HEALTHCARE

Three Australian whistleblowing sagas: lessons for internal and external regulation

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ABSTRACT

- The protracted and costly investigations into Camden and Campbelltown hospitals (New South Wales), The Canberra Hospital (Australian Capital Territory), and King Edward Memorial Hospital (Western Australia) recently uncovered significant problems with quality and safety at these institutions.
- Each investigation arose after whistleblowers alerted politicians directly, having failed to resolve the problems using existing intra-institutional structures.
- None of the substantiated problems had been uncovered or previously resolved by extensive accreditation or national safety and quality processes; in each instance, the problems were exacerbated by a poor institutional culture of self-regulation, error reporting or investigation.
- Even after substantiation of their allegations, the whistleblowers, who included staff specialists, administrators and nurses, received little respect and support from their institutions or professions.
- Increasing legislative protections indicate the role of whistleblowers must now be formally acknowledged and incorporated as a "last resort" component in clinical-governance structures.
- Portable digital technology, if adequately funded and institutionally supported, may help to transform the conscience-based activity of whistleblowing into a culture of self-reporting, linked to personal and professional development.

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The public inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary is widely regarded as a watershed in the regulation of the medical profession, both in the United Kingdom and elsewhere.[1] Many thought its recommended improvements in clinical governance pathways alone had the capacity to permanently enhance transparency and accountability in healthcare quality and safety.[2] The Bristol Inquiry was provoked by a whistleblower, whose actions caused him to be shunned and vilified by many senior colleagues, to the brink of resignation.[3] Yet, the dominant regulatory paradigm continues to be that whistleblowers are unnecessary in a system with overarching accreditation and regulatory councils, credentialling agencies, adequate peer review, adverse-events and mortality reviews, regular and thorough audits, risk-management strategies, and national data-based sentinel-event reporting.[4] The authoritative assumptions appear to be that individuals motivated by conscience should somehow "evolve" their concerns once they have formally involved the clinical governance system, regardless of how inadequately it performs, that its structures operate best without them, and that it would be best for everyone if whistleblowers simply calmed down. Analysis of the following three healthcare sagas suggests this is not true.

Whistleblowing's uncertain role in Australia

The Australian Council on Healthcare Standards (ACHS) is an institutional accreditation body established in 1974. Ninety percent of the country's healthcare organisations are current members.[5] In 1995, the Quality in Australian Health Care Study retrospectively established that adverse events were still involved in 16.6% of hospital admissions, at a cost of over $1 billion annually.[6] In January 2000, the Australian Council for Safety and Quality in Health Care (ACSQ) was established to lead national efforts to minimise the likelihood and consequences of clinical error.

Both the ACHS and the ACSQ currently emphasise quality-control systems that are predicated on routine professional disclosure of adverse or sentinel events to intra-institutional structures embedded in clinical-governance pathways. Yet, three recent Australian whistleblowing sagas suggest these systems discourage notifiers with the "ticker" to forcefully seek results.

In July 2002, the ACSQ released key findings from the inquiry into obstetrics and gynaecology services at the King Edward Memorial Hospital ("KEM" Inquiry), Perth, Western Australia.[7] The inquiry found that major deficiencies had been uncovered by "whistleblowers", rather than being identified, addressed or prevented through rigorous and routine safety and quality monitoring systems.[7]

Late in 2003, the New South Wales Health Care Complaints Commission (HCCC) handed down the report of its inquiry into safety and quality of care at Campbelltown and Camden hospitals, NSW. The inquiry was prompted by nurses at these hospitals contacting politicians because of a perceived inadequate institutional response to their concerns about patient safety.[8] The HCCC inquiry uncovered significant deficiencies in the standard of care. The investigation of the hospitals is ongoing, with the next report due this month.

Similarly, the report of the inquiry into neurosurgical services at The Canberra Hospital ("TCH" Inquiry) by the Australian Capital Territory Health Complaints Commissioner, released in December 2003, depicted another situation where the actions of a whistleblower, at acknowledged personal cost, were required to initiate a major quality and safety investigation.[9] This inquiry is also

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continuing, with external reviewers from the ACSQ scheduled to report late in 2004.

These three whistleblower-initiated inquiries raise important questions for healthcare regulators.

