Who really matters: a mixed methods investigation into inter-occupational and professional dynamics when managing patient flow.

Kathy Eljiz
BBC (Management/Marketing) Hons 1

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Dedication

This thesis is dedicated to my mother Nouha Eljiz who has been with me every step of the way. Your faith, strength, and love have kept me going. Thanks mum.
Acknowledgements

There are so many people who have been instrumental in shaping this thesis.

To the hospital staff who gave their time to fill in surveys and answer countless questions, I admire your perseverance and determination to make a difference to a system that does not always make sense. Your skills and dynamism are not acknowledged enough, but are very much appreciated.

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Finally, I would like to thank my family and friends for supporting me throughout my often tremulous journey. From helping me compile my questionnaire packages, to giving me unlimited access to your homes, I cannot express in words how much I appreciate you all being there for me.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in whole or part, for the degree at this or any other institution.

Kathy Eljiz
February 2009
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Abstract

Keywords: organisational culture, hospitals, networks, alliances, interpersonal, relationships

This study explores how formal and informal social networks and decision making about resources in the hospital setting are related.

Over the last few years, tensions between new public management of hospitals and increased demands has led to an increase in bottlenecks, stagnation of patient flow, and overcrowded emergency departments. These problems have led to an increase in access block for patients attempting to access the public hospital system. The introduction of Patient Flow Units has instigated the formalisation of a nurse manager function to coordinate patient flow. Nurses in such a pivotal position and who greatly influence hospital operations, tend to have special characteristics and use these to “get things done”. This thesis investigates interpersonal associations between professional (e.g. doctors and nurses) and functional groups (e.g. clinicians and managers), when making clinical and operational decisions when transferring a patient from the emergency department to a ward bed.

By employing a mixed methodology, this thesis first sought to establish a snapshot of organisational culture in three hospitals. Drawing on Degeling et al. (1998) and Fitzgerald (2002), an organisational cultural survey was distributed to a total of 1750 participants. The response rate was 11.65% This survey particularly addressed five cultural constructs including a sense of organisational commitment, perceptions of managerial role characteristics, perceptions of currently pursued organisational goals, perceptions of orientation to work values when choosing a job, and interactions with various professional constituencies.

In addition, 18 interviews were conducted and a total of 150 hours of observation of work processes, interactions between staff and environmental conditions were studied.
This investigation largely confirmed earlier studies by Degeling (2002) and Fitzgerald (2002) that professional groups believed that their organisation primarily exhibited an Elite style of management, that financial viability is the most important goal their organisation is pursuing, and staff welfare was a low priority. In addition, it found significant differences in cultural footprints between the small hospital, which had a more integrated culture, and the large hospital, which was more fragmented in nature. However, the major contribution of this investigation is demonstrated in the qualitative chapter. This thesis found that the role of “who matters the most” in relation to decision making about patient flow, changes depending on the stage of the decision making process. It also found that non-managerial nursing staff with no formal power or legitimacy could affect urgency.

The thesis comprises eight chapters. Following the introductory chapter, Chapter 2 considers the literature associated with the public health system in Australia with a focus on public hospitals in NSW. Chapter 3 critically examines the literature describing organisational culture, with an emphasis on subcultures. Chapter 4 contains a review of professional identity and roles, networks and alliances, social capital, deep smarts, and stakeholder theory. Description and justification of the research method selected to explore the thesis proposition follows in Chapter 5. Chapter 6 contains an outline of the findings concerning the analysis of the survey questionnaire to determine a cultural footprint of the three hospitals studied. Chapter 7 considers the different roles of professional groups (doctors, nurses, and others) and functional groups (clinicians and managers) in the operational phase of patient flow and in doing so contributes to knowledge. Finally, in Chapter 8, a discussion summarises the thesis findings, describes the implications, acknowledges limitations of the study and identifies avenues for future research.
I had started my second session of in-hospital observations when unfolding events made me contemplate about who and what really matters when managing patient flow. It was another busy night at the emergency department. Patients lined up in corridors, some waiting to be seen by a doctors and some waiting to be transferred to the ward. I remember seeing one patient when I first arrived, more than two hours ago. I kept wondering why was taking so long for him to be moved to the ward. Surely it would be more comfortable to be in a more restful environment, away from the hustle and bustle that characterises the activities in a busy emergency department.

