Asian** High power distance Low uncertainty avoidance Low individualism Medium masculinity *Pakistan* *Taiwan* *Thailand* *Hong Kong* *India* *Philippines* *Singapore*
V near Eastern High power distance High uncertainty avoidance Low individualism Medium masculinity *Greece* *Iran* *Turkey*	**VI Germanic** Lower power distance High uncertainty avoidance Medium individualism High masculinity *Austria* *Israel* *Germany* *Switzerland* *South Africa* *Italy*
VII Anglo Lower power distance Low to medium uncertainty avoidance High individualism High masculinity *Australia* *Canada* *Britain* *Ireland* *New Zealand* *USA*	**VIII Nordic** Low power distance Low to medium uncertainty avoidance Medium individualism *Denmark* *Finland* *The Netherlands* *Norway* *Sweden*

ANNEX 7 MAIN PARADIGMS AS PRESENTED BY GIOIA AND PITRE (1990)



The main paradigms of organizational studies by order of dominance.[106]

[106] From: Gioia, D. and Pitre, E. Multiparadigm perspectives of theory building. *Academy of Management Review. P. 586*

ANNEX 8 LIST OF QUESTIONS IN COMPREHENSIVE QUESTIONNAIRE

OE MODEL	QUESTIONS SUMMARY	QUESTION
OPEN SYSTEM	**Response to Environ/Cleints**	To what extent dpes the organization respond to changes in the health industry (such as new technologies, new services or new modes of delivery) by adopting and changing to these changes?
		To what extent does your department responde to changes in technologies and services by adopting and adjusting to these changes?
		To what extent does is the organization responsive to patient demands and needs?
		To what extent is your department responsive to patient/client demands and needs?
		To what extent do you consider the organization as a whole is able to predict and anticipate significant future changes in the wider external environment?
		Rate the extent to which your department is able to predict and anticipate significant future changes in the organization as a whole?
	Change and Decisions	To what extent are staff encouraged to submit proposals for improvement?
		To what extent are staff proposals taken into consideration and implemented?
		To what extent are decision taken in a timely and appropriate manner?
		To what extent are changes that have been decided upon implemented in a timely manner?
		To what extent do changes occuring in other parts of the organization affect the stability/ work of your department?
		To what extent do changes in the external environment affect the stability of your organization as a whole?
	Budget and Budgeting	To what extent is budget approval for equipment readily obtained?
		To what extent is budget approval for manpower readily obtained?
		To what extent is budget for new services/projects easily obtained?
		Are processes for obtaining budget for medical staff efficient?
		Are processes for obtaining budget for nursing staff efficient?
		Are processes for obtaining budget for administrative and general staff efficient?
		Are processes for obtaining budget for paramedical and therapy staff efficient?
		Are processes for obtaining budget for support services staff efficient?
		To what extent are the organization's projects & activities supported by community donations?
	Manpower Attraction	When there is an existing vacancy, to what extent is it possible to hire medical staff?
		When there is an existing vacancy, to what extent is it possible to hire nursingl staff?
		When there is an existing vacancy, to what extent is it possible to hire paramed & therapy staff?
		When there is an existing vacancy, to what extent is it possible to hire admin & support staff?

RATIONAL GOAL	**Mission and Objectives**	To what extent is the organization's mission statement clear and appropriate?
		To what extent are the organization's objectives specified and known to all staff?
		To what extent are your departmental objectives clear and specified?
	Objectives Achievement	To what extent does the organization achieve its objectives in time?
		To what extent does your department achieve its objectives in time?
	Impact on Pupulation	To what extent do the services offered by the organization make an impact on the population?
	Productivity	How would you rate the volume of work produced by the corporation in relation to the budget and staff invested in the corporation?
		How would your rate the productivity of the organization?
		How would your rate the productivity of your department?
INTERNAL PROCESS	**Information Flow**	To what extent is information related to your work clearly and promptly conveyed to you?
		When you do need information, to what extent is that information relating to you and your work easily obtained?
	Employee Awareness of Chan	To what extent are employees aware of major and minor changes that affect their work?
	Work Processes	To what extent are work processes/operations/activities organized and running smoothly?
		To what extent does the work run smoothly and in an organized manner when there are changes in staff and key persons or crisis?
	Policies and Procedures	To what extent are administrative activities controlled by policies and procedures in your dept?
		To what extent are administrative activities controlled by policies and procedures in general?
HUMAN RELATIONS	**Interprofession Relationships**	To what extent do the following staff workwith each other, respecting and trusting each other? (Medical-Medical, Medical-Nursing etc.. For each profession)
	Conflicts	How would you rate the relationship of the following staff? (Medical-Medical, Medical-Nursing etc.. For each profession)
	Staff Morale	How would you rate the morale of the following staff? (each profession listed)
	Skills and Training	Rate the extent to which the following staff are wel equipped in terms of skills, training and having the capacity to do their work well? (each profession listed)
ORGANIZAT-IONAL STRUCTURE	**Rigidity of Structure**	To what extent is your department's internal structure fixed and permanent?
		To what extent is the organization structure of the Corporation fixed and permanent?
	Planning of Structure	Do you think/consider that your deparmtment's internal organization structure has been planned?
		Do you think/consider that the Corporate organization structure has been planned?
	Evolution of Structure	Do you think/consider that your deparmtment's internal organization structure has been allowed to evolve?
		Do you think/consider that the Corporate organization structure has been allowed to evolve?
	Work Structuring Freedom	Within your department, rate the extent to which you consider that individuals have the freeedom to structure their own jobs.
		Within the organization as a whole, rate the extent to which you consider that individuals have the

		freeedom to structure their own work.
	Communication	In your deparmtnet, do you consider important communication travels through formal or informal channels?
		In the Corporation, do you consider important communication travels through formal or informal channels?
	Continuity During Changes	When organizational change is introduced into your department, to what extent do you consider that it is important to ensure continuity with past structures and procedures?
		When organizational change is introduced to what extent do you consider that management as a whole feels it is important to ensure continuity with past structures and procedures?
	Committees and Teams	Rate the use of committee and team meetings in your department.
		Rate the use of committee and team meetings in the organizational as a whole.
		Rate the effect of committee and team meetings in your department.
		Rate the effect of committee and team meetings in the organization as a whole.
BELIEFS AND ASSUMPTIONS	**Medical Involvement**	To what extent do you think medical staff should be involved in their department's management?
		To what extent do you think medical staff should be involved in the Corporations's Management?
	Nursing Involvement	To what extent do you think nursing staff should be involved in their department's management?
		To what extent do you think nursing staff should be involved in the Corporations's Management?
	Administrative Involvement	To what extent do you think administration should be involved in clinical matters?
		To what extent do you think administration should be involved in nursing matters?
ORGANIZAT-IONAL CULTURE	**Existing State**	Below are 20 descriptions, tick on the description that best describes Hamad Medical Corporation. Please tick 10 descriptions.(*)
	Stackeholders	Which groups should HMC be most concerned to satisfy. Please tick two only. (**)
	Desired State	Which of the following elements do you think are most important for the success of a corporation like HMC? Please tick a maximum of five. (***)
	Advices to Entrants	What three advices would you give to a colleague joining HMC for the first time?

Response Scores : 1-5 with 1 highest positive response and 5 lowest negative response

(*) Uses all opportunities, encourages team work, attracts top talent, encourages initiative and innovation, focuses on patient satisfaction, values and participates, training and development treats employees fairly and consistently, rewards superior performance, encourages expression of diverse view points, focuses on gaining confidence of patients, develops new services, tolerates well-meaning mistakes, checks and focuses on quality in performance, encourages loyalty and commitment to the corporation, is organized and encourages organization, promotes respecting chain of command, encourages experimenting new techniques, focuses on improving work processes, encourages establishing clear, well-documented work processes and policies, encourages the use of limited resources effectively.

(**) the patients, the government, the community, the board of directors, the professional associations, the staff, the management.

(***) Having staff that are satisfied and motivated, having highly skilled and knowledgeable staff, being able to adapt quickly to changes in industry/environment, being innovative, investing highly in human resources, investing highly in equipment and technology, having clear mission and objectives and achieving them, having an impact on the population, being highly productive, minimizing unnecessary expenditures, controlling budget, having open channels of communication, having very organized work processes/operations/activities, controlling activities through complete policies and procedures, focusing on quality of performance.

ANNEX 9 SAMPLE OF COMPREHENSIVE QUESTIONNAIRE

QUESTIONNAIRE

Measuring Hamad Medical Corporation's
Organisational Effectiveness

Dear Colleague,

Thank you for taking the time to answer these questions.

This questionnaire will be used for scientific research (PhD thesis) and its purpose is to assess overall organisational effectiveness as HMC, as a case study in organisational effectiveness. The questions on organisational effectiveness have been based on a modified version of the Competing Values Model developed by Quinn and Rohrbaugh and culture questions based on the Hay Group research.

Note that all answers will remain anonymous and in complete confidentiality.

Kindly return to me the completed questionnaire, in sealed envelope, or hand deliver at: Hanan Al-Kuwari, Asst. Administrative Director, Administration.

If you have any questions, please do not hesitate to contact me at ext. 3905.

Hanan M. Al-Kuwari

SECTION 1

Department Name: ______________________________

Post (or Title): ______________________________

Year of Joining HMC: ______________________________

Age: ______________________________

Sex: ______________________________

Qualifications:	**Less than secondary**	________
	Secondary	________
	University Graduate	________
	Post Graduate	________
	Other	________

SECTION II

1. To what extent do the following HMC staff work well with each other, respecting and trusting each other?

	Extremely well	Well	Somewhat well	Sometimes not well	Not well at all
a) Medical with					
Medical Staff					
Nursing Staff					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
b) Nursing with					
Nursing Staff					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
c) Paramedical with					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
d) Therapy with					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services					
e) General Administration with					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
f) Corporate Departments with					
Corporate Departments Staff					
Support Services Staff					
g) Support Services with					
Support Services					

2. How would you rate the relationship of the following HMC staff?

	Full unit	Sometimes insignificant conflicts	Some conflicts arise	Frequent conflicts	Always in conflicts
a) Medical with					
Medical Staff					
Nursing Staff					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
b) Nursing with					
Nursing Staff					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
c) Paramedical with					
Paramedical Staff					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
d) Therapy with					
Therapy Staff					
General Administration Staff					
Corporate Departments Staff					
Support Services					
e) General Administration with					
General Administration Staff					
Corporate Departments Staff					
Support Services Staff					
f) Corporate Departments with					
Corporate Departments Staff					
Support Services Staff					
g) Support Services with					
Support Services					

3. How would you rate the morale of the following HMC staff?

	Extremely high morale	High moral	Average morale	Low moral	Extremely low morale
a) Medical Staff					
b) Nursing Staff					
c) Paramedical Staff					
d) Therapy Staff					
e) General Administration Staff					
f) Corporate Departments Staff					
g) Support Services Staff					

4. Rate the extent to which the following HMC staff are well equipped in terms of skills, training and having the capacity to do their work well:

	Extremely high skills and training	Good Skills and training	Average Skills and Training	Poor Skills and training	No Skills and Training
a) Medical Staff					
b) Nursing Staff					
c) Paramedical Staff					
d) Therapy Staff					
e) General Administration Staff					
f) Corporate Departments Staff					
g) Support Services Staff					

SECTION III

5. To what extent does HMC response to changes in the health industry (such as new technologies, new services or new modes of delivery) by adopting and adjusting to these changes?

__ Highly responsive
__ Responsive
__ Responses but late
__ Rarely responsive
__ Not responsive at all

6. To what extent does your department respond to changes in technologies and services by adopting and adjusting to these changes?

__ Highly responsive
__ Responsive
__ Responses but late
__ Rarely responsive
__ Not responsive at all

7. To what extent is HMC responsive to patient demands and needs?

__ Highly responsive
__ Responsive
__ Responses but late
__ Rarely responsive
__ Not responsive at all

8. To what extent is your department responsive to patient/clients demands and needs?

__ Highly responsive
__ Responsive
__ Responses but late
__ Rarely responsive
__ Not responsive at all

9. To what extent do you consider the organization as a whole is able to predict and anticipate significant future changes in the wider external environment?

__ Excellent
__ Very good
__ Good
__ Poor
__ Does not predict and anticipate changes

10. Rate the extent to which your department is able to predict and anticipate significant future changes in the organization as a whole?

__ Excellent
__ Very good
__ Good
__ Poor
__ Does not predict and anticipate changes

11. To what extent are staff encouraged to submit proposals for improvement?

__ Very much encouraged
__ Encouraged
__ Somewhat encouraged
__ Little encouraged
__ Not encouraged at all

12. To what extent are staff proposals taken into consideration and implemented?

__ Always considered and implemented
__ Considered and sometimes implemented
__ Sometimes considered and implemented
__ Considered and sometimes implemented
__ Rarely considered and implemented never

13. To what extent are decisions taken in a timely and appropriately manner?

__ Extremely timely and appropriate decisions
__ Quick and appropriate decisions
__ Average speed of decisions
__ Slow decisions and sometimes inappropriate

14. To what extents are changes that have been decided upon implemented in a timely manner?

__ Always timely implementation
__ Mostly timely implementation
__ Somewhat timely implementation
__ Slow implementation
__ Extremely slow implementation

15. To what extent do changes occurring in other parts of the organization affect the stability/work of your department?

__ Very highly affect our work
__ Highly affects our work
__ Affects our work
__ Somewhat affects our work
__ Does not affect our work

16. To what extent do changes in the external environment affect the stability of your organization as a whole?

__ Very highly affect our work
__ Highly affects our work
__ Affects our work
__ Somewhat affects our work
__ Does not affect our work

17. To what extent is budget approval for equipment easily obtained?

__ Very easily obtained
__ Easily obtained
__ Somewhat difficult
__ Very difficult
__ Impossible

18. To what extent is budget of manpower easily obtained?

__ Very easily obtained
__ Easily obtained
__ Somewhat difficult
__ Very difficult
__ Impossible

19. To what extent is budget for new services/ projects easily obtained?

__ Very easily obtained
__ Easily obtained
__ Somewhat difficult
__ Very difficult
__ Impossible

20. Are processes for obtaining budget for medical staff efficient?

__ Extremely efficient
__ Very efficient
__ Somewhat efficient
__ Somewhat not efficient
__ Not efficient at all

21. Are processes for obtaining budget for nursing staff efficient?

__ Extremely efficient
__ Very efficient
__ Somewhat efficient
__ Somewhat not efficient
__ Not efficient at all

22. Are processes for obtaining budget for administrative and general staff efficient?

__ Extremely efficient
__ Very efficient
__ Somewhat efficient
__ Somewhat not efficient
__ Not efficient at all

23. Are processes for obtaining budget for administrative and general staff efficient?

__ Extremely efficient
__ Very efficient
__ Somewhat efficient
__ Somewhat not efficient
__ Not efficient at all

24. Are processes for obtaining budget for administrative and general staff efficient?

__ Extremely efficient
__ Very efficient
__ Somewhat efficient
__ Somewhat not efficient
__ Not efficient at all

25. To what extent are HMC projects and activities supported financially by community donations?

__ Majority of projects
__ Some projects
__ Few projects
__ Very little projects
__ No projects

26. When there is an existing vacancy, to what extent is it possible to hire medical staff?

__ Hiring is quick and extremely efficient
__ Hiring is quick and efficient
__ Hiring is somewhat quick and efficient
__ Hiring is time consuming and difficult
__ Hiring is extremely time consuming and difficult

28. When there is an existing vacancy, to what extent is it possible to hire nursing staff?

__ Hiring is quick and extremely efficient
__ Hiring is quick and efficient
__ Hiring is somewhat quick and efficient
__ Hiring is time consuming and difficult
__ Hiring is extremely time consuming and difficult

29. When there is an existing vacancy, to what extent is it possible to hire paramedical and therapy staff?

__ Hiring is quick and extremely efficient
__ Hiring is quick and efficient
__ Hiring is somewhat quick and efficient
__ Hiring is time consuming and difficult
__ Hiring is extremely time consuming and difficult

30. When there is an existing vacancy, to what extent is it possible to hire administrative and support services staff?

__ Hiring is quick and extremely efficient
__ Hiring is quick and efficient
__ Hiring is somewhat quick and efficient
__ Hiring is time consuming and difficult
__ Hiring is extremely time consuming and difficult

SECTION IV

30. To what extent is HMC's mission statement clear and appropriate?

__ Extremely clear
__ Somewhat clear
__ Vague
__ Not existent

31. To what extent are HMC's objectives specified and known to all staff?

__ Extremely clear and specified
__ Somewhat clear and specified
__ Vague
__ Very vague
__ Non existent

32. To what extent are your departmental objectives clear and specified?

__ Extremely clear and specified
__ Somewhat clear and specied
__ Vague
__ Very vague
__ Non existent

33. To what extent does HMC achieve its objectives in time?

__ Always achieved in time
__ Mostly achieved in time
__ Somewhat achieved in time
__ Rarely achieved in time
__ Never achieved in time

34. To what extent does your department achieve its objectives in time?

__ Always achieved in time
__ Mostly achieved in time
__ Somewhat achieved in time
__ Rarely achieved in time
__ Never achieved in time

35. To what extent do the services offered at HMC make an impact on the population?

__ Significant impact
__ Strong impact
__ Good impact
__ Small impact
__ No impact

36. How would you rate the volume of work produced by the Corporation in relation to the budget and staff invested in the corporation?