- Why does whistleblowing continue to play this significant role, despite a generalised reluctance among the profession, as well as accreditation and quality and safety bodies, to encourage or support it?
- Is there a link between this marginalisation of whistleblowers and poor institutional cultures of open disclosure, reporting, investigation and improvement?

Campbelltown and Camden hospitals inquiry

The HCCC Inquiry into Campbelltown and Camden Hospitals in the Macarthur Health Service (MHS) was initiated when nurses at these hospitals (including Nola Fraser, Yvonne Quinn, Vanessa Bragg, Sheree Martin and Valerie Owen) complained and later met with the NSW Minister for Health on 5 November 2002, after their and other nurses' intra-institutional attempts to improve patient care and safety were frustrated. The nurses' complaints related to a time when both hospitals had been partially accredited by ACHS.[5] The report of the Inquiry noted that "the nurse informants have paid a high personal price for their decisions to come forward. Some are no longer working as nurses or are not working at all. Those still working at the MHS report vilification and isolation by some of their colleagues because of the criticism of the health service brought about by the investigation."[8]

The most significant findings of the HCCC Inquiry were:

- Variability in staff reporting adverse events because of inappropriate culture and behaviour of different professional groups.
- Lack of positive feedback from management to staff who reported issues of quality and safety.
- Delay and failure by management in reviewing reports and implementing remedial action.
- Repeated challenge to the credibility of the whistleblowing nurses, which was not conducive to a culture that promotes safety through open discussion of adverse events.
- Failure by management to monitor and evaluate the implementation and effectiveness of any remedial action recommended.
- Inadequate resourcing of key quality and safety systems and personnel.[8]

The first five findings closely resembled those of the Kennedy Inquiry into Bristol paediatric cardiac services.[1]

Furthermore, public dissatisfaction with the results of the HCCC Inquiry led to the Minister establishing a Special Commission of Inquiry under the *Special Commissions of Inquiry Act* 1983 (NSW). The first report of this Inquiry, on 30 March 2004, found that the NSW HCCC improperly examined the 70 complaints made to them on this issue.[10] It also found that the HCCC failed to hold staff whose conduct was inadequate sufficiently accountable. A major lesson from the institutional response to the nurses' concerns may be that the expensive, ad-hoc, "catch-up" response involved in such inquiries does little to change institutional cultures and increase respect for the professional virtues that promote open disclosure. The HCCC Inquiry and subsequent related investigations came too late to transparently and efficiently balance public safety against the protection of organisational and professional reputation.[11]

King Edward Memorial Hospital inquiry

Throughout the 1990s, medical and nursing staff at King Edward Memorial (KEM) Hospital, in Western Australia, repeatedly and without result raised concerns with management about high error rates and a culture among consultants that minimised accountability and supervision of junior staff. During this period, the hospital regularly received ACHS accreditation focused on the nominal existence of structures and processes.[12] In 1999, a newly appointed Chief Executive Officer (CEO), Michael Moodie, wrote to the Metropolitan Health Service Board providing evidence of major quality and safety deficiencies. In doing so, as the investigation expressly recognised, the CEO was joining the ranks of whistleblowers. The deficiencies he highlighted included:

- Substandard patient care.
- Problems identifying and rectifying clinical issues by senior management.
- Inadequate systems to monitor and report adverse clinical incidents.
- Absence of a proper and transparent system to deal with patient complaints and claims.
- Lack of an overall clinical quality management system.
- Shortage of qualified clinical specialists, particularly after hours.
- Inadequate supervision of junior medical staff.[7]

The first three of these problems closely resembled inadequacies uncovered by the Bristol inquiry.[1]

The Health Service Board commissioned an investigation by an independent senior clinician, which was followed by a further 2-week review.[13] The CEO attempted to implement the resulting recommendations, but many senior clinicians questioned his own competence and refused to cooperate. One sought unsuccessfully to obtain a permanent injunction against release of the report.[7] The CEO was forced to resign.