The patient flow manager explains that the corridor patients are waiting to be transported to a ward that had been recently refurbished. However, beds and bed spaces were not ready to receive patients. This involves cleaners, ward orderlies and duty nurses, each with their heavy existing workloads already. The patient flow manager explains “when the emergency department is busy, usually the whole hospital is busy”. She was glad to report that the beds had been located in storage and delivered to the ward, and that cleaners were cleaning them. The beds were nearly ready to be made. The flow manager assured me that soon the patient in the ED corridor could be moved.

When we arrived at the ward, the nursing staff, obviously already busy, were speaking with the services staff about the extra beds and drawers. The patient flow manager briefed the staff about the situation and told the staff that she had brought beds, tables, and drawers. A nurse then asked where the other necessary equipment was. When the patient flow manager asked what equipment, the ward nurse responded “Well, where are the clickers? You can’t have a patient all the way at the end without a clicker. It’s dangerous”. The ward nurse then proceeded to speak about patient safety and the possibility that an elderly patient could have a fall and not be able to call the nurses without a buzzer. The patient flow manager then told then ward nurses that the two patients being sent to the ward were young, low
risk patients. When the ward nurse continued to argue, the patient flow manager used her position and the authority given to her by the executive of the hospital. The patient flow manager answered “the executive are well aware of the issues and they said to put the patients here”. Whilst the ward nurse was making the bed, she then turned around to the patient flow manager and said “well I don’t have a pillow for the patient. You need to get me a pillow”. The patient flow manager then spent 5 minutes ringing different wards to locate a spare pillow. When she found one, the patient flow manager responded with “there’s a pillow in maternity, you can have that one”. The ward nurse said to the patient flow manager “you’ll have to get it for me. How do you expect me to get the pillow? I don’t know where maternity is”. The patient flow manager then went to the maternity ward, found the pillow, and then took the pillow back to the ward.

More than two hours later, at least 4 and a half hours in total, the patient was finally settled into the ward.

This experience left me wondering about the seemingly mammoth task of ensuring organisational wheels move in unison and the importance of social interactions between people to get the job done. What seemed like a simple case of moving a patient from the emergency department to a ward required detailed coordination and the involvement of so many people. It led to me to wonder, how many people are involved in the processes and how do these different people influence the way that decisions are made about patient flow in hospitals.
# Glossary

<table>
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<th><strong>Access Block</strong></th>
<th>The term that describes the delay patients who need hospital admission experience in the emergency department when their inpatient bed is unavailable (ACEM, 2004; p. 2).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alliances</strong></td>
<td>Formed strategically for specific purposes.</td>
</tr>
<tr>
<td><strong>Deep Smarts</strong></td>
<td>A potent form of expertise, based on first-hand life experiences, providing insights drawn from tacit knowledge, shaped by beliefs and social forces (Leonard, ANZAM Plenary Session 2007; p. 3).</td>
</tr>
<tr>
<td><strong>Homophily</strong></td>
<td>Contact between similar people, which occurs at a rate higher than among dissimilar people (McPherson et al., 2001; p. 416).</td>
</tr>
<tr>
<td><strong>Informal Networks</strong></td>
<td>Outside of the formal structure of organizations and often describe the relationships of friendship networks, advice networks, trust networks, and communication networks (Pappas et al., 2004: p. 10).</td>
</tr>
<tr>
<td><strong>Legitimacy</strong></td>
<td>Authority or verification to use the ability to influence decisions (Mitchell et al., 1997).</td>
</tr>
<tr>
<td><strong>Magnitude</strong></td>
<td>Strength of relationships.</td>
</tr>
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*

Organisational culture includes cultural manifestations

+

that are unique to that particular organisation to point
that these manifestations are recognised by
organisational members as typical of their organisation.
Individual and group conflicts of cultural manifestations
are innate forces evident in organisational cultures that
will on occasion create sustained patterns as well as
unsustained patterns of integration (Eljiz; 2004; 2008).

,

The ability to influence decisions (Mitchell et al., 1997).

&

Priority given to stakeholder claims (Mitchell et al., 1997).

&

+

People and groups of people are connected to certain.
others, and this creates a network of interdependent
social exchanges where certain people become trusted
exchange partners and can be called upon for resources
and support (Oh, Chung and Labianca, 2004; p. 3).