__ Much higher than staff and budget
__ Higher than staff and budget
__ Proper output compared to staff and budget
__ Lower than staff and budget
__ Much lower than staff and budget

37. How would you rate the productivity of the Corporation?

__ Extremely productive
__ Very productive
__ Average productivity
__ Low productivity
__ Very low productivity

38. Specifically, how would you rate the productivity of your department?

__ Extremely productive
__ Very productive
__ Average productivity
__ Low productivity
__ Very low productivity

SECTION V

39. To what extent is information related to your work clearly and promptly conveyed to you?

__ Always clearly and promptly conveyed
__ Most times clearly and promptly conveyed
__ Sometimes clearly and promptly conveyed
__ Rarely clearly and promptly conveyed
__ Never clearly and promptly conveyed

40. When you need information, to what extent is that information relating to you and your work easily obtained?

__ Extremely easily
__ Easily
__ Quite easily
__ Sometimes difficult
__ Difficult

41. To what extent are HMC employees aware of major and minor changes that affect their work?

__ Extremely aware
__ Mostly aware
__ Sometimes aware
__ Rarely aware
__ Never Aware

42. To what extent are work processes/operations/activities organised and running smoothly:

__ Always organized and smooth
__ Mostly organized and smooth
__ Sometimes organized and smooth
__ Rarely organised and smooth
__ Never organized and smooth

43. To which extent does he work run smoothly and in an organized manner when there are changes in staff and key persons or crisis situation?

__ Always organized and smooth
__ Mostly organized and smooth
__ Sometimes organized and smooth
__ Rarely organised and smooth
__ Never organized and smooth

44. To what extent are administrative activities controlled by policies and procedures in your department?

__ There are policies and procedures for everything
__ There are policies and procedures for most everything
__ There are some activities not covered by policies and procedures
__ There are a lot of activities not covered by policies and procedures

45. To what extent are administrative activities controlled by written policies and procedures in the corporation?

__ There are policies and procedures for everything
__ There are policies and procedures for most everything
__ There are some activities not covered by policies and procedures
__ There are a lot of activities not covered by policies and procedures

SECTION VI

46. To what extent is your department's internal organization structure fixed and permanent?

__ Fixed and permanent
__ Somewhat flexible and changing
__ Extremely flexible and changing

47. To what extent is the organization structure of the corporation fixed and permanent?

__ Fixed and permanent
__ Somewhat flexible and changing
__ Extremely flexible and changing

48. Do you think/consider that your department's internal organizational structure has been planned?

__ Extremely well planned
__ Well planned
__ Somewhat well planned
__ Not well planned
__ Not planned at all

49. Do you think/consider that your department's internal organizational structure has been planned?

__ The structure is constantly evolved to adapt to changes
__ The structure is generally evolved to adapt to changes
__ The structure is sometimes evolved to adapt to changes
__ The structure is only rarely evolved to adapt to changes
__ The structure has not been allowed to evolved to changes

50. Do you consider that the corporation organization structure has been planned?

__ Extremely well planned
__ Well planned
__ Somewhat well planned
__ Not well planned
__ Not planned at all

51. Do you consider that the corporation organization structure has been planned?

__ The structure is constantly evolved to adapt to changes
__ The structure is generally evolved to adapt to changes
__ The structure is sometimes evolved to adapt to changes
__ The structure is only rarely evolved to adapt to changes
__ The structure has not been allowed to evolved to changes

52. Within your department, rate the extent to which you consider that individuals have the freedom to structure their own jobs?

__ Completely free to structure their work
__ Highly free to structure their work
__ Free to structure their work
__ Somewhat free to structure their work
__ Not free to structure their work at all

53. Within the organization as a whole, rate the extent to which you consider that individuals have the freedom to structure their own work?

__ Completely free to structure their work
__ Highly free to structure their work
__ Free to structure their work
__ Somewhat free to structure their work
__ Not free to structure their work at all

54. In your department, do you consider important communication travels through formal or informal channels?

__ Completely through formal channels
__ Mostly through formal channels
__ Mostly through informal channels
__ Always through informal channels

55. In the corporation, do you consider that important communication travels through formal or informal channels?

__ Completely through formal channels
__ Mostly through formal channels
__ Mostly through informal channels
__ Always through informal channels

56. When organizational change is introduced into your department to what extent do you consider that it is important to ensure continuity with past structures and procedures?

__ Extremely important
__ Very important
__ Somewhat important
__ Not important

57. In general when organization change is introduced to what extent do you consider that management as a whole feels it is important to ensure continuity with past organizational structures and procedures?

__ Extremely important
__ Very important
__ Somewhat important
__ Not important

58. Rate the use of committees and team meetings in your department.

__ Right amount of committees and meetings
__ More committees and meetings than needed
__ Less committees and meetings then needed

59. Rate the use of committees and team meetings in the organization as whole.

__ Right amount of committees and meetings
__ More committees and meetings than needed
__ Less committees and meetings then needed

60. Rate the effect of committees and team meetings in your department

__ Extremely helpful and productive
__ Helpful and productive
__ Somewhat not helpful and not productive
__ Slows work down and not productive

61. Rate the effect of committees and team meetings in the organization as a whole.

__ Extremely helpful and productive
__ Helpful and productive
__ Somewhat not helpful and not productive
__ Slows work down and not productive

SECTION VII

62. To what extent do you think medical staff should be involved in their department's management?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

63. To what extent do you think medical staff should be involved in the corporation's management?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

64. To what extent do you think nursing staff should be involved in their department's management?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

65. To what extent do you think nursing staff should be involved in the corporation's management?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

66. To what extent do you think administration should be involved in clinical matters?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

67. To what extent do you think administration should be involved in nursing matters?

__ Very highly involved
__ Highly involved
__ Involved in particular issues
__ Not involved

SECTION VIII

68. Below are 20 descriptions, tick on the descriptions that best describet the corporation (tick a maximum of 10 descriptions):

__ Capitalizes on opportunities

__ Encourages teamwork

__ Attracts top talent

__ Encourages initiative and innovation

__ Focuses on customer satisfaction

__ Values and participates in training and development

__ Treats employees fairly and consistently

__ Rewards superior performance

__ Encourages expression of diverse viewpoints

__ Focuses on gaining confidence of customers

__ Develops new services

__ Tolerates well-meaning mistakes

__ Checks and focuses on quality in performance

__ Encourages loyalty and committment to the corporation

__ Is organized and encourages organization

__ Promotes respecting the chain of command

__ Encourages experimenting new techniques

__ Focuses on improving work processes

__ Encourages establishing clear, well documented work processes

__ Encourages the use of limited resources effectively.

69. Which groups should HMC be most concerned to satisfy? Please tick only two.

__ The patients

__ The government

__ The community

__ The Board of Directors

__ The professional associations

__ The staff

__ The management

70. Which of the following elements do *you* think are most important for the success of a corporation like HMC? Please tick a maximum of five.

__ Having staff that are satisfied and motivated

__ Having highly skilled and knowledgeable staff

__ Being able to adapt quickly to changes in industry/environment

__ Being innovative

__ Investing highly in human resources

__ Investing highly in equipment and technology

__ Having clear mission and objectives and achieving them

__ Having an impact on the population

__ Being highly productive

__ Minimising unnecessary expenditures

__ Controlling budget

__ Having open channels of communication

__ Having very organized work processes/operations/activities

__ Controlling activities through complete policies and procedures

__ Focusing on quality of performance

71. What are three advices you would give to a colleagues joining HMC for the first time?

1. ....

2. ....

3. ....

QUESTIONNAIRE MATRIX

	GENERAL ADMINISTRATION										MEDICAL									
	Ad	QM	Aud	Fin	Per	HIS	Eng	OPD	Med	Admg	Obs	Car	Ped	Med	Sur	Ane	A&E	Reh	Ger	Psy
Directors																				
Section Heads SADN	6			3	4	4	4		4		5	5	5	5	5	4	4	5	5	5
ADN / Unit Heads			2							2										
Head Nurse		4						4												
Clerk	2	1		4	6	4	2	8	6	6										
	TOTAL:									76	TOTAL:									48

Male	Female
44%	56%

Sample Proporation

40%	.(120)
32%	.(96)
12%	.(36)
16%	.(48)

	NURSING											OTHER					THERAPAY									
	Ad	Ob	Med	Car	Sur	Ane	A&E	Reh	Ger	Psy	OPD	CSD	Cat.	HK	Tr.	Com	Lab	Rad	Ph	OT	PO	Phy	RT	Diet	Psy	Ane
ADN.	4																									
Supervisor	6											2	2	2		2	4	4	4	2	2	2	2	2	2	2
SNIV		4	4	4	4		3	4	4	4	1	2	2	2		2	4	2	2							
SNIII		6	6	6	6		6	6	6	6	6															
SII		3	3	3	3		3	3	3	3	3															
SI		1	1	1	1		1	1	1	1	1															
	TOTAL:										130	TOTAL:				16	TOTAL:									34

GRAND TOTAL: 304

	Directors
73	SADN/Section Head
42	ADN / Unit Heads
6	Supervisor
8	Head Nurse
48	SNIV
54	SNIII
27	SNII
9	SNI
39	Clerks

ANNEX 11 SAMPLE OF COMMITTEE/TEAM QUESTIONNAIRE

COMMITTEE/TEAM QUESTIONNAIRE

Dear Colleague,

Thank-you for taking the time to answer these questions.

This questionnaire will be used for scientific research (PhD thesis) and its purpose is to assess the effectiveness and productivity of committees and teams.

Please note that all answers will remain anonymous and in complete confidentiality.

Kindly return to me the completed questionnaire in sealed envelope, or hand deliver at: Hanan Al-Kuwari, Asst. Administrative Director, Administration.

If you have any questions do not hesitate to contact me at 3905.

Hanan M. Al-Kuwari

SECTION I

Committee /Team created by: ______________________

Which department do you belong to: ______________________

Please circle the word that best describes your role in the committee/team:

Chairman / Leader

Assistant Chairman

Member

Secretary

Other

Section II

1. Is the objective/goal of this team/committee clear to all members?

__ extremely clear to all
__ clear to most
__ somewhat clear
__ not explicit but assumed
__ not clear at all

2. Are the meetings well organized with agenda distributed and minutes taken?

__ extremely well organized
__ well organized
__ somewhat well organized
__ not organized
__ no need for agenda and minutes

3. Are the team/committee members appropriate for the objective of the committee?

__ all members are appropriate
__ most members are appropriate
__ most members are not appropriate

4. Is the size of the committee/team appropriate?

__ the size is very appropriate
__ more members are needed
__ less members would suffice

5. Do all members participate equally?

__ all members are extremely active
__ most members are active
__ participation is unequal
__ few of the members are the ones who participate the most

6. Do members feel free to express their opinion honestly?

__ always have no difficulty in expressing their opinion
__ most of the time have no difficulty in expressing their opinion
__ sometimes find it difficult to express their opinion
__ always find it difficult to express their opinion

7. When members state their opinion is it taken into consideration seriously?

__ opinions are always seriously considered
__ opinions are most always seriously considered
__ opinions are not always seriously considered
__ opinions are not seriously considered

8. Is communication between group members open and trusting?

__ communication is extremely open and trusting
__ communication is generally open and trusting
__ communication is not so open and trusting
__ communication is not open and trusting

9. Are issues carefully analysed and diagnosed during discussion?

__ issues are always carefully analysed
__ issues are generally carefully analysed
__ issues are not usually carefully analysed
__ issues are never carefully analysed

10. Are decisions made when necessary?

__ decisions are always made appropriately
__ decisions are sometimes hard to reach
__ decisions are always hard to reach

11. Is consensus sought over issues/decisions?

__ everyone must agree
__ majority must agree
__ few members need to agree
__ only the chairman must agree

12. Are decisions taken by the committee/team implemented properly by all departments/persons concerned?

__ committee decisions are always implemented
__ committee decisions are generally implemented
__ committee decisions are not usually implemented
__ committee decisions are never implemented
__ not appropriate (not decision-making committee)

13. Are issues discussed resolved or do the same issues return to the committee for discussions?

__ the same issues are never discussed again
__ the same issues sometimes come back for discussion
__ generally the same issues are discussed
__ the same issue are always discussed

14. How effective is this committee/team?

__ extremely effective
__ very effective
__ somewhat effective
__ not effective

15. Is the committee/team achieving the goals for which it was created?

__ yes, achieving its gaols
__ achieving most of its goals
__ achieving few of its goals
__ no, not achieving its goals

16. How useful and necessary is the presence of this committe/team?

__ extremely useful and necessary
__ useful and necessary
__ somewhat useful and necessary
__ can be substituted by merging with another commitee or assigning this responsibility to someone/some department
__ not needed at all

17. What is the reason for holding this meeting?

__ decision-making
__ discussion
__ information
__ providing support
__ other (please specify) ____________________________

19. This committee/team is composed of:

__ medical staff only
__ nursing staff only
__ paramedical staff only
__ administrative staff only
__ therapy staff only
__ support services staff only
__ corporate department staff only
__ a combination (please specify) ____________________

18. What can be done by top management to improve the effectiveness of this committee/teams?

20. What can be done by the Chairman / Team leader to improve the effectiveness of this committee?

Thank-you for your time.

ANNEX 12 REGROUPED LIST OF TEAM QUESTIONNAIRE QUESTIONS

GENERAL

1. Who created this committee/team ?
2. Which department do you belong to?
3. Tick the work that best describes your role in the committee/team.
(Leader/chairman, assistant chairman, member, secretary, other-please specify)
4. What is the reason for holding this committee/team?
(Decision-making, discussion, information, providing support, other- please specify)
5. This committee/team is composed of:
(Medical staff only, nursing staff only, paramedical staff only, administrative staff only, therapy staff only, support services staff only, corporate department staff only, a combination –please specify)

TEAM FUNCTIONING

1. Is the objective/goal of this committee/team clear to al members?
(Extremely clear to all, clear to most, somewhat clear, not explicit but assumed, not clear at all)
2. Are the meetings well organized with agenda distributed and minutes taken?
(Extremely well organized, well organized, somewhat well organized, not organized, no need for agenda or minutes)
3. Are the committee/team members appropriate for the objective of the committee?
(All members are appropriate, most members are appropriate, most are not appropriate)
4. Is the size of the committee/team appropriate?
(The size is very appropriate, more members are needed, less members would suffice)
5. Do all members participate equally?
(All the members are extremely active, most members are active, participation is unequal, few of the members are the ones who participate the most)
6. Do members feel free to express their opinion honestly?
(Always have no difficulty in expressing their opinion honestly, most of the time have no difficulty in expressing their opinion, sometimes find it difficult to express their opinion and always find it difficult to express their opinion)

7. When members state their opinion is it seriously taken into consideration?

(Opinions are always seriously considered, opinions are most always seriously considered, opinions are not always seriously considered, opinions are not seriously considered)

8. Is communication between committee/group members' open and trusting?

(Communication is extremely open and trusting, communication is generally open and trusting, communication is not so open and trusting, communication is not open and not trusting)

9. Are issues carefully analysed and diagnosed during discussion?

(Issues are always carefully analysed, issues are generally carefully analysed, issues are not usually carefully analysed, issues are never carefully analysed)

10. Are decisions made when necessary?

(Decisions are always made appropriately, decisions are sometimes hard to reach, decisions are always hard to reach)

11. Is consensus sought over issues/decisions?

(Everyone must agree, majority must agree, few members must agree, only chairman/leader must agree)

TEAM PERFORMANCE

1. Are decisions taken by the committee/team implemented properly by all departments/persons concerned?

(Committee decisions are always implemented, committee decisions are generally implemented, committee decisions are not usually implemented, committee decisions are never implemented, not applicable-not decision making committee)

2. Are issues discussed resolved or do the same issues return to the committee for discussion?

(The same issues are never discussed again, the same issues sometimes come back for discussion, generally the same issues are discussed, the same issues are always discussed)

3. Is the committee/team achieving the goals for which it was created?

(Yes- achieving its goals, achieving most of its goals, achieving few of its goals, no-not achieving its goals)

SELF ASSESSED EFFECTIVENESS

1. How effective is this committee/team?
(Extremely effective, very effective, somewhat effective, not effective at all)

IMPROVING TEAM EFFECTIVENESS

1. What can be done by top management to improve the effectiveness of this committee/team?

2. What can be done by the chairman/team leader to improve the effectiveness of this committee?

ANNEX 13 SAMPLING MATRIX FOR TEAM QUESTIONNAIRE

	MIXED	MEDICAL ONLY	NURSING ONLY	ADMINISTRATION ONLY	SUB-TOTALS
CORPORATE	8	8	8	8	**32**
HOSPITAL	8	8	8	8	**32**
DEPARTMENTAL	9	9	9	9	**36**
SUB-TOTAL	**25**	**25**	**25**	**25**	**100**