The Minister for Health, in consultation with the WA Premier, finally established a formal KEM Inquiry lasting 2 years and costing $7 million. Its recommendations on quality and safety emphasised:

- The need for strong, sustained leadership supporting a culture of open disclosure, transparency and effective response to the performance problem.
- A rigorous third-party accreditation system that assured acceptable practice and performance standards.
- Practical and useful data collection systems for interhospital comparisons.
- Standardised credentialling systems that ensure clinicians have appropriate skills and training.
- Reliable and consistent incident and adverse-event reporting systems and follow-up processes.
- Clear and tenable statutory requirements and systems for mortality reporting and investigation.[7]

Active steps have been taken to implement these recommendations.[14]

The Canberra Hospital inquiry

In December 2000, a rehabilitation physician at The Canberra Hospital (TCH), Gerard McLaren, frustrated by his protracted unsuccessful efforts to address patient safety concerns, convinced the ACT Minister for Health to order the ACT Health Complaints Commissioner to conduct an inquiry into neurosurgical services at

Comparison of whistleblowing "sagas" at The Canberra Hospital, King Edward Memorial Hospital, and Camden and Campbelltown ("Cam") hospitals

Characteristics shared by all three:

- Problem not detected by sentinel-event reporting.
- Senior clinicians viewed clinical governance structures as adequate at time of complaint.
- Whistleblower(s) discouraged and criticised by the institution.
- Direct approach to politicians needed.
- Poor institutional culture proven.
- More than one inquiry held.

Characteristics shared by two:

- Attempt to suppress report (The Canberra Hospital and King Edward Memorial Hospital).
- Whistleblower(s) complaint(s) conclusively proven ("Cam" hospitals and King Edward Memorial Hospital); at The Canberra Hospital, the first inquiry was "critical of standard of care"; findings of second inquiry are pending.

Professions of whistleblower(s) differed:

- Staff specialist (The Canberra Hospital)
- Nurses ("Cam" hospitals)
- Administrator (King Edward Memorial Hospital).

the hospital. The Commissioner's report was completed 2 years later. Although critical of the standard of care, it acknowledged that the inquiry was so hampered by clinicians' reluctance to provide evidence as to render impractical a finding on the issue.[15] The report was not made public.

However, early in October 2003, the Commissioner summarised the major findings of the TCH Inquiry in his annual report.[15] He mentioned the extent to which a poor institutional environment of self-regulation had hindered his efforts. He noted in particular:

- The staff specialist complainant had acted appropriately in raising these issues, but found himself in an "uncomfortable and vulnerable" position.
- Some surgeons claimed not to be able to comment on another surgeon's patients, thus compromising peer review.
- Some health professionals failed to meet their statutory obligations to assist the Commissioner's investigation, thus further compromising peer review.
- The information made available to the Commissioner was insufficient to allow him to form a final view about the standard-of-practice issues.
- Further investigation would have been necessary if the changes had not occurred to make a definitive finding.[15]

The first two deficiencies were similar to those uncovered by the Bristol inquiry.[1] The "changes" referred to involved the voluntary agreement of a neurosurgeon to cease operating at the hospital. The hospital had been accredited by ACHS during this period.[5]

The staff-specialist whistleblower was chastised by colleagues and threatened with defamation proceedings when he attempted to present anonymised cases from the suppressed report in a hospital grand rounds (personal observation of the authors, who were present). Continuing community and academic pressure saw the Health Minister, on 9 December 2003, finally table the Inquiry's report in the ACT Legislative Assembly. Its findings raised sufficient concern to justify a further, external investigation, involving reconsideration of all cases initially examined, as well as review of all cases managed by a particular neurosurgeon over a selected 6-month period. It also prompted the establishment of a "hotline" for concerned patients, which received about 200 responses.[9]

Discussion

Each of these inquiries validated whistleblowers' claims of suboptimal clinical practice sufficient to cause significant patient harm or unnecessary deaths. However, these inquiries were *ad hoc* and failed to conform to many basic standards of qualitative methodology.[16] All arose after establishment of, but not as a result of, attempts by the ACHS to assist public safety through accreditation, and by the ACSQ to improve sentinel incident-reporting and clinical-governance systems.

Each Australian state now has legislation legitimising the persistence of whistleblowers by offering them protection[17] (although institutional reprisals can often be carefully disguised as challenges to competence). Many states are now also considering legislation obliging practitioners to report impaired colleagues.[18] Despite this, whistleblowers continue to suffer from the myth of being vindictive "informers" whenever they challenge the prevailing institutional and regulatory culture of secrecy and self-protectionism. Whistleblowing involving reasonable and not vexatious complaints, made in good faith and in the public interest, is firmly supported by law.[17] It is illogical and counterproductive for it to be excluded from clinical governance pathways and structures for adverse-event reporting.