&

'

A collectivity of individuals among whom exchanges take
place that are supported only by shared norms or
trustworthy behaviour (Liebeskind, 1996; 430).

&

Small work groups that have their own shared set of
beliefs, values and attributes.

-

Includes time sensitivity and criticality, and is about how
essential it is for a decision to be made (Mitchell et al.,
1997).

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1. Introduction
1.1 Background to the Research

The researcher began the research out of an interest in organisational studies. During her honours research, the researcher investigated networks between professional groups at universities. A medical interest was spurred during discussions with her primary supervisor and medical school personnel at the university. These events led the researcher to commence this thesis in organisational studies in the health system.

The management of a hospital emergency department is particularly complex, because managers must negotiate increasing demands for services, in an environment full of constraints to service delivery and with professional and/or functional idiosyncrasies. In addition, stakeholder roles are ill defined and inter-professional behaviours are strongly contested. For an outline of the key terms used throughout the thesis, refer to the Glossary (pg. xvi).

The popular press continually refers to the health system as “being sick” pointing to an inability of hospitals to cope with increasing emergency department demands, resulting in lengthy wait times and a questioning of the quality of care delivered. The cause of increases in demand for the services in the emergency departments in NSW hospitals include a higher influx of patients (Booz Allen Hamilton, 2007), a decrease in the number of inpatient beds (Cameron and Campbell, 2003), and changes to the funding model (Hopkins and Speed, 2005; ACEM, 2004; Griggs and Atkins, 2004; Ford, 2002). In addition, the supply of services is hampered by a considerable shortage in the health workforce required to deliver services (Duckett,
The combination of such demand and supply issues has placed considerable pressure on the system and the people within it. These external issues are compounded by historically determined professional and functional differences that influence decision making practice in terms of urgency, legitimacy and power. In this research, stakeholder roles are closely examined to identify decision making saliency when transferring a patient from the emergency department into a ward bed.

1.2 Justification for the Research

Access block is the term that describes the delay experienced by patients who need hospital admission in the emergency department when their inpatient bed is unavailable (ACEM, 2004; p. 2). Access block is a fact of life in Australia and system changes implemented to deal with access block are not enough to combat access block from occurring (ACEM, 2004). There has been an increase in access block for patients attempting to access the public hospital system (Paoloni and Fowler, 2008; Mohsin et al, 2007). Human, financial and political costs are high.

Gaining a better understanding of the issues that are hampering patient flow may assist managers with their decision-making practices about resource allocation. Having this clearer understanding will assist hospital staff with better communication, and managers with better outcomes. In addition, administrators will have a better idea of who should occupy pivotal positions, and how to use social capital to solve the problems.
1.3 Organisational Theory Context

Built on an organisational cultural foundation (Martin, 2001), the framework used for this thesis is a combination of theories associated with *professional identity* built on Fitzgerald, (2002) and Friedson, (1988), *role theory* as proposed by Allen, (1997); *networks and alliances*, using ideas purported by Gulati and Gargiulo, (1999); *social capital* theory as used by Onyx and Bullen, (2004) and Nahapet and Ghoshal, (1998); and Mitchell’s *stakeholder theory* (1997).

To provide a sound foundation for the thesis, organisational culture literature is explored in an effort to better understand how the environmental influences guide the actions of various stakeholders involved in decision making about bed allocation. A three perspective theory is used to better understand the organisational cultures of the hospitals under investigation, for the reason that the three perspective theory allows the researcher to understand an organisation’s culture from multiple paradigms.

A comprehensive literature review reveals how these theories overlapped. Professional and functional delineations are explored in relation to occupational groups and subcultures. These occupational groups have distinct professional cultures, which shapes and is shaped by their professional identity. Specifically, an outline of the characteristics considered common for professionals within certain roles are considered in an effort to explain observed phenomena.

Stakeholder Theory assists in explaining how pivotal people can be identified and how much priority can be given to stakeholder claims based upon power, urgency,
and legitimacy. However, stakeholder theory does not deal with the magnitude or strength of relationships or stakeholders use of networks and informal power to make their stake a priority.