ANNEX 14: CODES AND CODES DESCRIPTION FOR TEAM QUESTIONNAIRE

NAME OF CODE	CODE	DESCRIPTION
MEMBERSHIP		
- MEMBERS SELECTION	MEM-SEL	Proper selection of chair and members; addition/change of members or chair.
- MEMBERS TRAINING	MEM-TR	Send/provide team members/ chair with training on team functioning, speciality area of team and/or corporate objectives.
COMMUNICATION		
- WITH ORGANIZATION	COMM-ORG	Communicate on behalf of team with rest of organization. Listen to suggestion from org. members that would improve the committee.
- WITH/ WITHIN COMMITTEE	COMM-COM	*For chair*; proper communication of goals and objectives, create a supportive participative environment of mutual self respect, control and participate in discussion and ensure equal participation. *For management*; proper feedback to committee, support, guidance and involvement.
- WITH TOP MANAGEMENT	COMM-TOP	To communicate on behalf of committee with higher levels, to keep in direct and periodic touch with top management on team issues/decisions.
DECISION		
- AUTHORITY	DEC-AUTH	Authorise team to take certain decisions/actions. Delegate more decision authority and independence to chairman/committee.
- IMPLEMENTATION	DEC-IMP	Seriously study and support proposals of committee, follow up and monitor the implementation of team decisions at the organisational level.
PROCEDURES		
- AGENDA	PROC-AG	Prepare, prioritise and distribute agenda.
- FREQUENCY	PROC-FR	Increase, decrease frequency and regularity of meeting
- PUNCTUALITY	PROC-PUNC	Strict adherence to committee schedule and make timing of committee appropriate to all members
- ORGANIZATION	PROC-ORG	Establish structure/rules/ procedures/standards for committee and mechanisms of support, feedback and follow

		up to the committee.
- OBJECTIVE AND ROLES	PROC-OB/R	Establish goals, objectives and guildline of committee and meetings. Define roles and responsibilities members.
RESOURCES		
- FUNDING	RES-FUND	Provide funding/budget when necessary, provide/raise allowance/incentives for members.
- TIME	RES-TIME	More time for the committee and members.
- MANPOWER	RES-MAN	Provide committee with manpower to implement recommendations.
HOSPITAL		
- RULES AND PROCEDURES	HOSP-R/P	Improve organisation's rules, standards of practices. Improve, document and clarify policies and procedures.
- STRUCTURE	HOSP- ST	Decentralise the organisation structure to delegate more authority to teams/committees.
- OBJECTIVE	HOSP-OB	Establish clear objectives and guidelines.
- ORGANISATION	HOSP-ORG	Improve processes and systems of the organisation.
SUPPORT	SUPP	For management/chairman to be more supportive of committee/ committee members
CHAIRMAN	CHAIR	Characteristics of chairperson; e.g. punctual, devotes time to committee, persistent with top management, takes initiative, responsible, skilled, motivates members, decision maker, sincerely committed, receptive, open-minded, fair, flexible, authoritative, firm, in control, ability to take responsibility, creative, understanding, involved.
EVALUATION	EVAL	Evaluate committee/committee members in light of goals.
APPRECIATION	APPR	Show appreciation of member's and committee's work.
SATISFIED	SAT	Satisfied with chairman, management or team functioning.

ANNEX 15 INTERVIEW QUESTIONS FOR DEPARTMENTAL HEADS

QUESTIONS ON ORGANIZATION AND ORGANIZATION STRUCTURE

1. What type of decisions, in your department, are you authorized to make without prior approval and what type requires prior approval?

2. Which decisions do you feel your superiors should decentralize? Or involve you more in?

3. Do you think you receive/have all the information you need to fulfill your role properly and take proper decisions? If not, what type of information would you need?

4. What type of conflicts (coordination problems) sometimes arise from working with other departments? Nursing? Medical? Paramedical? Therapy? Support Services? Administration? Etc...And how do you feel these can be minimized?

5. Do you think your department's organizational structure is the most efficient for provision of services? If not, how can the department's organizational structure be improved for better provision of services and better coordination of work internally and with other departments?

6. Are you generally involved in decisions and changes related to your department's organizational structure? If yes, describe your involvement in your department's last organizational structures.

ANNEX 16 INTERVIEW QUESTIONS FOR EXECUTIVES AND CORPORATE STAFF

QUESTIONS ON ORGANIZATION AND ORGANIZATION STRUCTURE

1. What type of decisions, in your department, are you authorized to make without prior approval and what type requires prior approval?

2. Which decisions do you feel your superiors should decentralize? Or involve you more in?

3. Do you think you receive/have all the information you need to fulfill your role properly and take proper decisions? If not, what type of information would you need?

4. What type of conflicts (coordination problems) sometimes arise from working with other departments? Nursing? Medical? Paramedical? Therapy? Support Services? Administration? Etc...And how do you feel these can be minimized?

5. Do you think your department's organizational structure is the most efficient for provision of services? If not, how can the department's organizational structure be improved for better provision of services and better coordination of work?

6. a) Do you think that HMC's present organizational structure is effective? And does it encourage coordination and decentralization?
   b) What do you think are the strengths (good points) and weaknesses (areas that could be improved) of HMC's present organizational structure?
   c) Do you think that the organization of HMC as a whole can be better structured to deliver better patient care?

7. Have you participated in the discussions of the formation of HMC's last two organizational structure?

TEXT BOUND INTO

THE SPINE

INTERVIEW MATRIX

Managing Director	**1**
Medical Director	**1**
Admin. Director	**1**
MOH	**2**
Board	**3**
Previous	**4**

Male:	Female
44%	56%

Sample Proportion: 40% Nursing (35)
32% Other (37)
12% Medical (15)
16% Professional & Technical (18)

	GENERAL ADMINISTRATION									MEDICAL										PARAMEDICAL			SUPPORT			
	Ad	PR	QM	Pla	Aud	Fin	Per	HIS	Eng	Obs	Car	Ped	Med	Sur	Ane	A&E	Reh	Ger	Psy	Lab	Rad	Pha	CSSD	Cat.	HK	TR
Directors	6	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1				
Section Heads SADN	6					2	2			1	1	1	1	1						3	2	2	1	1	1	1
ADN / Unit Heads																							1	1	1	
Head Nurse																										
	TOTAL: 24									TOTAL: 15										TOTAL: 10			TOTAL: 7			

	NURSING											OTHER			THERAPAY					
	Ad	Ob	Med	Car	Sur	Ane	A&E	Reh	Ger	Psy	OPD	OPD	Med	Admitting	OT	PO	OH	Die	Anes	RT
Directors	1																			
Section Heads SADN	6											2	2	2	1	1	1	1	1	1
ADN / Unit Heads		4	1	1	1		1	1	1	1	1							1	1	
Head Nurse		2	2	2	2	1	1	2	2	1	1									
	TOTAL: 35											TOTAL: 6			TOTAL: 8					

28	**Directors**
44	**Section Heads SADN**
17	**ADN / Unit Heads**
16	**Head Nurse**
GRAND TOTAL:	**117**

ANNEX 18 ANALYSIS GUIDE BY PROFESSION

Interviews summary:

1. Decisions Making

I - Types of decisions in your department you are authorized to make **without prior approval**

Decision	MD	NR	ADM	TH	PM	CD 1	CD 2	SS	Total
Most everything but inform/take opinion	1	8	2	1				1	**13**
Most everything try not to involve superior			1				1		**2**
About budget & staff within my budget	1	7	1	1	2				**12**
Day to day routine (minor staff management ie leaves, distribution, scheduling and minor problems)	7	33	13	6	5	2	7	7	**80**
Actual patient care/treatment/ clinical/technical issues	**7**	**4**		1	3		2	1	**18**
Training/Education issues	2			1					**3**
Things within SP of HMC	2	1					2	1	**6**
Total	**20**	**53**	**17**	**10**	10	**2**	**12**	**10**	**134**

II- Types of decisions in your department you **require prior** approval

Decision	MD	NR	ADM	TH	PM	CD 1	CD 2	SS	Total
Issues beyond my budget	1	1	1		**1**				**4**
Major staff issues (transfers, promotions, terminations)	2	18	1	3	2		1		**27**
Those required by SPs	1	2					3	1	**7**
Incidents and problems		6	1				2	1	**10**
Issues affecting patient care		7		1					**8**
Long term/ planning decisions			5		1		1		**7**
Issues requiring budget (e.g new budget, equipment and procedures)	5	17	7	3	2	1	3	2	**40**
Issues with other specialities/depts	2	1	2	1	1			1	**8**
Administrative issues	3	1		2	2			2	**10**
Issues outside HMC	1								**1**
Most decisions			2	1	1		2	2	**8**
Total	**15**	**53**	**19**	**11**	**10**	**1**	**12**	**9**	**130**

2. Decisions Making

I - Types of decisions you feel your superiors should **decentralize**

Decision	MD	NR	ADM	TH	PM	CD 1	CD2	SS	Total
Issues related to our Job	3	6	2	1	1		1	2	**16**
Complaints from patients and personnel			1						**1**
Staffing/Staff problems	2	8	3	2	2		1	1	**19**
Issues of my responsibility by the job description		3						1	**4**
No need- flexible and no decision making problems/ freedom	3	12	6	1	1		2	3	**28**
Issues related to our budget	1	3	2		1		1		**8**
Space utilization issues	1		1						**2**
Everything is centralized							1		**1**
Total	**10**	**32**	**15**	**4**	**5**		**6**	**7**	**79**

II- Types of decisions your superiors should **involve you** in more

Decision	MD	NR	ADM	TH	PM	CD 1	CD2	SS	Total
Work/issues related to my job/unit	1	4	3				4	4	**16**
Staffing management		2		**1**	1				**4**
Budget		1		**1**	1		1	2	**6**
Involved – most decisions through committees/meetings		5	1						**6**
Long term planning for HMC	1	1			1				**3**
Future projects and programs for my unit	1	1					1		**3**
Total	**3**	**14**	**4**	**2**	3		6	6	38

3. Information

I – Do you **receive all information** you need to full fill your role and take decisions:

Information	MD	NR	ADM	TH	PM	CD 1	CD 2	SS	Total
Yes – all needed available	7	18	9	1	2		5	5	47
Not fully	4	13	6	4	2	2	6	5	42
Total	**11**	**31**	**15**	**5**	**4**	**2**	**11**	**10**	**89**

II – **How** do you receive information:

Information	MD	NR	ADM	TH	PM	CD 1	CD 2	SS	Total
Through superior		9	3	**1**				**2**	**15**
Through memos and circulars		9	2						**11**
Through interdisciplinary		2							**2**

committees									
Through departmental committees/meetings		3							3
Through subordinates		1						1	2
Through Standard Practices	1	1		1				1	4
Through personal contacts	1	1						1	3
Total	**2**	**26**	**5**	**2**				**5**	**40**

II- Types of **information you would need**

Information	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Information from outside HMC (e.g. benchmarking information, ways other hospitals do things in order to improve)			3						**3**
From other HMC departments/hospitals		5	2	**1**	**1**	**1**	**1**		**11**
Hospital/Patient statistics	1		1						**2**
Administrative issues/decisions from superiors	4	4		3	1		1	4	**17**
l-t planning/future projects for hospital/unit	2	5	2		2	1	1	1	**14**
Budget/Finance Issues	1								**1**
Standard Practices/by laws							3		**3**
Total	**8**	**14**	**8**	**4**	4	**2**	**6**	**5**	**51**

4. **Coordination**
I – **Types of conflicts** with other departments

Conflicts	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
When depts take own decisions and work own way without coordinating	4	5	2		**1**			1	**13**
When no communication/miscom munication		16	2	**1**	2				**21**
When depts don't conduct their functions fully/up to level		12		**3**	1		2	1	**19**
When depts procedures lengthy		9			**1**				**10**
When depts trespass into my work		2	1						**3**
Constant change in other depts	1	2					1		**4**
Dual reporting/orders	1	4	6					1	**12**
When depts don't follow St. Practices/Protocoles	1	1	1				3		**6**
Bad attitude		7	1						**8**

No discipline in depts		3					1		**4**
Shortage of staff in other depts.		4	1					1	**6**
When depts don't have SPs/roles/functions	1	2	3	**1**			4	1	**12**
When depts are physically far	1								**1**
Coordination with Admin difficult	1	1							**2**
When dept is of different schooling/education	1	1							**2**
No conflicts	2	1		1	1			1	**6**
When depts don't understand our work	1				1		3	3	**8**
When depts circumvent my dept								1	**1**
Total	**14**	**70**	**17**	**6**	**7**		**14**	**10**	**138**

II - With **who**

Conflicts	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Depts with which work heavily		1	1						**2**
Corp Depts		8	3				3		**14**
Nursing	2	6	4	1	1				**14**
Paramedical		5	1						**6**
Medical	2	14	7		2		2	1	**28**
Administration	6	9	2				1	1	**19**
Support Services	1	6	2					1	**10**
Therapy		3	1						**4**
Social Workers				1					**1**
HGH				1					**1**
Total	**11**	**52**	**21**	**3**	**3**		**6**	**3**	**100**

III- How can these be **minimized**

Conflict Minimizing	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Computerization			1				1		**2**
Decentralization	1		2		**1**				**4**
Promote attitude/spirite of coordination	2	3	1						**6**
Defining/Redifining roles and resp. of depts	2	4	3				1	1	**11**
Mutidisciplinary committees/meetings	1	5	2	2	3			2	**15**
Additional staff to help coordination	1	2	2					1	**6**
Clear rules and SPs in each dept/committee	1	1	5				1	1	**9**
Proceduring conflict areas			1						**1**
Good working relations and communication		13	2	1	3		2		**21**
Following up implementation of decisions			1						**1**

	MD	NR	ADM	TH	PM	CD 1	CD 2	SS	Total
Faster response to issues from depts		1							**1**
Involvement in decisions taken by other depts that involve us	1	1			1			1	**4**
Better coordination		1						1	**2**
Respect for our profession		1	2		1				**4**
Socializing with other depts	1				2				**3**
Admin doing their job correctly	1						1		**2**
Depts doing their jobs properly	1						1		**2**
Total	**12**	**32**	**22**	**3**	**11**		**7**	**7**	**93**

5. Department Structure

I – Is department structure **most efficient** for provision of services

Dept. Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Yes	5	18	6	1	4		3	2	**39**
No/ Not really	7	13	5	4	2	4	9	5	**59**
No real structure its just on paper			2		1			1	**4**
Total									**92**

II- **Why**

Dept. Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Structure not changed as org changes			2				1		**3**
Work scattered			1						**1**
Problem not structure but process			1				1		**2**
Too centralized	1	5	3	3	4		4	1	**21**
Dept just grew in size with no structure		1	1				1	1	**4**
No communication between hospital levels	1	1							**2**
Staff posts and grades not right	1	4		2			5	1	**13**
Very well controlled		1							**1**
Unclear/Dual line of reporting	2	2	1						**5**
It is constantly developed				1			1		**2**
Provided decision making freedom		1							**1**
Has clear accountability		1							**1**
Still new- under development		1				1	1		**3**
Too many committees		1							**1**
Understaffed	1						2	1	**4**
Relies on character of superior		1	1		1				**3**

Not being implemented			1					1	**2**
Needs complete restructuring		2				2			**4**
Depts build empires			1						**1**
Physically far	1								**1**
Dept too big	1								**1**
Turnover in Admin thus no continuity	1					1			**2**
Total	**9**	**21**	**12**	**6**	**5**	**4**	**16**	**5**	**78**

II- How can it be **improved**

Dept. Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Decentralize	1	4	2	2			2	1	**12**
Changing/Adding posts	2	3	3	2	1			3	**14**
Changing grades	1	3	1	1	2			1	**9**
Changing procedures/business process engineering	1		2				1	1	**5**
Changing/Adding sections	2	2	2			2	2	1	**11**
Focus on HMC objectives/don't detract	2								**2**
Better communication between hospital levels	1								**1**
More organized		1					2	2	**5**
Complete seperation of hospital/unit (financial&mgt)	1		1		1				**3**
Departmental committees/meetings	1								**1**
Multiprofession committees/meetings	1								**1**
More space	1								**1**
Better trained staff		1	1				3		**5**
Involvement in decision making		1							**1**
Better problem solving			1						**1**
New medical in charge rather than administration		1							**1**
Clear Roles/Jobs descip/functions							1		**1**
Total	**14**	**16**	**13**	**5**	**4**	**2**	**11**	**9**	**74**

6a. HMC Structure
I – Is HMC structure **effective**

HMC Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Yes	6	1			1				**8**
No/ Not really	5	2	3		1		3		**14**
On paper only but not in real		3	1						**4**
Confusion of what is HMC structure		3	1			1	2		**7**
Total	**11**	**9**	**5**		**2**	**1**	**5**		**33**

6b. HMC Structure
I – Strenghts

HMC Structure	MD	NR	ADM	TH	PM	CD 1	CD2	SS	Total
Easy to reach top management and they listen/people in responsibility	3						1		**4**
Clear hierarchy/ lines of communication	2	1				1			**4**
Hard working staff/disciplined	2		1						**3**
Independence from Civil Services		1	2				2		**5**
Top management quick decision makers			1				1		**2**
Top management get all needed information			1						**1**
Top management recognized hard working staff		1			1				**2**
Encourages coordination and decentralization			**1**						**1**
Total	**7**	**3**	**6**		**1**	**1**	**4**		**22**