It is unlikely that optimal clinical governance structures, including limited screening for adverse occurrences, would have detected and remedied the deficiencies in the cases discussed.[19] Limited screening involves screening hospital records that have a high probability of containing an adverse event.[20] The gap in consistently changing performance would remain.

Creating clinical-governance structures, such as committees for privileged review of mortality and adverse events, is manifestly important to healthcare quality and safety. However, these inquiries show that the function of these structures may be distorted by negative institutional and political cultures. In the UK National Health Service, half the healthcare professionals who had detected a colleague's error or incompetence remained inhibited about reporting it.[21] Common explanations were that they "feared retribution", "didn't want to cause trouble", "wouldn't have been listened to" and that "no one would support me".[21] An important lesson from these three Australian whistleblowing sagas may be that many of the current practices of Australian accreditation organisations, as well as quality and safety organisations, appear to deflect whistleblowers' criticism of the system and those in charge of it. Overemphasis on these practices may be actively suppressing the positive institutional culture of open disclosure that the organisations themselves report as crucial.

The task of transforming whistleblowing in modern healthcare systems into a national standards framework of self-reporting, open disclosure and continuous revalidation has become the responsibility of practitioners willing to systematically monitor and improve their own professional behaviour and the behaviour of those they supervise. Resident and registrar trainees can be rapidly trained (in under 6 weeks) to report 98% of critical incidents occurring in their practice (95% CI, 96.9%–100%), using performance indicators programmed into portable digital

technology.[22] Furthermore, 50% of the incidents so reported result in minor or no adverse outcomes for the patient and probably represent the "near miss" incident data that have been the "holy grail" of safety experts in healthcare for over a decade (unpublished data, available on request from SNB). This type of highly successful self-reporting (or personal whistleblowing) should, but currently does not, receive funding and support from the major Australian quality and safety organisations.[23] It could apply to all health professionals and students.[24] Constant peer and self-review are likely to be more efficient means of remedying impaired staff performance than delayed, retrospective evaluations from sentinel reporting and medical-record review.[25] The need is urgent. The time for change in the Australian healthcare quality and safety agenda is now.

Competing interests

None identified.

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Original paper

How important are quality and safety for clinician managers? Evidence from triangulated studies

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Abstract

Aims to discover the work hospital clinician managers think they do and observe them in practice. A total of 14 managerial interests and concerns were identified in focus group discussions. Clinician managers' jobs are pressurised, and are more about negotiation and persuasion than command and control. Their work is of considerable complexity, pace and responsibility and it is predicated more on managing inputs (e.g. money and people) than care processes, systems, outputs and outcomes. Thus the capacity of clinicians in these roles to respond to reforms such as those envisaged in the Bristol Inquiry may be problematic. Qualitative studies are re-affirmed as important in providing grounded insights into not only clinical activities, but also organisational behaviour and processes.

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Introduction

Organisational researchers have long sought to document what managers do when they practise management. Beginning with a seminal study by Carlson (1951), followed by contributions from Mintzberg (1971), Stewart (1967, 1998) and Kotter (1982a), managerial empiricists have assembled a body of evidence on the scope and modes of managerial work activity. A major finding is that managerial work is not conducted in the orderly, measured mode that the earliest literature supposed and prescribed (e.g. Urwick, 1938). Managers do not systematically carry out pre-determined functions like planning, leading, organising and coordinating (Fayol, 1949). Instead, managers are busy and reactive. Their work is fragmented, discontinuous and unpredictable.

Managers' days are governed by demanding schedules which include many arranged meetings interspersed with unanticipated face-to-face and telephone encounters. They spend much intellectual energy sensemaking (Weick, 1995) - i.e. working out "what is going on around here". There is little evidence that managers plot strategy or devise policy in a masterfully imperious way. An apt metaphor for the organisational manager is not chess grandmaster but perpetual juggler or even reactive puppet.