Social capital theory is clear about the use of alliances and networks as a way for pivotal people in organisations to influence decision making. However, it is unclear exactly what the dynamics between inter-occupational and professional groups are when making decisions about resource allocation.

This review of the literature confirmed that stakeholders in positions of formal power have the ability to influence decisions about patient flow in hospitals. However, the literature review also highlighted deficiencies in these theories to explain how inter-occupational and professional dynamics, through relationships, may influence the flow of patients. This begged the question: who really matters? Health service providers, particularly hospitals, are placed under continued pressure to engage in good public relations with the Australian population. A major and recurrent issue is the accessibility of acute hospital services. This includes improving processes around the allocation of ward beds to emergency department patients to improve patient flow.

This thesis argues for the need to investigate how informal relationships influence decision making in patient flow, particularly when stakeholders are affiliated with diverse subcultures and professional groups. Answering the questions may have implications for the management of patient flow in the emergency department.
1.4 Research Problem and Research Questions

During the exploratory phase of this research, emergency department managers voiced their concerns about the lack of clarity in the process of bed allocation. The formal rules and procedures were not always used, and the managers questioned why some people in the organisation were able to organise transfers more efficiently than others. An exhaustive literature review on patient flow showed no immediate solutions.

The problem is that hospital services access is impaired in most emergency departments. There is no immediate prescription to solve this problem. However, upon closer investigation it seems that alternative methods are used, alternative to formal rules and procedures for improving patient flow, involving inter-relationship dynamics.

This makes the researcher question how formal and informal social networks and decision making about resources in the hospital setting are related. Specifically, the following research questions are posed:

How does informal social networking interact with decision making about resources and,
How can this be explained from an organisational culture perspective?

In order to answer the research problem posed above, the following sub questions were asked:
1) How can the organisational culture be described in a:
   a. small hospital
   b. medium hospital
   c. large hospital

2) Do subcultures exist within these hospitals, and if so, how can they be differentiated?

3) (i) How are alliances created and boundaries crossed between stakeholders from different organisational cultural backgrounds?
   (ii) How are decisions about resources allocation (i.e. material resources) made when stakeholders are affiliated with diverse subcultures?

4) Does the magnitude/thickness of stakeholder relationships influence decision-making outcomes, and if so how?

1.5 Delineation of Scope and Key Assumptions

The scope of the research included investigating only the process of transferring the patient from the emergency department to the ward. The research does not investigate the patient flow process after the patient is admitted to the ward. A further scope is that the research mainly investigates the social interactions between the flow manager and ward staff.
A key assumption of the research is that the size of hospital matters when investigating organisational culture. Therefore, three hospitals: one small, one medium, and one large were chosen. The research is limited to three hospitals in NSW Australia, and as such generalisations cannot be made across other hospitals.

1.6 Methodology

This research is undertaken in three hospitals in NSW, each chosen for their size in terms of available beds. In this research these hospitals will be referred to as “large size hospital” (approximately 750 beds), “medium size hospital” (approximately 200 beds), and “small size hospital” (approximately 120 beds). Size is an important consideration, because the assumption is that the organisational culture of a hospital varies depending on its size.

This research adopts a mixed methods approach to social science field research. Using a multi methods framework allows for the cross checking of the data generated to assist with gaining a better understanding of the hospital environments. The subsequent analysis of the data collected during this research examined the inter-occupational and inter-professional dynamics in three emergency departments to determine decision making saliency when managing patient flow.

First, a survey questionnaire is used to gain a snapshot of the organisational culture of each of the three (3) hospitals examined in the study. A total of three hundred and fifty (350) surveys were distributed to the small sized hospital and fifty-two (52) were returned indicating a response rate of 14.86%. A total of six hundred (600) survey questionnaire packages were distributed to the medium sized hospital and seventy-
one (71) were returned indicating a response rate of 11.83%. A total of eight hundred (800) surveys were distributed to the large sized hospital and sixty-six (66) were returned indicating a response rate of 8.25%. Such a cultural snapshot will give an idea of the values and beliefs of the hospitals studied. 18 semi-structured interviews, 150 hours of observation and a review of the formal rules and procedures are used to understand why specific cultural manifestations are occurring in each of the hospitals.