II- Weaknesses

HMC Structure	MD	NR	ADM	TH	PM	CD 1	CD2	SS	Total
Deviated from primary goal (referral)	1								**1**
Some heads take adv. Of posts for personal benefits	1	1				1	1		**4**
No communication mechanisms		3	2			2	1		**8**
Very centralized decision making/management	15	6	13			3	6		**43**
Interferences from corporate depts in hospitals management		2				1			**3**
Some depts think they can function in isolation		1				1	1		**3**
Indiv/Depts forget corporation mission of patient care	1	2	1						**4**
High turn over in administration			1						**1**
No medical audit			1						**1**
Not decided if wants decentralization			1						**1**
No clear roles and functions		3	4		2	2			**11**
Unclear/Dual reporting (hospital vs corp.depts)		2	2				1		**5**
People misplaced in posts	2	1					1		**4**
Weak administrative processes	3	1	1		1	3	2		**11**
Demoralization/ demotivated/ Insecure	6	4	3			4	4		**21**
Discrimination in applying rules and regulations	1	4	2		2	2			**11**
Relies heavily on individual's character	1	2	1		1	1	2		**8**

No training to work with this structure		1	2						**3**
Grey areas		1							**1**
No meetings			1						**1**
Need new staff			1				1		**2**
Weak salaries			2		2	2			**6**
No career development		1	3			1	1		**6**
Favoritism	1	3				2			***8***
No planning	1	2	3		1	3			**10**
No clear documented processes		2	3			2			**7**
No accountability							1		**1**
Weak /inefficient staff							1		**1**
Structure changes to suit individuals in posts		1						1	**2**
No computerization							1		**1**
Too much bureacracy			1						**1**
Too many committees	1								**1**
Aspects of matrix and centralized structure			1						**1**
Relies on personal contacts for coordination	1								**1**
Total	**35**	**46**	**49**		**9**	**30**	**24**	**1**	**193**

II- **How** can HMC be better structure

HMC Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD2**	**SS**	**Total**
Focus on HMC objective (referral hosp) and load will decrease.	2								**2**
Reduce number of committees	1								**1**
Decentralize decision to dept heads	4		3		1		1		**9**
Make smaller in size	1								**1**
Knowledgeable, creative, enthousiastic people in key posts	1		1				2		**4**
People who work for public not personal benefit	1								**1**
Better cooperation	1								**1**
Involving staff in planning	3		2						**5**
Separate hospitals/unit	2		1		1		1		**5**
Hold staff accountable	1						1		**2**
Regular multiprofession meetings	1								**1**
Hard working staff	1						1		**2**
Clear JD, roles and functions		1	2		1			1	**5**
Total	**19**	**1**	**9**		**3**		**6**	**1**	**39**

7a. Participation

I – Are you **involved** in changes in your department structure

Dept. Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD2**	**SS**	**Total**
No/Not really	2	5	2	1			4	1	**15**
No cannot interfer with		4	1						**5**

structure/fixt									
Yes	3	14	3	2	4		2	5	**33**
Structure has not been changed in a long time		1							**1**
Total	**5**	**24**	**6**	**3**	**4**		**6**	**6**	**54**

II- **Describe** involvement

Dept. Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Opinion sought no real involvement		1							**1**
Recently created new units		2	1					2	**5**
We are ordered and execute			1						**1**
For staff allocation		1							**1**
Involved in decision	1	3							**4**
Give proposals for implementation				1					**1**
Involved in discussions	2	4	2		2		1	3	**14**
Total	**3**	**11**	**4**	**1**	2		**1**	**5**	**27**

7b. Participation

I – Were you **involved** in formation of HMC last two structures

HMC Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Yes	2	1	2						**5**
No	2	2	4		2	1	5		**16**
Not formally	3	1							**4**
Total	**7**	**4**	**6**		**2**	**1**	**5**		**25**

II- **Describe** involvement

HMC Structure	**MD**	**NR**	**ADM**	**TH**	**PM**	**CD 1**	**CD 2**	**SS**	**Total**
Discussion but no real involvement		1			1				**2**
Set up present org structure			1						**1**
Informal discussions			1						**1**
Heard gossip about it	1								**1**
Briefed about it by top mgt		1							**1**
Through committee	1								**1**
About my speciality	1								**1**
Total	**3**	**2**	**2**		1				**8**

Note:
- MD = Medical
- NR = Nursing
- ADM = Administration
- TH = Therapy
- PM =Paramedical
- CD1 = Corporate Departments with non-staff functions
- CD2 = Corporate Departments with staff functions
- SS = Support Services

ANNEX 19 ANALYSIS GUIDE BY HOSPITAL

1. Decisions Making

I - Types of decisions in your department you are authorized to make **without prior approval**

Decision	**WH**	**HGH**	**RH**	**CDs**	**Total**
Most everything but inform/take opinion	3	4	5	1	13
Most everything try not to involve superior	1			1	2
About budget & staff within my budget	4	6	2		12
Day to day routine (minor staff management ie leaves, distribution, scheduling and minor problems)	10	30	22	18	80
Actual patient care/treatment/ clinical/technical issues		12	3	3	18
Training/Education issues		1	2		3
Things within SP of HMC			2	4	6
Total	18	53	36	27	134

II- Types of decisions in your department you **require prior** approval

Decision	**WH**	**HGH**	**RH**	**CDs**	**Total**
Issues beyond my budget	2	2			4
Major staff issues (transfers, promotions, terminations)	4	13	9	1	27
Those required by SPs	1	2		4	7
Incidents and problems	2	3	1	4	10
Issues affecting patient care	3	3	2		8
Long term/ planning decisions	1	5		1	7
Issues requiring budget (e.g new budget, equipment and procedures)	5	16	12	7	40
Issues with other specialities/depts		4	3	1	8
Administrative issues		7	1	2	10
Issues outside HMC			1		1
Most decisions		4		4	8
Total	18	59	29	24	130

2. Decisions Making

I - Types of decisions you feel your superiors should **decentralize**

Decision	**WH**	**HGH**	**RH**	**CDs**	**Total**
Issues related to our Job	2	6	5	3	16
Complaints from patients and personnel	1				1
Staffing/Staff problems	2	10	5	2	19
Issues of my responsibility by the job description	1		1	2	4
No need- flexible and no	2	13	7	6	28

decision making problems/ freedom					
Issues related to our budget	1	5	1	1	8
Space utilization issues			2		2
Everything is centralized				1	1
Total	9	34	21	15	79

II- Types of decisions your superiors should **involve you** in more

Decision	**WH**	**HGH**	**RH**	**CDs**	**Total**
Work/issues related to my job/unit	4	3	1	8	16
Staffing management	2	2			4
Budget	1	2		3	6
Involved – most decisions through committees/meetings	3	3			6
Long term planning for HMC		2	1		3
Future projects and programs for my unit		1	1	1	3
Total	10	13	3	12	38

3. Information

I – Do you **receive all information** you need to full fill your role and take decisions:

Information	**WH**	**HGH**	**RH**	**CDs**	**Total**
Yes – all needed available	7	20	9	11	47
Not fully	4	14	9	15	42
Total	11	34	18	26	89

II – **How** do you receive information:

Information	**WH**	**HGH**	**RH**	**CDs**	**Total**
Through superior	5	3	5	2	15
Through memos and circulars	5	1	4	1	11
Through interdisciplinary committees	2				2
Through departmental committees/meetings	2	1			3
Through subordinates	1			1	2
Through Standard Practices		1	1	2	4
Through personal contacts		1	1	1	3
Total	15	7	11	7	40

II- Types of **information you would need**

Information	**WH**	**HGH**	**RH**	**CDs**	**Total**
Information from outside HMC (e.g. benchmarking information, ways other hospitals do things in order to improve)	3				3
From other HMC departments/hospitals	2	1	6	2	11
Hospital/Patient statistics		1	1		2

Administrative issues/decisions from superiors		7	5	5	17
l-t planning/future projects for hospital/unit		6	4	4	14
Budget/Finance Issues		1			1
Standard Practices/by laws				3	3
Total	5	16	16	14	51

4. **Coordination**
I – **Types of conflicts** with other departments

Conflicts	**WH**	**HGH**	**RH**	CDs	**Total**
When depts take own decisions and work own way without coordinating	4	5	3	1	13
When no communication/miscommunication	5	8	7	1	21
When depts don't conduct their functions fully/up to level	3	7	6	3	19
When depts procedures lengthy	4	4	2		10
When depts trespass into my work	1	1	1		3
Constant change in other depts	2		1	1	4
Dual reporting/orders	3	5	2	2	12
When depts don't follow St. Practices/Protocoles	1	2		3	6
Bad attitude	2	6			8
No discipline in depts	1	2		1	4
Shortage of staff in other depts.		4	1	1	6
When depts don't have SPs/roles/functions		5	1	6	12
When depts are physically far			1		1
Coordination with Admin difficult		2			2
When dept is of different schooling/education		2			2
No conflicts		5		1	6
When depts don't understand our work		2		6	8
When depts circumvent my dept				1	1
Total	26	60	25	27	138

II - With **who**

Conflicts	**WH**	**HGH**	**RH**	**CDs**	**Total**
Depts with which work heavily	2				2
Corp Depts	4		7	3	14
Nursing	1	10	3		14
Paramedical	2	2	2		6
Medical	6	15	4	3	28

Administration	3	10	4	2	19
Support Services	4	2	3	1	10
Therapy		2	2		4
Social Workers			1		1
HGH			1		1
Total	23	41	27	9	100

III- How can these be **minimized**

Conflict Minimizing	WH	HGH	RH	CDs	Total
Computerization	1			1	2
Decentralization	1	3			4
Promote attitude/spirite of coordination	2	3		1	6
Defining/Redifining roles and resp. of depts	3	5		3	11
Mutidisciplinary committees/meetings	3	9	1	2	15
Additional staff to help coordination	3	2		1	6
Clear rules and SPs in each dept/committee	4	3		2	9
Proceduring conflict areas	1				1
Good working relations and communication	4	11	4	2	21
Following up implementation of decisions	1				1
Faster response to issues from depts	1				1
Involvement in decisions taken by other depts that involve us		2	1	1	4
Better coordination	1			1	2
Respect for our profession		4			4
Socializing with other depts		3			3
Admin doing their job correctly		1		1	2
Depts doing their jobs properly		1		1	2
Total	24	47	6	16	93

5. Department Structure

I – Is department structure **most efficient** for provision of services

Dept. Structure	WH	HGH	RH	CDs	Total
Yes	6	18	9	5	38
No/ Not really	5	16	8	21	50
No real structure its just on paper	1	2		1	4
Total	12	36	17	27	92

II- **Why**

Dept. Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Structure not changed as org changes	2			1	3
Work scattered	1				1
Problem not structure but process	1			1	2
Too centralized	2	8	4	7	21
Dept just grew in size with no structure	1	1		2	4
No communication between hospital levels	1	1			2
Staff posts and grades not right	1	6		6	13
Very well controlled	1				1
Unclear/Dual line of reporting	1	2	2		5
It is constantly developed			1	1	2
Provided decision making freedom			1		1
Has clear accountability			1		1
Still new- under development			1	2	3
Too many committees			1		1
Understaffed			1	3	4
Relies on character of superior		2	1		3
Not being implemented		1		1	2
Needs complete restructuring		1		3	4
Depts build empires		1			1
Physically far		1			1
Dept too big		1			1
Turnover in Admin thus no continuity		1		1	2
Total	11	26	13	28	78

II- How can it be **improved**

Dept. Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Decentralize	2		5	5	12
Changing/Adding posts	2	4	5	3	14
Changing grades	2	5	1	1	9
Changing procedures/business process engineering	3			2	5
Changing/Adding sections	4	1	1	5	11
Focus on HMC objectives/don't detract	1	1			2
Better communication between hospital levels	1				1
More organized	1			4	5
Complete seperation of hospital/unit (financial&mgt)		2	1		3
Departmental committees/meetings			1		1
Multiprofession committees/meetings			1		1

More space			1		1
Better trained staff		1	1	3	5
Involvement in decision making			1		1
Better problem solving	1				1
New medical in charge rather than administration		1			1
Clear Roles/Jobs descip/functions				1	1
Total	17	15	18	24	74

6a. HMC Structure
I – Is HMC structure **effective**

HMC Structure	WH	HGH	RH	CDs	Total
Yes		6	2		8
No/ Not really	1	7	2	4	14
On paper only but not in real		1	2	1	4
Confusion of what is HMC structure	1	1		5	7
Total	2	15	6	10	33

6b. HMC Structure
I – **Strenghts**

HMC Structure	WH	HGH	RH	CDs	Total
Easy to reach top management and they listen/people in responsibility	1	1	1	1	4
Clear hierarchy/ lines of communication	1	1	1	1	4
Hard working staff/disciplined		2	1		3
Independence from Civil Services		2		3	5
Top management quick decision makers		1		1	2
Top management get all needed information		1			1
Top management recognized hard working staff		1		1	2
Encourages coordination and decentralization		1			1
Total	2	10	3	7	22

II- Weaknesses

HMC Structure	WH	HGH	RH	CDs	Total
Deviated from primary goal (referral)	1				1
Some heads take adv. Of posts for personal benefits	1		1	2	4
No communication mechanisms	2	2	1	3	8
Very centralized decision making/management	5	21	6	11	43
Interferences from corporate	1			2	3

depts in hospitals management					
Some depts think they can function in isolation			1	2	3
Indiv/Depts forget corporation mission of patient care		2	1	1	4
High turn over in administration			1		1
No medical audit			1		1
Not decided if wants decentralization			1		1
No clear roles and functions		4	2	5	11
Unclear/Dual reporting (hospital vs corp.depts)		1	2	2	5
People misplaced in posts		2	1	1	4
Weak administrative processes		4	1	6	11
Demoralization/ demotivated/ Insecure		10	2	9	21
Discrimination in applying rules and regulations		6	1	4	11
Relies heavily on individual's character		3	1	4	8
No training to work with this structure		2	1		3
Grey areas			1		1
No meetings		1			1
Need new staff		1		1	2
Weak salaries		4		2	6
No career development		3		3	6
Favoritism		2		6	8
No planning		5		5	10
No clear documented processes		3		4	7
No accountability				1	1
Weak /inefficient staff				1	1
Structure changes to suit individuals in posts				2	2
No computerization				1	1
Too much bureacracy		1			1
Too many committees	1				1
Aspects of matrix and centralized structure	1				1
Relies on personal contacts for coordination		1			1
Total	12	78	25	78	193

II- **How** can HMC be better structure

HMC Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Focus on HMC objective (referral hosp) and load will decrease.	1		1		2
Reduce number of committees	1				1
Decentralize decision to dept heads	1	7		1	9

Make smaller in size	1				1
Knowledgeable, creative, enthousiastic people in key posts	1	1		2	4
People who work for public not personal benefit	1				1
Better cooperation			1		1
Involving staff in planning		4	1		5
Separate hospitals/unit		3	1	1	5
Hold staff accountable		1		1	2
Regular multiprofession meetings		1			1
Hard working staff		1		1	2
Clear JD, roles and functions		1		4	5
Total	6	19	4	10	39

7a. Participation

I – Are you **involved** in changes in your department structure

Dept. Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
No/Not really	1	5	4	5	15
No cannot interfer with structure/fixt	2		3		5
Yes	6	16	4	7	33
Structure has not been changed in a long time			1		1
Total	9	21	12	12	54

II- **Describe** involvement

Dept. Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Opinion sought no real involvement	1				1
Recently created new units	1	2		2	5
We are ordered and execute	1				1
For staff allocation	1				1
Involved in decision	2	1	1		4
Give proposals for implementation			1		1
Involved in discussions		9	1	4	14
Total	6	12	3	6	27

7b. Participation

I – Were you **involved** in formation of HMC last two structures

HMC Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Yes	2	2	1		5
No		9	1	6	16
Not formally			4		4
Total	2	11	6	6	25

II- **Describe** involvement

HMC Structure	**WH**	**HGH**	**RH**	**CDs**	**Total**
Discussion but no real involvement	1	1			2
Set up present org structure	1				1
Informal discussions			1		1
Heard gossip about it			1		1
Briefed about it by top mgt			1		1
Through committee		1			1
About my speciality		1			1
Total	2	3	3		8

Note:

WH = Women's Hospital
HGH = Hamad General Hospital
RH = Rumailah Hospital
CDs = Corporate Departments

ANNEX 20 HMC ANALYSIS GUIDE

DECISION MAKING

1. Authorized without prior approval:

Majority for HMC

Majority: Day to Day routine (80 times)
2nd: Actual patient care/treatment/clinical/technical issues (18 times)
3rd: Most everything but inform/take opinion (13 times)
4th: About my budget and staff within my budget (12 times)
5th: Things within SP of HMC (6 times)
6th: Training/Education issues (3 times)
Least: Most everything try not to involve superior (2 times)

Majority for HMC by Hospital

WH: Day to Day routine (10 times)
HGH: Day to Day routine (30 times)
RH: Day to Day routine (22 times)
CD:Day to Day routine (18 times)

Majority for HMC by Profession

Medical: Day to Day routine; actual patient care/treatment/clinical/technical issues (7 times each)
Nursing: Day to Day routine (33 times each)
Administration: Day to Day routine (13 times)
Therapy: Day to Day routine (13 times)
Paramedical: Day to Day routine (5 times)
CD1: Day to Day routine (2 times)
CD2: Day to Day routine (7 times)
Support Services: Day to Day routine (7 times)