There is widespread support in the medical literature for the establishment of clinician management structures in hospitals (Sang, 1993; Hickie, 1994; Heyssel *et al.*, 1984; Smith *et al.*, 1989; Chantler, 1989) but there is little empirical and theoretical understanding of how clinician managers conceptualise and do management. Articles (often editorial or anecdotal contributions) that have discussed the tasks, functions or problems facing clinician managers have emphasised their many challenges and responsibilities. These include the difficulties in facing and overcoming resistance to change (Degeling, 1992), grappling with both the clinical and resource dimensions of care (Fitzgerald and Sturt, 1992; Packwood *et al.*, 1991; Rea, 1995), complexities inherent in managing autonomous

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professionals (Quinn *et al.*, 1996), ethical and other difficulties faced by clinician managers in allocating and utilising resources (Lemieux-Charles *et al.*, 1993), and deep-seated conflicts between managers and professionals (Raelin, 1986; Degeling, 1994; Southon, 1996).

Commentators have pointed to the time pressures placed on clinician managers if they continue simultaneously, as many do, as part-time practising clinicians (Willcocks, 1993). The literature also highlights the need for managerial training for clinician managers (Prideaux, 1993); the need for them to play a leading role in addressing shortfalls in information systems (Braithwaite, 1993; Thomas *et al.*, 1995); and the importance of acquiring skills in implementing tools and approaches such as clinical pathways, quality improvement, evidence-based medicine and utilisation review to manage acute care processes, costs and outcomes (Coast, 1996; Braithwaite *et al.*, 1995; Graham and De Porter, 1991). Ever since the systems and management failures which compromised patient care at Bristol in the NHS and more recently now the Inquiry's findings have been released (Kennedy, 2001), these roles and how they are carried out have assumed greater importance. Clinician managers are part of the front line - some of the primary cogs in the wheel - in the effort to provide safe systems of care, continuous improvement, and to secure sound outcomes.

Clinician managers thus bear considerable responsibilities for managing acute health care processes. We know about the importance of their work anecdotally and have a generalised perspective of the problems they face. However, we lack systematic baseline data on their behaviour, and a framework for understanding their managerial activities. An important step in the examination of clinician managers' work is to hear what they say they do and examine whether this is consistent with how they behave.

Methods

We sought to develop a grounded theory (Glaser and Strauss, 1967) of clinician managers' work activity through a triangulation technique in which corroborating data were sought from four sources. First, detailed participant ethnographic work was conducted in one teaching hospital between 1989 and 1994 by the first-named author as it restructured into clinical directorates (Braithwaite, 1995; Hickie, 1994). Second, four focus groups of Australian hospital clinician managers were held during 1996 and 1997. Participants (25 males, 39 females) were clinicians (n = 52) and business managers (n = 12) working in clinical directorates. The clinician groups comprised 14 medical managers, 29 nurse managers and nine allied health managers. Numbers in focus groups ranged from ten to 23. Participants were asked to discuss their experiences in clinical management, the management work they did, the demands placed upon them and how they balanced the demands.

The discussions were taped, transcribed and content-analysed (Krippendorf, 1980; Berelson, 1952; Holsti, 1963) using the software package Textpack version 5.0 (Mohler and Zuell, 1995). We followed Weber (1990) in the text analysis, and ignored frequently used words such as functors and articles (e.g. the, and, that), words derived from the verb to be (e.g. is, are) and ambiguous words. Words were then categorised using a grounded process in which logically related word types that exhibit "family resemblances' (Wittgenstein, 1953) were clustered to identify managers' work interests and concerns, their orientation toward their work, and the organisational roles and positions with which they identified.

Third, a complementary analysis of the transcripts was conducted by a panel of four experts with extensive knowledge of, and experience in, the participants' professions. Experts held a postgraduate qualification in either management or health administration in addition to their professional qualification. Panellists were instructed to interpret and summarise what was being said by providing answers to four questions (see Table I). Following the University of California at Los Angeles/Rand Corporation (UCLA/RAND) method (Fink *et al.*, 1987) they reviewed individually and then met as a group to resolve controversy, reduce error, encourage consensus and minimise dispersal of ratings (Fink, 1997). This process provides a means of improving the study's construct validity.