The data was analysed using quantitative and qualitative methods of analysis. Excel was used to analyse the descriptive data, such as gender and age of respondents SPSS™ was used to undertake factor analysis and run ANOVA tests. Leximancer™ assisted with the identification of the themes, and QSR NVivo™ was used to sort the semi-structured interviews and observation data for analysis.

Triangulation of the data was applied and enabled the researcher to use the qualitative methods to overcome the weaknesses of the quantitative methods and vice versa. Using a survey questionnaire, the researcher was able to get a wide sample of respondents to answer questions that allowed her to determine a cultural footprint of the hospital environments. Conversely, using semi structured interviews, observations and conversation, the researcher was able to gain a more in depth understanding of the cultural environments of the hospitals.

Central to the multi methods approach success is the reflexivity employed at all phases of the research protocol. Adopting this approach to organisational cultural research was necessary because each organisation’s culture is unique and
meanings about cultural manifestations differ across as well as within cultures. Meaning in this study is understood to be constructed by the participants. Also, this constructed meaning has practical implications for health managers.

Researcher biases may have impacted upon the research. However these were largely overcome by bringing to the fore the researcher’s preconceived judgments, personal feelings and beliefs, and expectations through the practice of reflexivity. Possible participant biases included response bias and social desirability bias. Participant bias was reduced by conversing with and observing participants in different environments. In addition, ethical issues are considered.

1.7 Outline of this Thesis

The thesis comprises eight chapters. Following the introductory chapter, Chapter 2 considers the literature associated with the public health system in Australia with a focus on public hospitals in NSW.

Chapter 3 critically examines the literature describing organisational culture, with an emphasis on subcultures. The researcher establishes that a three perspective theory will be used to better understand the organisational cultures of the hospitals under investigation, for the reason that the three perspective theory allows the researcher to understand an organisation’s culture from multiple paradigms. Furthermore, the research discusses the use of an organisational cultural perspective to be able to better interpret human interactions from both an insider and an outsider point of view.
Chapter 4 contains a review of professional identity and roles, networks and alliances, social capital, deep smarts, and stakeholder theory. It then reveals an area surrounding the consideration of informal attributes to determine who matters when making decisions, which has not as yet been fully investigated.

Description and justification of the research method selected to explore the thesis proposition follows in Chapter 5. This research adopts a mixed methods approach to social science field research. Central to its success is the reflexivity employed at all phases of the research protocol. The research protocol allowed the gathering of data from different sources. Amongst these sources was a survey questionnaire, which provided a snapshot of the cultural environment of each of the three hospitals. Semi structured interviews were used to understand more about why manifestations in the environment were happening. Observation and conversations with staff also allowed the researcher to gain a greater insight into the culture of each of the hospitals.

Chapter 6 contains an outline of the findings concerning the analysis of the survey questionnaire to determine a cultural footprint of the three hospitals studied. The chapter identifies professional subcultural differences by assessing the responses of three professional groups including doctors, nurses, and others. It also identifies functional group differences between clinicians and managers. These differences are examined by first analysing at all respondents views as one data set. Further differences emerge by looking at professional group differences between each of the three hospitals.
Chapter 7 considers the different roles of professional groups (doctors, nurses, and managers) in the operational phase of patient flow and in doing so contributes to knowledge. The purpose of this chapter is to answer the research questions about network and alliance creation/crossing between diverse stakeholder groups in relation to decision making about patient flow.

Finally, in Chapter 8, a discussion summarises the thesis findings, describes the implications, acknowledges limitations of the study and identifies avenues for future research. The researcher argues for the need to look at informal attributes to distinguish how powerful a stakeholder claim can be considered, particularly when stakeholders are affiliated with diverse subcultures and professional groups.

1.8 Summary

Access block has become a major issue facing the Australian health system, where patients wait in the emergency department for a ward bed. This delay in transferring patients from the emergency department to a ward bed increases confusion and frustration amongst various stakeholders, including patients and hospital staff. Having a greater understanding of the way that beds are allocated in the Emergency Department will assist managers and researchers in identifying opportunities for improvement.

There are a number of people involved in the process of bed allocation. A combination of Social Capital theory, Stakeholder Theory and Professional Identity theory explains how the pivotal people in decision making about bed allocation can be identified. Aided by the hospital’s cultural footprint, a greater understanding of the
organisational behaviour surrounding the process of bed allocation assists in the unravelling of the ways in which a hospital functions.