2. Requires prior approval:

Majority for HMC

Majority: Issues requiring budget (40 times)
2nd: Major staff issues (27 times)
3rd: Incidents and problems; administrative issues (10 times each)
4th Issues affecting patient care; issues with other specialities/depts; most decisions (8 times)
5th: Those required by SPs; Long term/planning decisions (7 times each)
6th: Issues beyond my budget (4 times)
Least: Issues outside HMC (1 time)

Majority for HMC by Hospital

WH: Issues requiring budget (5 times)
HGH: Issues requiring budget (16 times)
RH: Issues requiring budget (12 times)
CDs: Issues requiring budget (7 times)

Majority by profession:
Medical: Issues requiring budget (5 times)
Nursing: Major staff issues (18 times)
Administration: Issues requiring budget (7 times)
Therapy: Issues requiring budget; major staff issues (3 times each)
Paramedical: Major staff issues; issues requiring budget (2 times each)
Corp Depts 1: Issues requiring budget (1 times)
Corp Depts 2: Issues requiring budget; those required by SPs (3 times each)
Support Serv: Issues requiring budget; administrative issues; most decisions (2 times each)

3. **Should be decentralized:**

Majority for HMC
Majority: No need (28 times)
2nd: Staffing/staff problems (19 times)
3rd: Issues related to our job (16 times)
4th : Issues related to budget (8 times); everything is very centralized (1 time each)
5th : issues related to job description (4 times)
6th: Space utilization issues (2 times)
Least: Everything is centralized (1 time)

Majority for HMC by Hospital
WH: No need; staffing/staff problems; issues related to our job (2 times)
HGH: No need (13 times)
RH: No need (7 times)
CD: No need (6 times)

Majority for HMC by Profession
Medical: Issues related to our job; no need (3 times each)
Nursing: No need (12 times)
Administration: No need (6 times)
Therapy: Staffing/Staff problems (2 times)
Paramedical: Staffing/Staff problems (2 times)
Corp Depts 2: No need (2 times)
Support Serv: No need (3 times)

4. **Should involve you more:**

Majority for HMC
Majority: Issues related to my job/unit (16 times)
2nd: Involved; budget (6 times each)
3rd : Staffing management (4 times each)
Least: Future projects/programs for unit; long term planning for HMC (3 times each)

Majority for HMC by Hospital
WH: Work/issues related to my job/unit (4 times)
HGH:Work/issues related to my job/unit; involved (3 times each)
RH: Involved; long term planning for HMC; Future projects and programs for my unit (1 time each)
CDs: Work/issues related to my job/unit (8 times)

Majority for HMC by Profession
Medical: Work/issues related to my job/unit; long term planning for HMC; future projects and programs for my unit (1 time each)

Nursing: Involved (5 times)
Administration: Work/issues related to my job/unit (3 times)
Therapy: Staffing managent; budget (1 time each)
Paramedical: Staffing/Staff problems; budget; long-term planning for HMC (1 time each)
Corp Depts 2: Work/issues related to my job/unit (4 times)
Support Serv: Work/issues related to my job/unit (4 times)

INFORMATION

1. Do you receive all the information you need?

Majority for HMC
Yes (47 times)
No/Not fully (42 times)

Majority for HMC by Hospital
WH: Yes (7 times)
HGH:Yes (20 times)
RH: Yes; No/not fully (9 times each)
CD: No/Not fully (15 times each)

Majority for HMC by Profession
Medical: Yes (7 times)
Nursing: Yes (18 times)
Administration: Yes (9 times)
Therapy: No/Not fully (4 times)
Paramedical: Yes;No/Not fully (2 times each)
Corp Depts 1: Not fully (2 times)
Corp Depts 2: Not fully (6 times)
Support Serv: Yes; No/Not fully (5 times each)

2. How do you receive it?

Majority for HMC
Majority: Superior (15 times)
2nd : Memos and Circulars (11 times)
3rd : Standard practices (4 times)
4th: Through departmental committees/meetings; through personal contacts (3 times each)
Least: Interpersonal committees; subordinates(2 times each)

Majority for HMC by Hospital
WH: Superior; memos and circulars (5 times each)
HGH: Superior (3 times)
RH: Superior (5 times)
CDs: Superior; Standard Practices (2 times each)

Majority for HMC by Profession
Medical: Standard Practices; Personal contacts (1 time each)
Nursing: Superior; memos and circulars (9 times each)
Administration: Superior (3 times)
Therapy: Superior; Standard Practices (1 time each)
Support Serv: Superior (2 times)

3. **Information you would need?**

Majority for HMC
Majority: Admininistrative issues/decisions from superiors (17 times)
2nd: long term planning/future projects (14 times)
3rd: from other HMC depts/hospitals (11 times)
4th: Standard Practices/by Laws; information from outside HMC (3 times each)
5th: Hospital/Patient Statistics (2 times)
Least: Budget/Finance Issues (1 time)

Majority for HMC by Hospital
WH: Information from outside HMC (3 times)
HGH: Administrative issues/decisions from superiors (7 times)
RH: From other HMC departments/hospitals (6 times)
CDs: Administrative issues/decisions from superiors (5 times)

Majority for HMC by Profession
Medical: Administrative issues/decisions from superiors (4 times)
Nursing: From other HMC departments/hospitals; long term planning/future projects (5 times each)
Administration: Information from outside HMC (3 times)
Therapy: Administrative issues/decisions from superiors (3 times)
Paramedical: long term planning/future projects (2 times)
Corp Depts 1: long term planning/future projects; from other HMC depts/hospitals (1 times each)
Corp Depts 2: Standard Practices/by Laws (3 times)
Support Serv: Admininistrative issues/decisions from superiors (4 times)

COORDINATION

1. **Types of conflicts**

Majority for HMC
Majority: when no communication/miscommunication (21 times)
2nd: when depts don't conduct their functions fully/up to level (19 times)
3rd: when depts take own decisions and work own way without coordinating (13 times)
4th: dual reporting/orders; when depts don't have SPs/roles/functions (12 times each)
5th: when depts procedures lengthy (10 times)
6th: bad attitude; when depts don't understand our work (8 times each)
7th: when depts don't follow SPs/protocoles; shortage of staff in other depts; no conflicts (6 times each)
8th: constant change in other depts; no discipline in depts (4 times each)
9th: when depts tresspass into my work (3 times)
10th: coordination with administration difficult; when dept is of different schooling/education (2 times each)
11th: when depts are physically far; when depts circumvent my department (1 time each)

Majority for HMC by Hospital
WH: When no communication/miscommunication (5 times)
HGH: When no communication/miscommunication (8 times)
RH: When no communication/miscommunication (7 times)
CD: when depts don't understand our work; when depts don't have SPs/roles/functions (6 times each)

Majority for HMC by Profession
Medical: when depts take own decisions and work own way without coordinating (4 times)
Nursing: When no communication/miscommunication (16 times)
Administration: Dual reporting/orders (6 times)
Therapy: when depts don't conduct their functions fully/up to level (3 times)
Paramedical: when no communication/miscommunication (2 times)
Corp Depts 2: when depts don't have SPs/roles/functions (4 times)
Support Serv: when depts don't understand our work (3 times)

2. **Who?**

Majority for HMC
Majority: Medical (28 times)
1st: Administration (19 times)
2nd: Corp Depts; Nursing (14 times each)
3rd: Support Services (10 times)
4th: Paramedical (6 times)
5th: Therapy (4 times)
6th: Depts with which work heavily (2 times)
Least: Social Workers; HGH (1 time each)

Majority for HMC by Hospital
WH: medical (6 times)
HGH:medical (15 times)
RH: Corp Departments (7 times)
CDs: Corp. Depts; medical (3 times each)

Majority for HMC by Profession
Medical: administration (6 times)
Nursing: medical (14 times)
Administration: medical (7 times)
Therapy: nursing; social workers; HGH (1 time each)
Paramedical: medical (2 times)
Corp Depts 2: Corp Depts (3 times)
Support Serv: medical; administration; support services (1 time each)

3. **Minimized?**

Majority for HMC
Majority: good working relations and communication (21 times)
2nd: multidisciplinary committees/meetings (15 times)
3rd: defining/redefining roles and responsibilities of depts (11 times)
4th: clear rules and SPs in each dept/committee (9 times)
5th: additional staff to help coordination; promote attitude/spirite of coordination (6 times each)
6th: decentralize; involvement in decisions taken by other depts that involve us; respect our profession (4 times each)
7th: socializing with other depts (3 times)
8th: depts doing their jobs properly; administration doing their job correctly; better coordination; computerization (2 times each)
Least: faster response to issues from depts; following up implementation of decisions; procedurizing areas of conflicts (1 time each)

Majority for HMC by Hospital
WH: good working relations and communication (4 times)
HGH: good working relations and communication (11 times)
RH: good working relations and communication (4 times)
CDs: defining/redefining roles and responsibility (3 times)

Majority for HMC by Profession
Medical: promote attitude/spirite of coordination; defining/redefining roles and responsibilities of departments (2 times each)
Nursing: good working relations and communication (13 times)
Administration: clear rules and SPs in each dept/committee (5 times)
Therapy: multidisciplinary committees/meetings (2 times)
Paramedical: multidisciplinary committees/meetings; good working relations and communication (3 times each)
Corp Depts 2: good working relations and communication (2 times)
Support Serv: multidisciplinary committees/meetings (1 time)

DEPARTMENT STRUCTURE

1. **Most efficient?**

Majority for HMC
Majority: No/Not really (50 times)
2nd: Yes (38 times)
Least: No real structure its just on paper (4 times)

Majority for HMC by Hospital
WH: Yes (6 times)
HGH: Yes (18 times)
RH: Yes (9 times)
CDs: No/not really (21 times)

Majority for HMC by Profession
Medical: No/Not really (7 times)
Nursing: Yes (18 times)
Administration: Yes (6 times)
Therapy: No/Not really (4 times)
Paramedical: No/Not really (4 times)
Corp Depts 1: No/Not really (4 times)
Corp Depts 2: No/Not really (9 times)
Support Serv: No/Not really (5 times)

2. **Why?**

Majority for HMC
Majority: too centralized (21 times)
2nd: staff posts and grades not right (13 times)
3rd: unclear/dual line of reporting (5 times)
4th: dept just grew in size with no structure; understaffed; needs complete restructuring (4 times each)
5th: structure not changes as organization changes; still new- under development; relies on character of superior (3 times each)
6th: problem not structure but process; no communication between hospital levels; it is constantly developed; no being implemented; turnover in administration thus no continuity (2 times each)

Least: work scattered; very well controlled; provided decision making freedom; has clear accountability; too many committees; depts build empires; physically far; dept too big (1 time each)

Majority for HMC by Hospital
WH: too centralized; structure not changed as organization changes (2 times each)
HGH: too centralized (8 times)
RH: too centralized (4 times)
CDs: too centralized (7 times)

Majority for HMC by Profession
Medical: unclear/dual line of reporting (2 times)
Nursing: too centralized (5 times)
Administration: too centralized (3 times)
Therapy: too centralized (3 times)
Paramedical: too centralized (4 times)
Corp Depts 1: need complete restructuring (2 times)
Corp Depts 2: staff posts and grades not right (5 times)
Support Serv: too centralized; dept just grew in size no structure; staff posts and grades not right; understaffed; not being implemented (1 time each)

3. **How can it be improved?**

Majority for HMC
Majority: Changing/Adding posts (16 times)
2nd: decentralize (12 times)
3rd: changing/adding sections (11 times)
4th: changing grades (9 times)
5th: changing procedures/ business process engineering; more organized; better trained staff (5 times each)
6th: complete seperation of hospital/unit (financial and management) (3 times)
7th: focus on HMC's objectives-don't detract (2 times)
Least: better communication between hospital levels; departmental committees/meetings; multiprofession committees/meetings; more space; involvement in decision making; better problem solving; new medical in charge rather then administration; clear roles/job descriptions/functions (1 time each)

Majority for HMC by Hospital
WH: Changing/adding sections (4 times)
HGH: changing grades (5 times)
RH: decentralize; changing/adding posts (5 times each)
CDs: decentralize; changing/adding sections (5 times each)

Majority for HMC by Profession
Medical: changing/adding posts; changing/adding sections; focus on HMC objectives/don't detract (2 times only)
Nursing: decentralize (4 times)
Administration: changing/adding posts (3 times)
Therapy: decentralize; changing/adding posts (2 times each)
Paramedical: changing grades (2 times)
Corp Depts 1: changing/adding section (2 times)
Corp Depts 2: better trained staff (3 times)
Support Serv: changing/adding posts (3 times)

HMC ORGANIZATION STRUCTURE

1. **Effective?**

Majority for HMC
Majority: No/not really (14 times)
2nd: Yes (8 times)
3rd: confusion of what is HMC structure (7 times)
Least: on paper only but not in real (4 times)

Majority for HMC by Hospital
WH: no/not really; confusion of what is HMC structure (1 times each)
HGH: no/not really (7 times)
RH: yes; no/not really; on paper only but not in real (2 times each)
CDs: confusion of what is HMC structure (5 times)

Majority for HMC by Profession
Medical: Yes (6 times)
Nursing: on paper only but not in real; confusion of what is HMC structure (3 times)
Administration: no/not really (3 times)
Paramedical: yes; no/not really (1 time each)
Corp Depts 1: confusion of what is HMC structure (1 time)
Corp Depts 2: no/not really (3 times)

2. **Strengths**

Majority for HMC
Majority: Independence from Civil Services (5 times)
2nd: easy to reach top management and they listen/people in responsibility; clear hierarchy/lines of communication (4 times each)
3rd: hard working staff/disciplined (3 times)
4th: top management quick decision makers; top management recognized hard working staff (2 times each)
Least: top management get all needed information; encourages coordination and decentralization(1 time each)

Majority for HMC by Hospital
WH: easy to reach top management and they listen/people in responsibility; clear hierarchy/lines of communication (1 times each)
HGH: hard working staff/disciplined; independence from Civil Services (2 times each)
RH: easy to reach top management and they listen/people in responsibility; clear hierarchy/lines of communication; hard working staff/disciplined (1 times each)
CDs: independence from Civil Services (3 times)

Majority for HMC by Profession
Medical: easy to reach top management and they listen/people in responsibility (6 times)
Nursing: clear hierarchy/lines of communication; independence from Civil Services; top management recognized hard working staff (1 times each)
Administration: independence from Civil Services (2 times)
Paramedical: top management recognized hard working staff (1 time)
Corp Depts 1: clear hierarchy/lines of communication (1 time)
Corp Depts 2: independence from Civil Services (2 times)

3. Weaknesses

Majority for HMC
Majority: very centralized decision making/management (43 times)
2nd: demoralization/demotivated/insecure (21 times)
3rd: no clear roles and functions; weak administrative processes; discrimination in applying rules and regulations (11 times each)
4th: no planning (10 times)
5th: no communication mechanisms; relies heavily on individual's character; favoritism (8 times each)
6th: no clear documented processes (7 times)
7th: weak salaries; no career development (6 times)
8th: unclear/dual reporting (hospital vs. corp. depts) (5 times)
9th: some heads take advantage of posts for personal benefits; individual/depts forget corporation mission of patient care; people misplaced in posts (4 times each)
10th: interferences from corporate depts in hospitals management; some depts think they can function in isolation; no training to work with this structure (3 times each)
11th: need new staff; structure changes to suit individuals in posts (2 times each)
Least: deviated from primary goal (referral); high turnover in administration; no medical audit; not decided if wants decentralization; grey areas; no meetings; no accountability; weak/inefficient staff; no computerization; too much bureaucracy; too many committees; aspects of matrix and centralized structure; relies on personal contacts for coordination (1 time each)

Majority for HMC by Hospital
WH: very centralized decision making/management (5 times)
HGH: very centralized decision making/management (21 times)
RH: very centralized decision making/management (6 times)
CDs: very centralized decision making/management (11 times)

Majority for HMC by Profession
Medical: very centralized decision making/management (15 times)
Nursing: very centralized decision making/management (6 times)
Administration: very centralized decision making/management (13 times)
Paramedical: no clear roles and functions; discrimination in applying rules and regulations (2 times each)
Corp Depts 1: demoralization/demotivated/insecure (4 times)
Corp Depts 2: very centralized decision making/management (6 times)
Support Serv: structure changes to suit individuals in posts (1 time)

4. How can it be better structure?

Majority for HMC
Majority: decentralize decisions to dept heads (9 times)
2nd: involving staff in planning; separate hospitals/units; clear job description, roles and functions (5 times each)
3rd: knowledgeable, creative, enthousiastic people in key posts (4 times)
4th: focus on HMC objective (referral hospital) and load will decrease; hold staff accountable; hard working staff (2 times each)
Least: reduce number of committees; make smaller in size; people who work for public not personal benefit; better cooperation; regular multiprofession meetings (1 time each)

Majority for HMC by Hospital
WH: focus on HMC objective (referal hospital); reduce number of committees; decentralize decision to dept heads; make smaller in size; knowledgeable, creative, enthousiastic people in key posts; people who work for public not personal benefit (1 time each)
HGH: decentralize decisions to dept heads (7 times)
RH: focus on HMC objective (referral hosptial); involving staff in planning; better cooperation, separate hospitals/units (1 time each)
CDs: clear job description, roles and functions (4 times)