Table I Expert panellists' responses to the focus group discussions

Question	Summary of responses
What do the focus group transcripts and data say to you about management in clinical settings?	Clinician managers are: Striving for improvement Facing a similar set of interests and concerns Busy and challenged in their work Concerned about insufficient resources by which to manage
How is management being defined by clinician managers?	There are many tasks which clinician managers perform. The main ones centre on: Financial issues General clinical directorate management issues People management issues There is less effort being placed on: Data management Quality improvement
Why have clinician-management posts been created?	For three main reasons: Devolving tasks to those best able to do them Strengthening measures of accountability and responsibility Improving resource management
What benefits emerge from clinician managers' activities?	Effectiveness of management performance is hard to assess Many responsibilities and tasks have been allocated to and accepted by clinician managers Accountability of clinicians and clinical units has sharpened However, clinicians remain autonomous to a considerable extent and there is resistance to some clinician-managers' initiatives

Fourth, case studies were constructed involving non-participant observations of the medical and nurse managers' behaviour in two clinical directorates in two large Australian tertiary referral hospitals of over 800 beds. Staff from all levels and positions were initially interviewed to document background information about the hospital. The four managers were then observed over a six-month period over 1997 and 1998 in their ongoing daily work including management and professional meetings and other workplace activities as well as lunchtime and corridor encounters. Field notes of these observations were created.

Instead of measurements of validity and reliability sought in experiments and clinical trials, qualitative research uses techniques such as triangulation (seeking corroborating data, or identifying divergent information from multiple sources) (Malterud, 2001). In another context, qualitative research processes have been termed "real-time science" (Berwick, 1996). This method can provide insights into how people see and talk about their world and go about their lives in naturalistic settings.

Results

Talking management

The Textpack analysis reduced the 10,830 words managers spoke during the focus groups to 1,112 different types of words. From these 14 categories of interests and concerns emerged. Table II summarises the scope of each lexical category.

Figure 1 shows that participants' most frequently occurring managerial interests and concerns centred on people; organisational/ institutional issues; structure and hierarchy; and financial matters. The emphasis on these four concerns is striking, with more than 50 per cent of substantive words spoken belonging to these categories. The least frequently occurring categories of talk concerned quality issues, data, strategy and planning, and external relationships. Together these accounted for almost 5 per cent of substantive managerial words spoken.

Clinician managers' orientation: sanguine or pessimistic?

In their discussion, the participants were more often optimistic than pessimistic in their

Table II Defining categories of clinician-management interests and concerns

Category	Exemplar words and concepts
People	Staffing, motivating, assigning work, delegating, disciplining
Organisational	Buildings, beds, equipment, reports
Structure and hierarchy	Decentralising, departments, directorates, restructuring
Finance	Budgeting, revenue, accounting, resource management
Customer orientation	Complaints, compliments, customer queries and needs
Education, development	Training, teaching and learning, education
Achievement orientation	Objectives, goals, priorities, results, successes
Change	Inertia, rapid, new ways of working, resistance
Process	Systems, processes, procedures
Decision making	Deciding, decisions, problem resolution, consensus
External relations	Suppliers, external agencies, outside companies
Strategy and planning	Longer term planning, strategic goals, plans
Data	Information, data, information technology
Quality	Continuous improvement, TQM, quality

language, in a ratio of about 3:1. The exception was the financial category. Here there was a reversal. Positive words were outweighed by negative words, in a similar ratio of about 1:3. A vignette from a focus group showing a medical manager's dilemma illustrates this:

> My job is to get the staff to look after the patients and to control the budget and finances and ... um ... to basically promote the staff and the hospital but it is only worthwhile if you make a difference. Recently I read that today's manager is there not only to promote change but to ... er ... cope with change and make a difference. It is very difficult in today's climate to do this. There is a lack of money for various reasons ... under-funding is a very serious issue. The positive side is that adversity leads to a superb team and very good services even under very difficult financial conditions. The challenges for the future are getting some liquid resources and getting back that resource availability, managing the resources, regaining the ability to set priorities ... to nurture and preserve the [quality] ethos.

Clinician managers' attention to roles and positions

Roles and positions were mentioned on 222 occasions in the focus groups. They are classified into five types in Table III - general organisational, divisional, workers and professionals, patient/client and external. Most reference was made to workers and professionals (41 per cent), divisional (41 per cent) and general organisational positions (10 per cent). Fewer than 10 per cent of references were to patients.

Panellists' interpretations

Table I summarises the expert panellists' answers to the questions posed to them in their review of the focus group transcripts.

Ethnographic observations

The ethnographic field work, conducted across more than a decade of observations, showed that the main organisational interests and concerns of clinician managers could be classified using the 14 headings, thereby supporting the validity of the framework. The field notes, which had been written chronologically as the ethnographies progressed over several observational studies, were mapped to the 14 categories exhibited in Table II. They fitted readily into this framework without the need for force, and in similar proportions to the focus group discourse summarised in Table II.