This investigation now commences with a description of the health system, which follows in Chapter 2.
2. The Health Context
2.1 Introduction

This chapter is the first of three literature review chapters, describing, analysing and synthesising the background to this study, the gaps in the literature and the emergence of the research questions to be studied. Whilst the main driver for the research questions is the theoretical framework, the research is highly driven by theories in practice. Therefore, it is necessary to first provide some background to the context in which this research takes place, before critically analysing the theoretical knowledge within this context.

This research is undertaken in three hospitals in NSW, each chosen for their size in terms of available beds. One hospital is classified as a Principal Referral Hospital, and two hospitals are classified as Major Metropolitan Hospitals (Jong and Corben, 1998). In this research these hospitals will be referred to as "large size hospital" (approximately 750 beds), "medium size hospital" (approximately 200 beds), and "small size hospital" (approximately 120 beds).

This chapter is divided in two sections. Section one will describe the Australian health system and give an overview of hospital structures, with a focus on hospitals in NSW. Specifically, demand and supply of health services through public hospitals are outlined. Section two provides a more thorough examination of the management of patient journeys through the emergency department. Specific attention is given to the general management of beds in hospitals, with a focus on the management of access block in NSW hospitals, through initiatives introduced at the Government level, the Area Health Service level, and the individual hospital level.
2.2 Australian Public Health Care System

The Australian health system is a two tiered system. This means that both the States and Commonwealth are responsible for the funding of public hospitals. Following an amendment to section 51 subsection xxiiiA (Australia) of the constitution, the Commonwealth government has power over the provision of some services, including social services and pharmaceutical benefits scheme, sickness and hospital benefits, medical and dental services. However, the division of roles and responsibilities between the State Government and the Federal Government is somewhat indistinct. This has provided an opportunity for both levels of Government to avoid taking responsibility for public outcry about underfunding the public hospitals and to actively engage in cost shifting between them. In Australia, hospitals account for one third of the total health expenditure (Duckett, 2007; p. 135). Total health expenditure in Australia “grew by 7.1% between 2004–05 and 2005–06 to $86.9 billion or $4,226 per person. This represents a $5.8 billion increase from 2004–05, or $225 more per person than the previous year” (Health Expenditure Australia, 2005-06; p. xiv). Given the level of such expenditure, and the increase in expenditure in recent years, there is a need to examine what some of the costs are, and to consider if the money is being spent efficaciously. Therefore, doing research into hospital efficiencies is warranted.

Public health is mainly funded through the Australian Taxation System via a universal health care insurance program called ‘Medicare’. Medicare was introduced in 1984 and allows all Australian residents to receive treatment in public hospitals. The principal objective of Medicare is to remove or reduce financial barriers to access to health care for all Australian residents (Correa-Velez, et al, 2005). All
working Australians contribute through their wages according to how much they earn. Private Health Insurance is encouraged via tax incentive schemes, but is not compulsory. Therefore, there is burden on acute public hospitals. The context of this research is acute hospitals and therefore the emphasis of the discussion is on public hospitals in NSW.

### 2.3 Organisational Structure of the NSW Health System

Public hospitals are governed by Australian Health Care Agreements. The Australian Health Care Agreements are five-year agreements shared between the Australian Government and each State and Territory. The agreements are “vehicles for the Government to provide significant funding to assist the states and territories to provide free public hospital services to the Australian community” (Health Insite: Department of Health and Ageing, 2008). The agreements are supposed to provide an interface between the state hospitals, primary care and aged care.

The NSW state public health organisation is known as NSW Health, and is responsible for the services and investments in health in NSW. Some of the services include acute and public health services, mental services, and community services. These services are provided through a mix of hospital based and allied health based facilities.

As the responsible authority, NSW Health monitors the performance of NSW public hospitals. This performance is measured against set goals and reported in NSW Health Annual Report (NSW Health, 2008). For example, staff safety, patient safety, and benchmarks of surgical cases are set goals. The achievement of these goals is
measured by the achievement of Key Performance Indicators (KPI). Some of the Key Performance Indicators (KPI’s) that NSW Health reports on include the management and maintenance of the NSW Health System’s assets, such as total maintenance cost, total operating costs, and annual maintenance expenditure. In summary, while the Commonwealth government’s role includes funding public hospitals, the States are responsible for providing funding for resource allocation, and to monitor if funds are spent to achieve set goals and objectives. The discussion now moves to an overview of the operational management of public hospitals.