Majority for HMC by Profession
Medical: decentralize decisions to dept heads (4 times)
Nursing: clear job description, roles and functions (1 time)
Administration: decentralize decisions to dept heads (3 times)
Paramedical: decentralize decisions to dept heads; separate hospitals/units; clear job descriptions/roles/functions (1 time each)
Corp Depts 2: knowledgeable, creative, enthousiastic people in key posts (2 times)
Support Serv: clear job descriptions/roles/functions (1 time)

PARTICIPATION- DEPARTMENT STRUCTURE

1. **Are you involved in changes in dept structure?**

Majority for HMC
Majority: Yes (33 times)
2nd: No/not really (15 times)
3rd: no cannot interfere with structure/fixt (5 times)
Least: structure has not been changes in a long time (1 time)

Majority for HMC by Hospital
WH: Yes (6 times)
HGH: Yes (16 times)
RH: No/not really; yes (4 times each)
CDs: Yes (7 times)

Majority for HMC by Profession
Medical: yes (3 times)
Nursing: yes (14 time)
Administration: yes (3 times)
Therapy: yes (2 times)
Paramedical: yes (4 times)
Corp Depts 2: no/not really (4 times)
Support Serv: yes (5 times)

2. **Describe involvement**

Majority for HMC
Majority: involved in discussions (14 times)
2nd: recently created new units (5 times)
3rd: involved in decisions (4 times)
Least: opinion sought no reel involvement; we are ordered and execute; for staff allocation; give proposals for implementation (1 time each)

Majority for HMC by Hospital
WH: involved in decision (2 times)
HGH: involved in discussions (9 times)
RH: involved in decision; give proposals for implementation; involved in discussions (1 time each)
CDs: involved in discussions (4 times)

Majority for HMC by Profession
Medical: involved in discussions (2 times)
Nursing: involved in discussions (4 times)
Administration: involved in discussions (2 times)
Therapy: give proposals for implementation (1 time)
Paramedical: involved in discussions (2 times)
Corp Depts 2: involved in discussions (1 time)
Support Serv: involved in discussions (3 times)

PARTICIPATION- ORGANIZATION STRUCTURE

3. **Are you involved in changes in org. structure?**

Majority for HMC
Majority: No (16 times)
2nd: yes (5 times)
Least: not formally (4 times)

Majority for HMC by Hospital
WH: Yes (2 times)
HGH: No (9 times)
RH: not formally (4 times)
CDs: No (6 times)

Majority for HMC by Profession
Medical: not formally (3 times)
Nursing: no (2 times)
Administration: no (4 times)
Paramedical: no (2 times)
Corp Depts 1: no (1 time)
Corp Depts 2: no (5 times)

4. **Describe involvement**

Majority for HMC:
Majority: Discussion but no real involvement (2 times)
2nd and Least: set up present organization structure; informal discussions; heard gossip about it; briefed about it by top management; through committee; about my speciality (1 time each)

Majority for HMC by Hospital:
WH: discussion but no real involvement; set up present organization structure (1 time each)
HGH: discussion but no real involvement; through committee; about my speciality (1 time each)
RH: informal discussions; heard gossip about it; briefed about it by top management (1 time each)

Majority for HMC by Profession:
Medical: hear gossip about it; through committee; about my speciality (1 time each)
Nursing: discussion but no real involvement; briefed about it by top management (1 time each)
Administration: set up present organization structure; briefed about it by top management (1 time each)
Paramedical: discussion but no real involvement (1 time)

ANNEX 21 HMC FORMAL ORGANIZATIONAL STRUCTURE, 1987

TEXT BOUND INTO

THE SPINE

MEDICAL DIRECTOR
Dr. M. Hammoudeh
. Medical Staff
. Resident Program
. Pharmacy
. Nursing
. Respiratory Therapy
PERSONNEL
H. Al Murri
(Acting)
ADMINISTRATIVE DIRECTOR
Mr. C.I. Gustafson
Facility Planning
PUBLIC RELATIONS
S. Al Muhanadi
. Social Service
. Security
HGH
MEDICAL/SURGICAL/
PEDIATRICS/
CRITICAL CARE UNIT
ASSISTANT DIRECTOR
L. Weller
. Engineering
. Medical Staff - Admin.
ASST. FOR ADMIN.
Ali Janahi
. Admitting/UR
. Laboratory
. Radiology
. Public Areas
. Bio-Medical
OUTPATIENT
ASST. DIRECTOR
A. Namu
. OPD Clinics Admin.
. Cardiac Cath.Lab.
. Renal Dialysis
. Non-invasive Cardiology
. CUCC
ASST. FOR ADMIN.
I. Hashim
. Accident & Emergency
. Endoscopy
. Medical Records
. Neurophysiology
WOMEN'S
OBSTETRICS &
GYNECOLOGY/
NURSERY/OP
ASST. DIRECTOR
O. Hashisho, MD
. New Women's
Hospital Planning
ASST. FOR ADMIN.
H. Hilal
. Finance
. Materials
Management
. Health Information
Systems
SUPPORT SERVICES
ASST. DIRECTOR
M. Al Malki
. Catering
. Laundry
. C.S.S.D.
. Library
ASST. FOR ADMIN.
H. Haddad
. Communications
. Transport
. Copy Center
. Translation
. Mail Service
RUMAILAH
PSYCHIATRY/
GER/REHAB.
ASST. DIRECTOR
M. Ali Jassim
(Acting)
. Prosthetics & Orthotics
. Physical Therapy
. Occupational Therapy
. Housekeeping
. Dental Clinic
ASST. FOR ADMIN.
M.Z. Al Naimi
. Rumailah Inpatient/OP
. T.B./Burns Center
. Associated Clinics
. (Geriatrics, Dev.Dis.,
Psychiatry & T.B.)
. Polyclinic
. Dermatology
Approved : Dr. Hajar A. Hajar
Managing Director
Approved : Charles I. Gustafson
Administrative Director
Approved : Dr. Mohammed Hammoudeh
Medical Director
Date: Sept 28, 1987

ANNEX 22 PROPOSED ORGANIZATIONAL STRUCTURE FOR WH, 1990

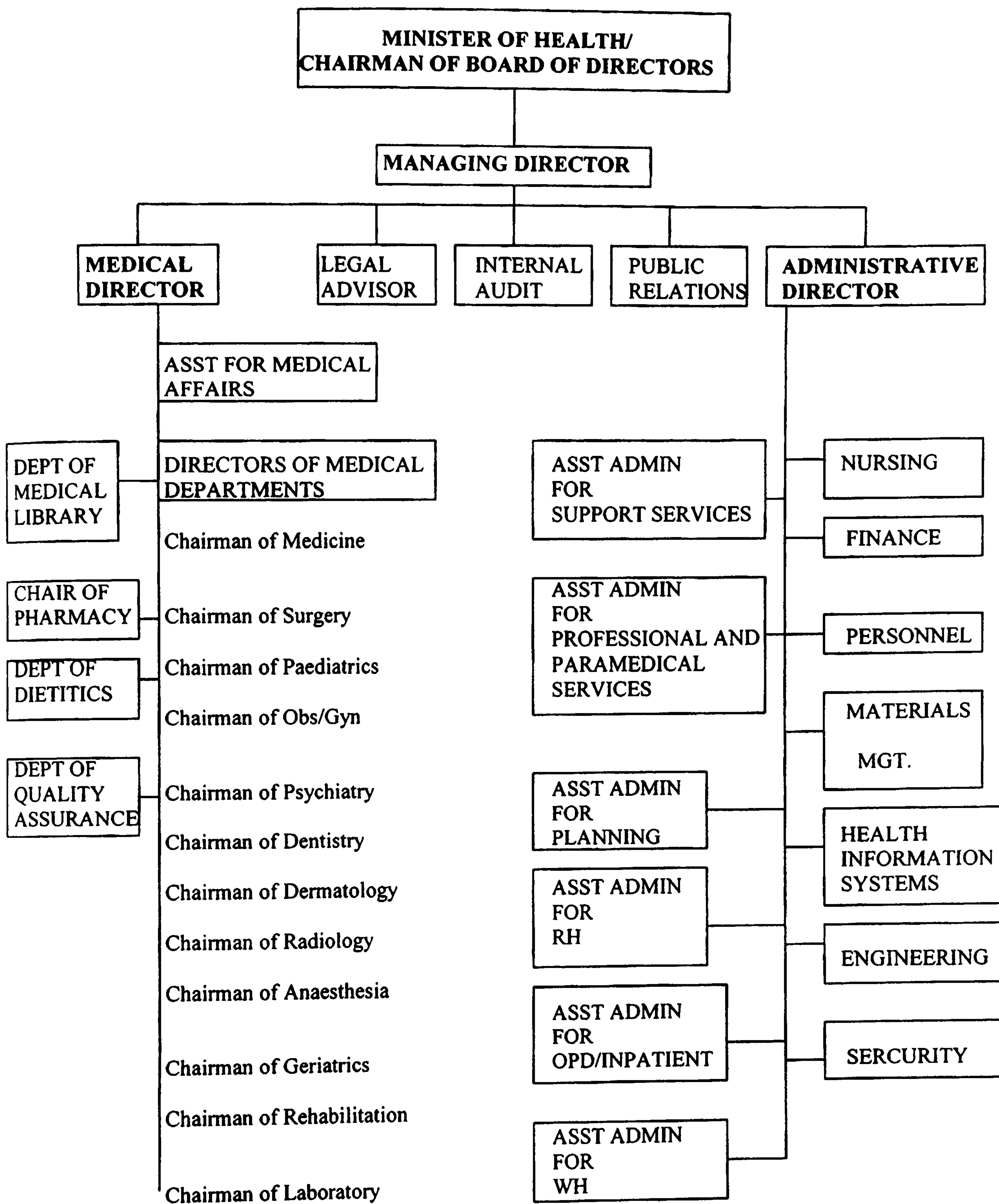
ORGANISATION CHART
CORPORATE
OPERATIONAL
Finance
H.I.S
Personnel
MEDICAL DIRECTOR
MEDICAL
DIRECTOR OF NURSING
MULTIDISCIPLINARY GROUPS
EXECUTIVE COMMITTEE
ADMINISTRATIVE DIRECTOR
NON-MEDICAL
HOSPITAL DIRECTOR
Support Services at Corporate/H.G.H.Level
CHAIRMAN OF ANAESTHESIA
CHAIRMAN OF PAEDIATRICS
CHAIRMAN OF OBST./GYNAE.
MEDICAL STAFF
CHIEF OF NEONATOLOGY
MEDICAL STAFF
ANAESTHESIOLOGY W.H.
HGH MEDICAL SERVICES
Nursing (Operational)
DIRECTOR OF NURSING
A.D.N.
A.D.N.
A.D.N.
Professional Support Services
PHARMACY
LABORATORY
ULTRASOUND
PHYSIOTHERAPY
PUBLIC RELATIONS
SOCIAL SERVICES
Support Services
ASSTT. HOSP. DIRECTOR
ADMINISTRATION
ADMITTING
MEDICAL REC.
OUTPATIENT
PATIENT ACC.
HOUSEKEEPING
SECURITY
Mat. Mgt.
Engineering
Respiratory Therapy
Laboratory
Radiology
Catering
Laundry
Transport
Communication
C.S.S.D.
Copy Centre
Mail Service.
CLINICAL SERVICES GROUPS
GROUP A
EMERGENCY ROOM
L & D UNIT
N.I.C.U.
GROUP B
O.P.D.
DAY CARE, OP.TH.
U/S, PHYSIO.
GROUP C
INPATIENTS SERVICES
KEY :
DIRECT
INDIRECT
PROFF.

ANNEX 23 HMC FORMAL ORGANIZATIONAL STRUCTURE, 1992

MANAGING DIRECTOR

- [ME]DICAL DIRECTOR
  - Chairmen of Medical Depts. Departments
    - Medicine : Dr. Al Arabi
    - Surgery : Dr. Crass
    - Pediatrics : Dr. A. Shamma
    - Dental : Dr. A.Tavas
    - Psychiatry : Dr.M. El Islam
    - Cardiology : Dr. Hajar
    - Gyn/Ob : Dr. Farouk
    - Laboratory : Dr.B.Azadeh
    - Radiology : Dr. M.Nork
    - Anesthesia : Dr. M. Takroury
  - Director of Quality Assurance
  - Director of Medical Education Dr. J.Ferlinz
  - Director of Pharmacy Mr.A.Bassili
  - Director of Dietetics and Nutrition Section Dr. A.Hassan
- Internal Auditor
- Director of Public Relations Mr. S. Al Mohanadi
- ADMINISTRATIVE DIRECTOR
  - Mr.M.Al Malki (Support Services)
  - Dr.A.Al Malki (In/Outpatient H.G.H.)
  - Dr.O.Hashisho (Planning Coordinator)
  - Mr.A.Al Janahi (Rumailah Hosp)
  - Mr.S.Al Abdullah (Women's Hosp)
  - Director of Nursing Mr. W.Remig
  - Director of Finance Mr. G.Tallent
  - Director of Personnel Mr.T.Al Khater
  - Director of Materials Management Mr. H.Al Marri
  - A/Director of H.I.S. Mr.I.Zubaidi
  - Director of Engineering Mr. Fudaili
  - Head of Security Mr.E. Suwaidi

ANNEX 24 HMC FORMAL ORGANIZATIONAL STRUCTURE, 1994-1996


MINISTER OF HEALTH/
CHAIRMAN OF BOARD OF DIRECTORS
MANAGING DIRECTOR
MEDICAL DIRECTOR
LEGAL ADVISOR
INTERNAL AUDIT
PUBLIC RELATIONS
ADMINISTRATIVE DIRECTOR
ASST FOR MEDICAL AFFAIRS
DEPT OF MEDICAL LIBRARY
DIRECTORS OF MEDICAL DEPARTMENTS
Chairman of Medicine
CHAIR OF PHARMACY
Chairman of Surgery
DEPT OF DIETITICS
Chairman of Paediatrics
Chairman of Obs/Gyn
DEPT OF QUALITY ASSURANCE
Chairman of Psychiatry
Chairman of Dentistry
Chairman of Dermatology
Chairman of Radiology
Chairman of Anaesthesia
Chairman of Geriatrics
Chairman of Rehabilitation
Chairman of Laboratory
ASST ADMIN FOR SUPPORT SERVICES
ASST ADMIN FOR PROFESSIONAL AND PARAMEDICAL SERVICES
ASST ADMIN FOR PLANNING
ASST ADMIN FOR RH
ASST ADMIN FOR OPD/INPATIENT
ASST ADMIN FOR WH
NURSING
FINANCE
PERSONNEL
MATERIALS MGT.
HEALTH INFORMATION SYSTEMS
ENGINEERING
SERCURITY

ANNEX 25 HMC FORMAL ORGANIZATIONAL STRUCTURE, 1997

MASTER ORGANIZATION CHART
BOARD OF DIRECTORS
MANAGING DIRECTOR
Quality Management
Training & Development
Legal Adviser
Planning Coordinator
Internal Audit
Public Relations
MEDICAL DIRECTOR
ADMINISTRATIVE DIRECTOR
Asst. to Adm. Director
Outpatient Services
Asst. Hospital Director
Asst. Medical Director
(Administration)
Hamad Gen. Hospital
Asst. Hospital Director
Special Projects & Programs
Asst. Hospital Director
Rumailah Hospital
Asst. Hospital Director
Women's Hospital
Asst. Hospital Director
Support Services
Asst. Hospital Director
Personnel Dept.
Finance Dept.
Materials Mgt. Dept.
Nursing Dept.
Engineering Dept.
Health Info. Sys. Dept.
Security Dept.
OPD
Medical Record
Admitting
Pharmacy
Laboratory
Radiology
E M S
Medicine
Surgery
Pediatrics/PEC
Cardiology
Critical Care Units
A & E
Renal Dialysis
Psychiatry
Geriatrics/Rehabilitation
Occupational Therapy
Dermatology
Dental
Physical Therapy
T. B. Unit
Burns Unit
Social Services
Obstetric &
Gynecology
NICU
I V F
Health Science
Library
Communication
Transport
Catering
Laundry
CSSD
Housekeeping
Mail Service

ANNEX 26 RESTRUCTURING OF ORGANIZATIONAL STRUCTURES ATTEMPT, HMC, 1997.

1. RH
2. HGH
3. WH

HMC STEERING COMMITTEE
Managing Director
Medical Director
Administrative Director

Medical Advisory Committee

Administrative Advisory Committee

Non-medical Support Services

Rumailah Hospital

RH EXEC. COMMITTEE
A. H. D.-RH (Facilitator)
Chairmen of Departments(7)
Sr. A. D. N. - RH

Hamad Gen. Hospital

HGH EXEC. COMMITTEE
A.H.D. - HGH (Facilitator)
Chairmen of Departments (9)
Sr. A. D. N. - HGH

Women's Hospital

WH EXEC. COMMITTEE
A.H.D. - WH (Facilitator)
Chairmen of Department (2)
Sr. A.D.N. - WH

Corporate Support Services

Clinical Services

Psychiatry
Chairman
Administrator
A. D. N.

Geriatric
Chairman
Administrator
A. D. N.

Dermatology
Chairman
Administrator
A. D. N.