However, the ethnographic observations revealed some activities that could not be classified using the 14 categories. These are best described as social talk and behaviour. The field notes captured as much of the daily lives of the participants as possible, in a detailed, micro-analytic way. This included general conversations, gossip, chat about last night's TV, or the weekend football or cricket results. This intercourse could be construed as "inefficiency" or "non-work". However, it has been known for a long time (Kotter, 1982b) that managers of all types spend a considerable amount of time socialising, telling stories and talking about current events, organisational

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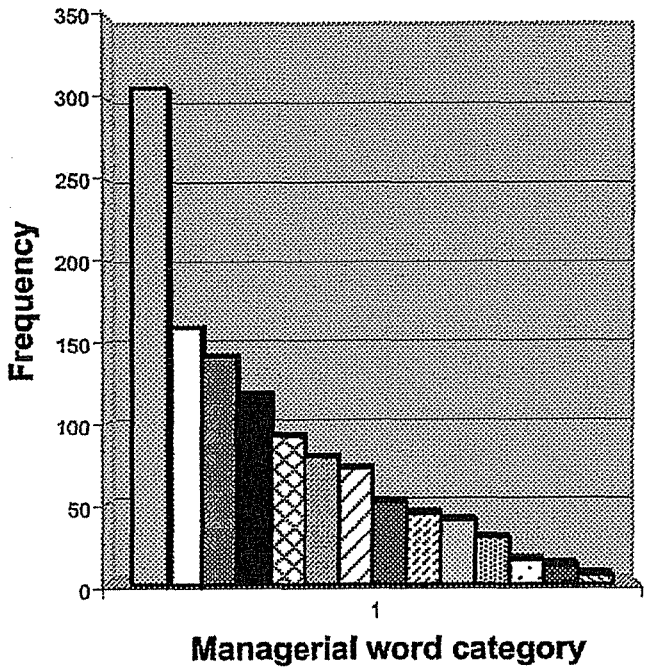
Figure 1 Categorised interests and concerns (n = 1,164) of clinician managers as reflected in their talk



politics, local and world affairs and the like. Thus there could be a fifteenth category of managers' behaviour, namely informal social interaction, not usually discussed under the management label.

Discussion

We have exposed major managerial interests and concerns of groups of clinician managers. Despite differing, often anecdotal opinions in past literature about what clinician managers do, and an even greater range of normative views about what they should do, the present studies provide some qualitative evidence for their work.

The findings support our view that clinician managers have risen to prominence for three main reasons. Hospitals have devolved managerial tasks to those who, it is believed, can best carry them out. Decentralising the locus of hospital management responsibility and accountability to an intermediate organisational level is seen as "a good thing", and has emerged as crucial to clinical governance. Addressing resource management issues such as trying to make savings, create efficiencies, manage costs and improve productivity and performance is now thought to be the province of those who have both clinical knowledge and managerial responsibilities.

The grounded triangulation technique revealed substantial agreement across multiple studies regarding the scope of clinician managers' work. Overall, there is a degree of frustration expressed by clinician managers about the fast pace of their work, the wide scope of their roles, and the multiplicity of difficulties and constraints they face. However, they exhibit a widespread, generalised striving for improvement. This is underscored by the relatively high numbers of achievement words they use (the "achievement orientation" category in Table II).

The data highlight that despite their busy jobs, clinician managers are largely optimistic about their work except when dealing with finances. The clear implication is that they are trying to overcome numerous challenges but are concerned about the lack of resources available to do what they believe needs to be done. Resource management in particular poses dilemmas and, in some cases, deep ethical challenges for professionals not traditionally required to make hard choices based on concepts like opportunity costs, trade-offs and rationing.