2.3.1 Hospital Classifications in NSW

NSW Health comprises eight (8) Area Health Services and the Ambulance Service of NSW. There are several different types of public hospitals in the NSW Health system. NSW Health classifies public hospitals in NSW according to the peer group to which they belong (refer to Appendix 1). Peer grouping is the process “by which a cohort of facilities is divided into mutually exclusive and exhaustive subsets” (Public Hospital Comparison Data Book, 1997/1998). There are several purposes for the use of peer grouping hospitals including: activity and cost comparisons, cost benchmarking, selecting hospitals to participate in the NSW Hospital Cost Data Collection, planning services, and other benchmarking activities at a hospital or clinical level. This includes, for example, comparisons of length of stay of patients receiving a hip replacement (Public Hospital Comparison Data Book, 1997/1998). Peer grouping allows for comparison between hospitals in relation to how resources are being allocated and setting benchmarks for control.
Public Hospitals in NSW broadly fall under two categories: Metropolitan Area Health Services and Rural Area Health Services. Each Area Health Service is responsible for all of the public hospitals and health care facilities in the designated area. They are responsible for the strategic planning/directions of the designated area hospitals. The Area Health Services have advisory health councils and consult with community/consumer councils to understand the needs of the consumers in the Area. Each hospital in the Area Health Service has a General Manager who is responsible for the daily functioning of the hospital. The General Manager reports to the CEO of the Area Health Service on a daily basis. Examples of some of the reports include the number of admissions, issues about bed capacity (access block), and incidents.

The three hospitals chosen as part of this study belong to two different Area Health Services in Western Sydney with a culturally diverse population. Western Sydney is the second fastest growing population in Australia, as well as the third largest economy in Australia (Greater Western Sydney Economic Development Board, 2008). A large proportion of the staff who work in the hospitals also live in Western Sydney. As this study examines the interpersonal relationships between hospital workers in relation to the decision making processes about the transfer from the emergency department to a ward bed, it is therefore important to consider the composition of the health workforce.

2.4 Health Workforce

The Australian Bureau of Statistics classifies people working in the health system as either Health Professionals or Associate Health Professionals. In 2006-07
“approximately 423,400 people were employed in health occupations in Australia, comprising 4% of the total number of employed people (table 11.33). The largest components of the health workforce were registered nurses (169,800), generalist medical practitioners (37,000) and enrolled nurses (27,700)” (ABS, 2008). It is clear that a sizeable part of the total health expenditure is allocated to labour costs. Labour costs account for approximately 70-80 per cent of health costs (Duckett, 2007; p. 66).

In the past 20 years, the Australian health workforce has changed significantly, with “increasing specialisation in the workforce, both within the professions (for example additional specialisation in the medicine and nursing) and also due to the creation of new professions” (Duckett, 2007; p. 69). This study focuses on interactions between members of three professional groups (doctors, nurses, and others) and two functional groups (managers and clinicians).

A major issue for health workforce policy relates to the role of the professional (registered) nurse. The educational preparation of all nurses is improving, associated with the move to university-based education and continuing refinement of the university curricula. As a result, alternative career pathways have been/are being created to allow expansion of nurses’ role to make some clinical decisions that were previously made by medical doctors only. The broader educational preparation provides a foundation to take on more complex roles and tasks, in addition to aiding in developing highly skilled nurses. For example, NSW was the first state to consider the potential of nurse practitioners. This new role allows specially educated nurses to provide an alternative avenue for treatment complementing general practitioners.
and emergency doctors in many primary care tasks; they are also accredited to undertake high-level triage functions in hospital emergency departments. However, the extent to which nurses (should) have independent prescribing rights remains a critical issue for determining the future role of the nurse.

The NSW health care system exists in a socio political environment and the characteristics of that environment affect not only the system itself but also the interaction of the health care system with other aspects of society. In addition to the changing roles of consumers of health care, some key problems facing the current health care system are mostly internal ones: choices about the roles of doctors and nurses, addressing the inequalities in health outcomes, ensuring quality of care, and addressing technical, process and allocative inefficiencies, including increasing demands for services (Duckett, 2007).