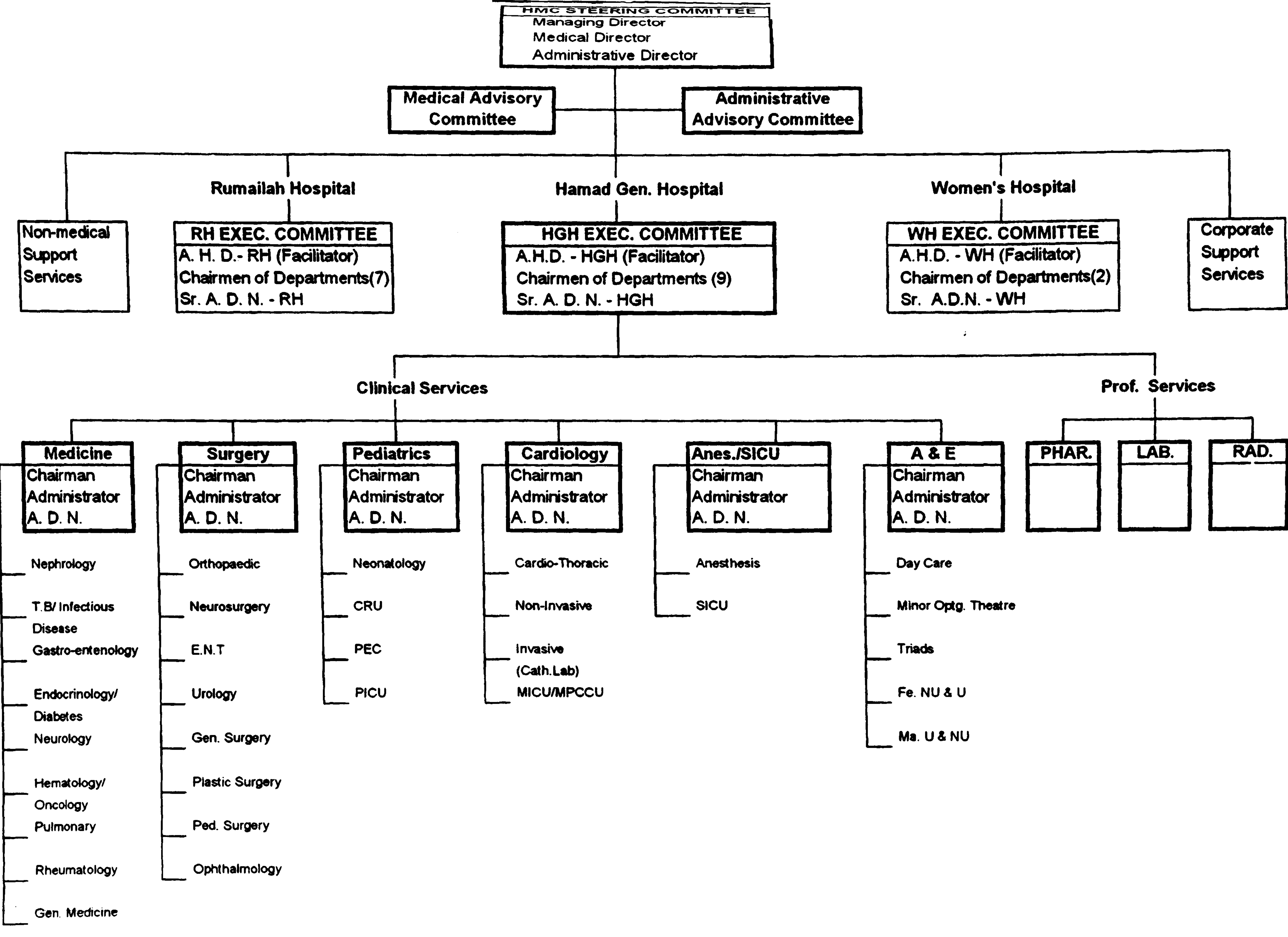
Physical Med.
Chairman
Administrator
A. D. N.
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Prosthetics/Orthotics

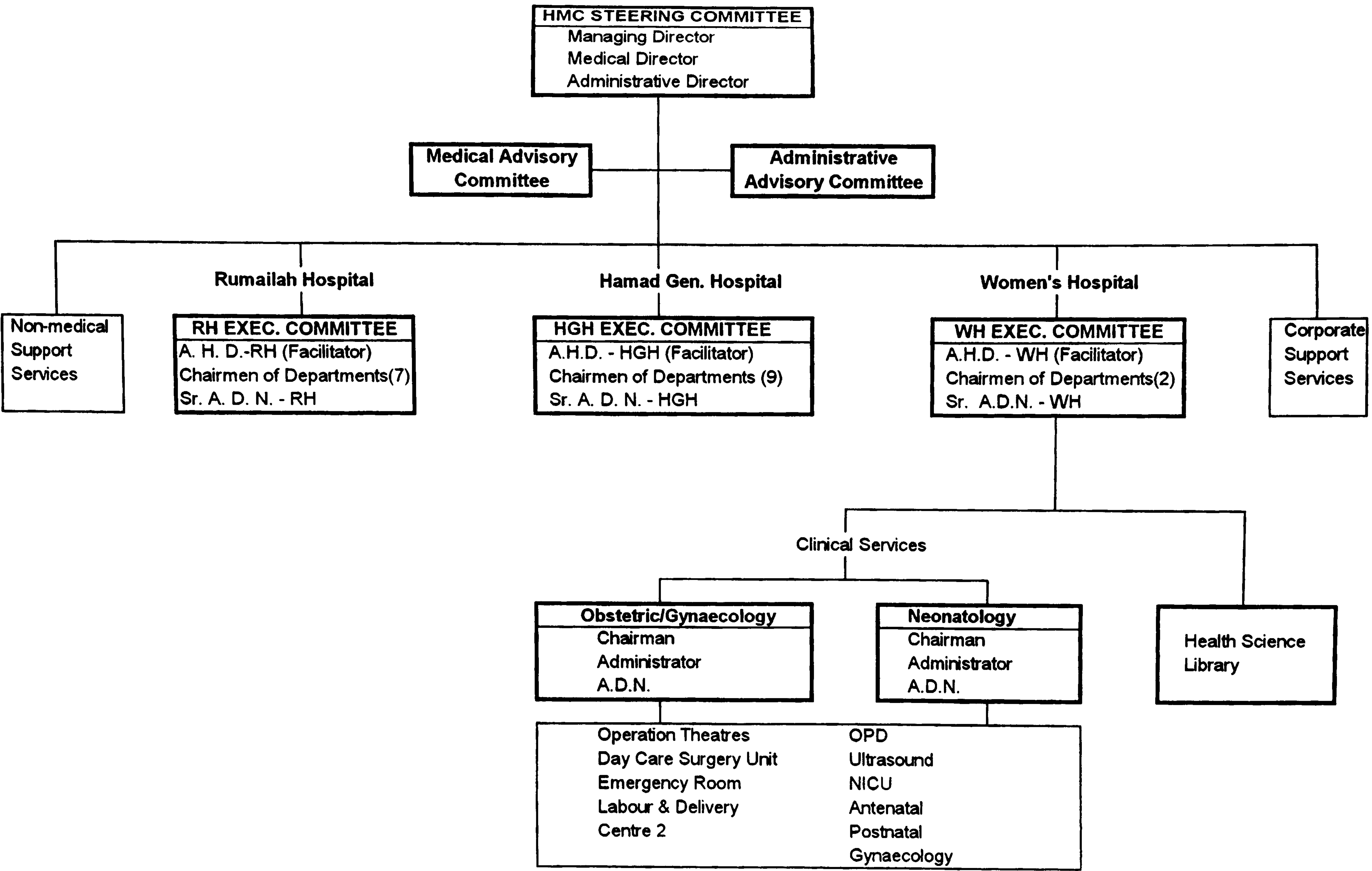
Dental
Chairman
Administrator
A. D. N.
- RH
- OPD Annex

Burns Unit
Chairman
Administrator
A. D. N.

T. B. UNIT
Chairman
Administrator
A. D. N.

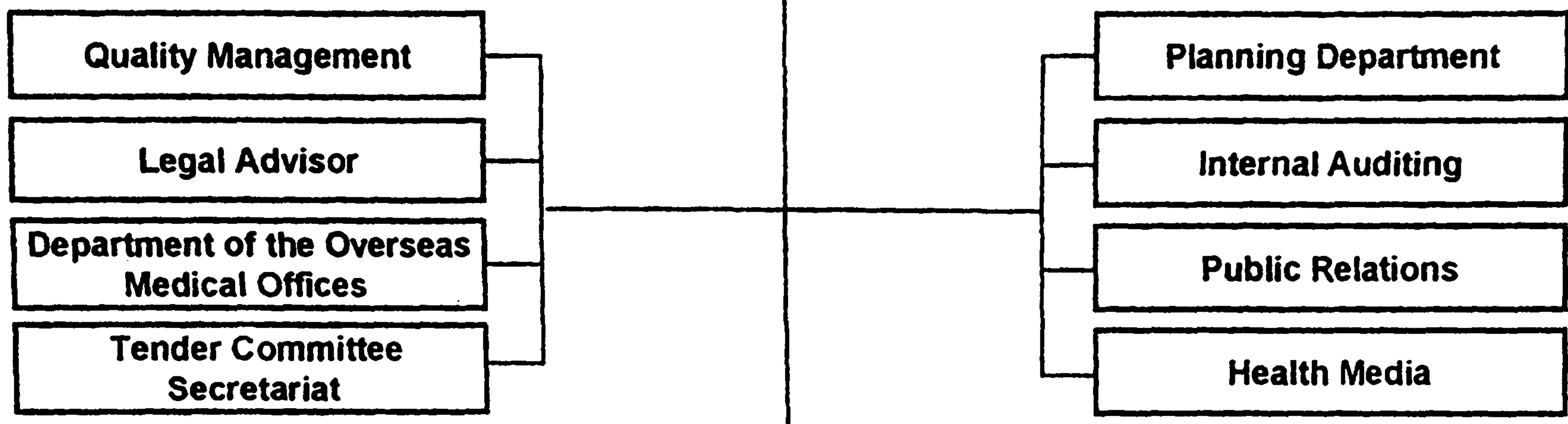
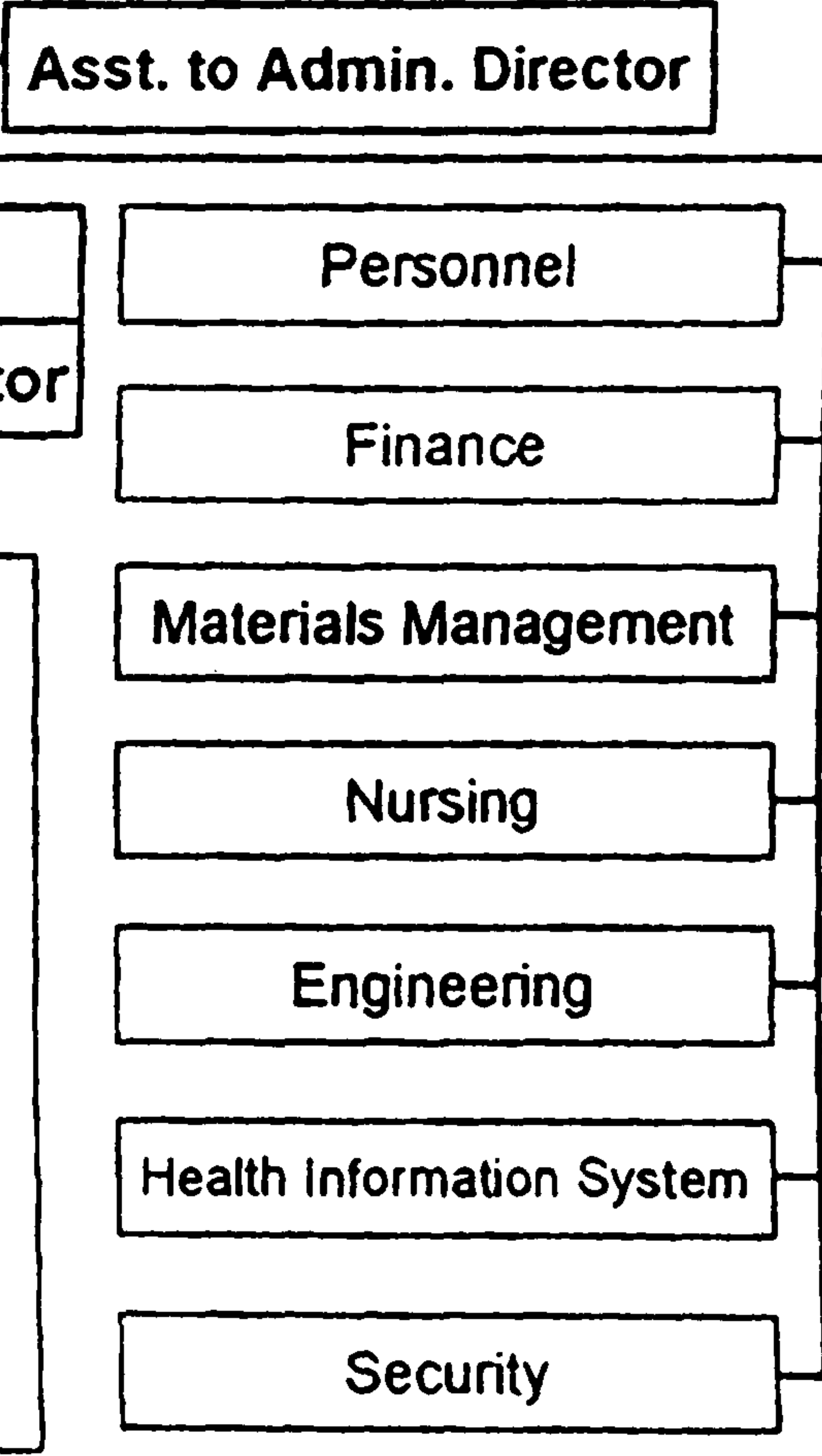
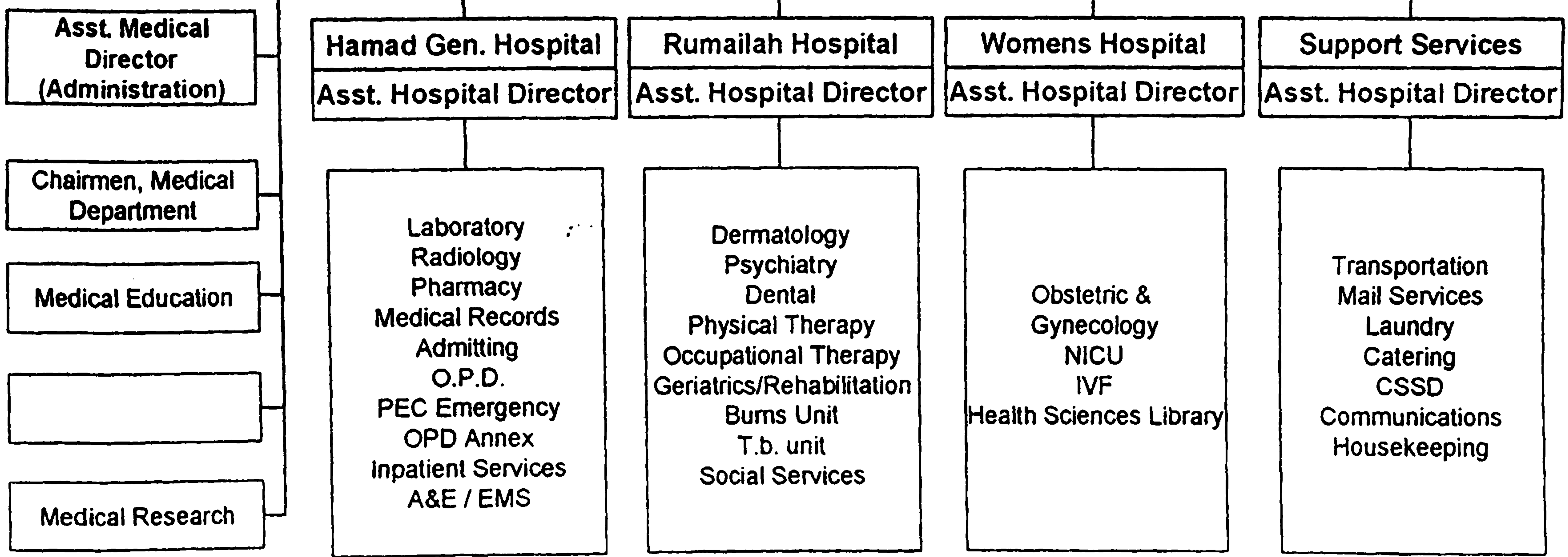
Social Services


HMC STEERING COMMITTEE
Managing Director
Medical Director
Administrative Director
Medical Advisory Committee
Administrative Advisory Committee
Non-medical Support Services
Rumailah Hospital
RH EXEC. COMMITTEE
A. H. D.- RH (Facilitator)
Chairmen of Departments(7)
Sr. A. D. N. - RH
Hamad Gen. Hospital
HGH EXEC. COMMITTEE
A.H.D. - HGH (Facilitator)
Chairmen of Departments (9)
Sr. A. D. N. - HGH
Women's Hospital
WH EXEC. COMMITTEE
A.H.D. - WH (Facilitator)
Chairmen of Departments(2)
Sr. A.D.N. - WH
Corporate Support Services
Clinical Services
Prof. Services
Medicine
Chairman
Administrator
A. D. N.
Nephrology
T.B/ Infectious Disease
Gastro-entenology
Endocrinology/ Diabetes
Neurology
Hematology/ Oncology
Pulmonary
Rheumatology
Gen. Medicine
Surgery
Chairman
Administrator
A. D. N.
Orthopaedic
Neurosurgery
E.N.T
Urology
Gen. Surgery
Plastic Surgery
Ped. Surgery
Ophthalmology
Pediatrics
Chairman
Administrator
A. D. N.
Neonatology
CRU
PEC
PICU
Cardiology
Chairman
Administrator
A. D. N.
Cardio-Thoracic
Non-Invasive
Invasive (Cath.Lab)
MICU/MPCCU
Anes./SICU
Chairman
Administrator
A. D. N.
Anesthesis
SICU
A & E
Chairman
Administrator
A. D. N.
Day Care
Minor Optg. Theatre
Triads
Fe. NU & U
Ma. U & NU
PHAR.
LAB.
RAD.