For our study participants, management is centrally concerned with managing people and financial resources, dealing with organisational or institutional issues like bed management or equipment problems and attending to structure and hierarchy matters. There are claims in past literature that important aspects of clinical managerial work include quality management (Fitzgerald and Sturt, 1992; Kirkman-Liff and Schneller, 1992), information systems development and data management (Bernstein,

Table III Roles and positions most frequently mentioned

Role and position mentioned	Times mentioned	Per cent of total roles and positions mentioned
General organisational		
CEO (n = 4), general manager (n = 9), executive (n = 7), employer (n = 1), bureaucrat (n = 2)	23	10.4
Divisional		
Divisional head (n = 3), director (n = 15), manager (n = 49), administrator (n = 4), nurse manager (n = 3), business manager (n = 9), clinician manager (n = 7)	90	40.5
Workers and professionals		
Clinician (n = 31), physician (n = 9), doctor (n = 9), GP (n = 1), employee (n = 2), specialist, visiting medical officer (n = 8), nurse (n = 23), non-clinician (n = 1), allied health (n = 4), surgeon (n = 1), secretary (n = 3)	92	41.4
Patient/client		
Customer (n = 1), patient (n = 15)	16	7.2
External		
Politician (n = 1)	1	0.5
Total	222	100

1993; Abernethy and Stoelwinder, 1986), organising external relationships and stakeholders, formulating strategy, and planning for future services (Corbridge, 1995; Allen, 1995). The evidence provided here suggests that these are of lower priority for clinician managers than other aspects of management. According to the findings, clinician managers do not emphasise managing with data, quality improvement, external relationships and strategy and planning.

Most managers in health care seem to face considerable challenges, regardless of context and country. They are in the main pushed for time, obliged to make complex decisions under pressure, have more to do than can readily be accomplished, and are less strategic and more crisis-driven than assumed by the uninitiated. The present studies underscore this. Read the literature on clinician-managers across developed health systems and the conclusion to be reached is that there is no reason to suppose, for instance, that British or American hospital clinician managers are substantially different from their Australian counterparts described here. If this is the case, then responding to the leadership and clinician-management recommendations from for example the English inquiry into failure of management in Bristol (to the effect that clinicians in management roles should be afforded sufficient time to carry out their multiple tasks and be provided with sufficient training and support to do the work) looms very large indeed. It is not clear how this will be accomplished, or how clinician-management behaviour can be encouraged to change in the directions desired. The work of our clinician managers was centrally about inputs (managing money, people and things) rather than systems and outcomes. Yet to be considered well managed, safe and of high quality any health care system will need to attend to all of these.

Like everyone, clinician managers are interested in matters in which they are directly engaged, or that present to them in their immediate environment. The content analyses reveal, for example, that the roles and positions they most frequently mention are those closest to their most pressing concern - running a directorate or division of a hospital. Development of a wider perspective on organisational and clinical matters may be important for the future if we are to encourage broader systems thinking.

For many social scientists, informal workplace discourse represents the organisational glue that cements relationships, and facilitates the backstage efforts to make progress. Sociologically, these conversations

help define to others who we are, and our needs, aims and aspirations, and reflect the "we" who are bound together for common purposes. Despite their busy workloads, personal interaction seemed an important constituent in clinician managers' goal-directed behaviour. Clinician managers, even those with an inclination to introversion, cannot sensibly be isolates, disengaged from social exchange.

Evaluating the effectiveness of managers has long been seen as problematic, and clinician managers are no exception. Our participants recounted organisational benefits and advances they had made that they attributed to their efforts. These were mainly in the areas of improvements to budgets, policies, and practical aspects of management. Nevertheless, the effect clinician managers have had or are having as a result of their activities is hard to judge. Any alleged benefits remain in the realm of untested claims rather than empirically sustainable facts.

Notwithstanding the emergence of directorates and divisions, clinicians in hospitals retain considerable autonomy. They are not passive employees who are to be directed or controlled, but fellow professionals whose efforts can often benefit from being better coordinated. Because of their power, however, this may mean that latent or actual resistance to change initiatives of clinician managers can be considerable. The job of a clinician manager is much more about negotiation and persuasion than command and control.

An important question facing qualitative researchers concerns the status of their data. A key question is whether these findings can be considered generalisable to larger populations. The answer usually tendered by biomedical researchers is no: generalisability essentially means that randomised, statistical data can be used to make definitive inferences from sample to population (Healey, 1990). The qualitative test is whether it is reasonable to assume the findings are transferable beyond the confines of the setting, reflecting the issues and concerns of counterparts elsewhere (Judd *et al.*, 1991). This seems the case to us, and is supported by the growing interest in qualitative, narrative accounts of clinicians' activity. At the very least it may be claimed, in Prideaux's (1993) words, that they "provide an insight into the nature of the issues involved".

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