HMC STEERING COMMITTEE
Managing Director
Medical Director
Administrative Director
Medical Advisory Committee
Administrative Advisory Committee
Rumailah Hospital
Hamad Gen. Hospital
Women's Hospital
Non-medical Support Services
RH EXEC. COMMITTEE
A. H. D.-RH (Facilitator)
Chairmen of Departments(7)
Sr. A. D. N. - RH
HGH EXEC. COMMITTEE
A.H.D. - HGH (Facilitator)
Chairmen of Departments (9)
Sr. A. D. N. - HGH
WH EXEC. COMMITTEE
A.H.D. - WH (Facilitator)
Chairmen of Departments(2)
Sr. A.D.N. - WH
Corporate Support Services
Clinical Services
Obstetric/Gynaecology
Chairman
Administrator
A.D.N.
Neonatology
Chairman
Administrator
A.D.N.
Health Science Library
Operation Theatres
Day Care Surgery Unit
Emergency Room
Labour & Delivery
Centre 2
OPD
Ultrasound
NICU
Antenatal
Postnatal
Gynaecology

ANNEX 27 HMC FORMAL ORGANIZATIONAL STRUCTURE, 1999.

Hamad Medical Corporation
Organizational Structure

ANNEX 28 LIST OF CORPORATE STRUCTURE STRENGTHS

- Independence from Civil Services (mentioned 5 times / 22 responses to this question)
- Easy to reach top management and they (people in responsibility) listen (4/22)
- Clear hierarchy/lines of communication (4/22)
- Has hard working/disciplined staff (3/22)
- Top management quick decision makers (2/22)
- Top management recognizes hard working staff (2/22)
- Top management receives all needed information (1/22)
- Encourages coordination and decentralization (1/22)

ANNEX 29 LIST OF CORPORATE STRUCTURE WEAKNESSES

LIST OF CORPORATE STRUCTURE WEAKNESSES
Very centralized decision making/management (43 times)
Demoralized/demotivated/insecure staff (21 times)
No clear roles and functions (11 times)
Weak administrative processes (11 times)
Description in applying rules and regulations (11 times)
No planning (10 times)
No communication mechanisms (8 times)
Relies heavily on individual's character (8 times)
Favoritism (8 times)
No clear documented processes (7 times)
Weak salaries (6 times)
No career development (6 times)
Unclear/dual reporting (hospital vs. corporate departments) (5 times)
Some heads take advantage of posts for personal benefit (4 times)
Individual/departments forget corporate mission of patient care (4 times)
People misplaced in posts (4 times)
Interferences from Corporate Departments in hospital management (3 times)
Some departments think they can function in isolation (3 times)
No training to work with this structure (3 times)
Need new staff (2 times)
Structure changes to suit individuals in posts (2 times)
Deviated from primary goal (referral hospital) (1 time)
High turnover in administration (1 time)
No medical audit (1 time)
Not decided if wants decentralization (1 time)
Grey areas (1 time)
No meetings (1 time)
No accountability (1 time)
Weak/inefficient staff (1 time)
No computerization (1 time)
Too much bureaucracy (1 time)
Too many committees (1 time)
Aspects of matrix and centralized structure (1 time)
Relies on personal contacts for coordination (1 time)

ANNEX 30 WEAKNESSES OF DEPARTMENTAL STRUCTURE

Department Structure Weaknesses	Times mentioned
Too centralized	21
Staff posts and grades not right	13
Unclear/dual reporting	5
Department just grew in size with no structure	4
Needs complete restructuring	4
Structure not changed as organization changes	3
Still new- under development	3
Relies heavily on character of superior	3
Problem not structure but process	2
No communication between hospital levels	2
Not being implemented	2
Turnover in administration thus no continuity	2
Work scattered	1
Too many committees	1
Departments build empires	1
Physically far	1
Too big	1

ANNEX 31 METHODS OF IMPROVING DEPARTMENT STRUCTURE

Method to Improve Department Structure	Times mentioned
Changing/Adding posts	16
Decentralize	12
Changing/adding sections	11
Changing grades	9
Changing procedures/business process engineering	5
More organized	5
Better trained staff	5
Focus on HMC objectives don't detract	2
Better communication between hospital levels	1
Departmental committees/meetings	1
Multiprofession committees/meetings	1
More space	1
Involvement in decision making	1
Better problem solving	1
New medical instead of administrative in charge	1
Clear roles/job descriptions/functions	1

ANNEX 32 CULTURAL CHARACTERISTICS BY HOSPITAL

Table of Characteristics found to describe HMC by Hospital (not shared perceived characteristics in bold):

HGH:	WH:
▪ Develops new services ▪ Focuses on patient satisfaction ▪ Encrourages the use of limited resources effectively ▪ Values training and development ▪ Focuses on improving work processes ▪ Focuses on gaining confidence of patients ▪ Encourages experimenting new techniques ▪ **Encourages teamwork** ▪ Checks and focuses on quality in performance ▪ Promotes respecting the chain of command	▪ Focuses on patient satisfaction ▪ Focuses on gaining confidence of patients ▪ Values and participates in training and development ▪ Encourages establishing clear, well documented work processes and policies ▪ Develops new services ▪ Promotes respecting chain of command ▪ Focuses on improving work processes ▪ Encourages the use of limited resources effectively ▪ Encourages experimenting new techniques ▪ Checks and focuses on quality in performance
RH:	Corp. Depts:
▪ Focuses on patient satisfaction ▪ Focuses on gaining confidence of patients ▪ Checks and focuses on quality in performance ▪ Develops new services ▪ Encourages the use of limited resources effectively ▪ **Encourages loyalty and commitment to the corporation** ▪ Values and participates in training and development ▪ Encourages establishing clear, well documented work processes and policies ▪ Promotes respecting the chain of command ▪ Encourages experimenting new techniques	▪ Focuses on patient satisfaction ▪ Develops new services ▪ Focuses on gaining confidence of patients ▪ Values and participates in training and development ▪ **Tolerates well-meaning mistakes** ▪ Focuses on improving work processes ▪ Encourages the use of limited resources effectively ▪ Promotes respecting the chain of command ▪ **Encourages loyalty and commitment to the Corporation** ▪ **Uses all opportunities**

ANNEX 33 CULTURAL CHARACTERISTICS BY PROFESSION

Table of Characteristics found to describe HMC by Profession(not shared perceived characteristics in bold)

MEDICAL:	NURSING:
▪ Focuses on patient satisfaction ▪ Values and participates in training and development ▪ Develops new services ▪ Focuses on gaining confidence of patients ▪ Encourages the use of limited resources effectively ▪ Focuses on improving work processes ▪ Checks and focuses on quality in performance ▪ **Rewards superior performance** ▪ Encourages experimenting new techniques ▪ **Attracts top talents**	▪ Focuses on patient satisfaction ▪ Focuses on improving work processes ▪ Develops new services ▪ Focuses on gaining confidence of patients ▪ Values and participates in training and development ▪ Encourages establishing clear, well documents work processes and policies ▪ Encourages the use of limited resources effectively ▪ Checks and focuses on quality in performance ▪ **Encourages teamwork** ▪ Promotes respecting chain of command
ADMINISTRATION:	**PARAMEDICAL:**
▪ Focuses on patient satisfaction ▪ Develops new services ▪ **Tolerates well meaning mistakes** ▪ Focuses on gaining confidence of patients ▪ Values and participates in training and development ▪ Promotes respecting the chain of command ▪ Encourages the use of limited resources effectively ▪ Encourages establishing clear, well documented work processes and policies ▪ Focuses on improving work processes ▪ Encourages experimenting new techniques	▪ Encourages experimenting new techniques ▪ Develops new services ▪ Encourages the use of limited resources effectively ▪ Focuses on improving work processes ▪ Checks and focuses on quality in performance ▪ Focuses on patient satisfaction ▪ Promotes respecting the chain of command ▪ **Tolerates well-meaning mistakes** ▪ Focuses on gaining confidence of patients ▪ Values and participates in training and development
THERAPY:	**SUPPORT SERVICES:**
▪ Encourages the use of limited resources effectively ▪ Promotes respecting the chain of command ▪ Develops new services ▪ **Tolerates well-meaning mistakes** ▪ Focuses on improving work	▪ Develops new services ▪ Focuses on patient satisfaction ▪ Encourages establishing clear, well documented work processes and policies ▪ Promotes respecting the chain of command

processes ▪ **Encourages loyalty and commitment to the Corporation** ▪ Values and participates in training and development ▪ Focuses on patient satisfaction ▪ Encourages establishing clear, well documented work processes and policies ▪ Checks and focuses on quality in performance	▪ Focuses on gaining confidence of patients ▪ Checks and focuses on quality in performance ▪ Focuses on improving work processes ▪ **Encourages loyalty and commitment to the Corporation** ▪ Values and participates in training and development ▪ **Encourages initiative and innovation**
CORPORATE DEPTS: ▪ Focuses on patient satisfaction ▪ Develops new services ▪ Focuses on gaining confidence of patients ▪ Focuses on improving work processes ▪ Values and participates in training and development ▪ **Uses all opportunities** ▪ Encourages the use of limited resources effectively ▪ Encourages experimenting new techniques ▪ **Tolerate well-meaning mistakes** ▪ **Encourages teamwork**	

ANNEX 34 ADVICE TO COLLEGUES JOINING HMC FOR THE FIRST TIME

Advices to Colleagues joining HMC for the first time

Advices	**Score (times mentioned)**
Use opportunities/facilities available	1
Be alert at all times	1
Have a high self-esteem/ don't be sensitive	1
Be a fighter	1
Feel you belong to Corporation	1
Don't listen/believe promises	2
Learn the local language	2
Accept corrections	3
Do best to maintain standard of Corporation	4
Develop interpersonal skills	4
Keep focused on your work at all times	5
Produce good quality work	5
Respect State, its policies and culture	6
Don't hesitate to ask questions/advice	7
Motivate yourself	7
Communicate through formal channels/respect chain of command	8
Don't compare yourself to others/ don't expect equal/fair remuneration	8
Don't expect recognization/rewards/better remuneration	8
Don't listen/believe in rumours and intrigues	10
Plan and organize your work to achieve plans	11
Think seriously before joining/don't join/look for another job	12
Be creative/innovative	12
Know/understand organization/contract before applying/signing	13
Know your job/job description	14
Co-operate and have good working relations with co-workers	16
Be flexible to changes, adaptative and open minded	16
Participate in team work/ work as member of team	16
Be polite, respectful, honest, with high morals smiling and presentable	21
Be productive	22
Don't be discouraged/demotivated easily; be patient	23
Keep patients centre of your work, focus on patient satisfaction	23
Motivate yourself into professional development/unit development	27
Work professionally	29
Be sincere and loyal towards your job	35
Know and abide by HMC structure, rules and regulations	46
Total:	**420**

ANNEX 35 SKILLS AND TRAINING BY PROFESSION TABLES

35.1 Perceived Medical Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	7	27	24	1		3	62
WH	2	18	10	1		4	35
RH	3	14	11			1	29
CD	8	20	7	1	1	8	45
Total	**20**	**79**	**52**	**3**	**1**	**16**	**171**
Percentage	**12%**	**46%**	**30%**	**2%**	**1%**	**9%**	**100%**

35.2 Perceived Nursing Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	9	30	21		1	1	62
WH		25	7	2		1	35
RH	5	14	8	2			29
CD	7	22	8	1		7	45
Total	**21**	**91**	**44**	**5**	**1**	**9**	**171**
Percentage	**12%**	**53%**	**26%**	**3%**	**1%**	**5%**	**100%**

35.3 Perceived Paramedical Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	4	23	26	3	1	5	62
WH		18	12			5	35
RH	1	10	15	2		1	29
CD	4	15	15	3		8	45
Total	**9**	**66**	**68**	**8**	**1**	**19**	**171**
Percentage	***5%***	***39%***	***40%***	***5%***	***1%***	***11%***	***100%***

35.4 Perceived Therapy Staff Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	6	17	31	1	1	6	62
WH	1	15	11			8	35
RH	1	4	17	5		2	29
CD	5	13	16	1		10	45
Total	**13**	**49**	**75**	**7**	**1**	**26**	**171**
Percentage	***8%***	***29%***	***44%***	***4%***	***1%***	***15%***	***100%***

35.5 Perceived Administrative Staff Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	5	18	26	4	1	8	62
WH	5	13	9	1		7	35
RH	3	11	12	2		1	29
CD	1	21	11	3	1	8	45
Total	**14**	**63**	**58**	**10**	**2**	**24**	**171**
Percentage	*8%*	*37%*	*34%*	*6%*	*1%*	*14%*	*100%*

35.6 Perceived Corporate Staff Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	4	14	31	3	1	9	62
WH	3	16	8	1		7	35
RH	2	9	13	2		3	29
CD	2	19	14	3		7	45
Total	**11**	**58**	**66**	**9**	**1**	**26**	**171**
Percentage	*6%*	*34%*	*39%*	*5%*	*1%*	*15%*	*100%*

35.7 Perceived Support Services Staff Skills and Training

Hospital	Extremely high	Good	Average	Poor	No skills and training	Missing	Total
HGH	4	13	31	4	1	9	62
WH		11	12	2	1	9	35
RH	1	9	12	4	1	2	29
CD	3	17	16	4	1	4	45
Total	**8**	**50**	**71**	**14**	**4**	**24**	**171**
Percentage	*5%*	*29%*	*42%*	*8%*	*2%*	*14%*	*100%*

ANNEX 36 MORALE BY PROFESSION TABLES

36.1 Perceived Morale of Administrative Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH	1	13	37	3	1	7	62
WH	4	13	11	1		6	35
RH	2	9	9	4		5	29
CD	4	11	12	8	2	8	45
Total	**11**	**46**	**69**	**16**	**3**	**26**	**171**
Percentage	*6%*	*27%*	*40%*	*9%*	*2%*	*15%*	*100%*

36.2 Perceived Morale of Corporate Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH	1	12	36	4		9	62
WH		13	15	2		5	35
RH	1	8	11	2	1	6	29
CD	4	10	12	10	2	7	45
Total	**6**	**43**	**74**	**18**	**3**	**27**	**171**
Percentage	*4%*	*25%*	*43%*	*11%*	*2%*	*16%*	*100%*

36.3 Perceived Morale of Support Services Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH	2	9	37	6	1	7	62
WH		9	17	3		6	35
RH		4	12	5	4	4	29
CD	1	9	17	10	4	4	45
Total	**3**	**31**	**83**	**24**	**9**	**21**	**171**
Percentage	*2%*	*18%*	*49%*	*14%*	*5%*	*12%*	*100%*

36.4 Perceived Morale of Medical Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH	1	13	39	6		3	62
WH		9	19	3		4	35
RH		7	12	7	1	2	29
CD	2	13	18	6		6	45
Total	**3**	**42**	**88**	**22**	**1**	**15**	**171**
Percentage	*2%*	*25%*	*51%*	*13%*	*1%*	*9%*	*100%*

36.5 Perceived Morale of Nursing Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH		16	31	12	2	1	62
WH	1	7	17	7	1	2	35
RH	1	7	12	4	4	1	29
CD	2	12	17	7	2	5	45
Total	**4**	**42**	**77**	**30**	**9**	**9**	**171**
Percentage	*2%*	*25%*	*45%*	*18%*	*5%*	*5%*	*100%*

36.6 Perceived Moral of Paramedical Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH		14	32	8	1	7	62
WH		11	16	5		3	35
RH		4	16	4	1	4	29
CD	2	8	18	7	1	9	45
Total	**2**	**37**	**82**	**24**	**3**	**23**	**171**
Percentage	*1%*	*22%*	*48%*	*14%*	*2%*	*13%*	*100%*

36.7 Perceived Morale of Therapy Staff

Hospital	Extremely high morale	High Morale	Average Morale	Low Morale	Extremely Low Morale	Missing	Total
HGH	1	9	41	2		9	62
WH		8	18	2		7	35
RH		4	14	3	1	7	29
CD	3	5	20	7		10	45
Total	**4**	**26**	**93**	**14**	**1**	**33**	**171**
Percentage	*2%*	*15%*	*54%*	*8%*	*1%*	*19%*	*100%*