Thus far, this chapter has centred on a description of the health system to provide some background to the context in which this research takes place. The next section gives more detail about the processes within NSW hospitals. First, it will define and discuss the causes of access block. It will then discuss the current initiatives implemented to deal with the issue of access block. Further, it will look at the issues of emergency department flow. Furthermore, the bed management reporting mechanisms that NSW Hospitals use will be explored/examined/elucidated. Finally, this review of the context will assist with understanding of the overall system changes implemented by NSW Health in attempting to reduce access block by implementing Emergency Access Performance (EAP) strategies. This detail is
necessary to provide a background to understanding inter-occupational and professional dynamics when managing patient flow.

2.5 Bed Management in NSW Hospitals

Over the last few years, tensions between new public management of hospitals and increased demand has led to an increase in bottlenecks, stagnation of patient flow, and overcrowded emergency departments (Richardson, 2006; Fry, Thompson, and Chan, 2004; Liu, Hobgood, and Brice, 2003). These problems have led to an increase in the likelihood of access block for patients attempting to access the public hospital system (Paoloni and Fowler, 2008; Mohsin et al, 2007). The increase in access block has led to the introduction of Patient Flow Units.

2.5.1 Access Block

Access block is “the term that describes the delay patients who need hospital admission experience in the emergency department when their inpatient bed is unavailable” (ACEM, 2004; p. 2). Access block is caused by several issues: first, there is an increase in demand for services as a result of higher influx of patients due to demographical changes of the population, the changing nature of patient conditions, and as a result of a better informed community. Secondly, access block, and patient flow bottlenecks are likely a result of demand and supply dynamics due to the changing management of resources in the delivery of service. Thirdly, health funding model changes have affected access to hospital services; and fourthly, the changing workforce has an impact on patient services in hospitals.
2.5.2 Higher Influx

There has been an increase in demand for emergency admissions due to changing demographics (Booz Allen Hamilton, 2007; ACEM; 2004). As the Australian population continues to age, more aged care facilities are referring patients to the emergency department (ED), which has the expertise to provide treatment the aged facilities do not (Booz Allen Hamilton, 2007; ACEM, 2004). These elderly patients reside in the beds as they wait for long term placement into nursing homes. Alternatively, these elderly patients are discharged back into the community to circumvent the strain on the overcrowded aged care system (Cameron and Campbell, 2003; p. 100). Therefore, this increase in patients with higher dependency needs will result in patients occupying beds in the ED and other wards for lengthier periods of time, thereby increasing bottlenecks in the hospital system. Diminished flow in the hospital system affects the flow of patients out of ED, resulting in access block.

Australian emergency departments also have to cope with changing patient morbidity (Booz Allen Hamilton, 2007; ACEM, 2004). More patients with chronic disease are attending the ED more frequently and for longer periods of time. Emergency Department Length of Stay (EDLOS) has increased due the complexity of illness of elderly people as well as lengthier stays in the ED for elderly patients awaiting transfer to an aged care facility (Liew et al., 2003). These delays have a significant impact on the ED as bed managers continue to face the problem of getting patients out of the ED into wards and other facilities within an acceptable timeframe. Such delays have a significant impact upon the decision-making practices of ED and hospital bed managers.
In addition, there are several flow-on effects of mental health services shortages on hospitals in Australia, especially as specialist psychiatric hospitals have closed over the past few years (Duckett, 2007). This has resulted in more mental health related presentations to emergency departments, which, according to Duckett (2007) are usually more intensive than other presentations (p. 248). The average length of stay for mental health patients in public hospitals is around 14 days (Duckett, 2007; p. 248). This extended average length of stay has resulted in patients occupying beds for longer periods of time, thereby reducing the number of beds for other patients.

Additionally, better informed patients have resulted in an increase in demand for ED services. More patients are self-referring to the ED based on their own research and on the recommendation of family and friends. The under-24 age group in particular is using the hospital system more frequently as it is more convenient for them to access free doctor/specialist services in the one location (Booz Allen Hamilton, 2007). Further, population health campaigns have resulted in an increased awareness of the facilities that are available to the public (Booz Allen Hamilton, 2007). For example, campaigns have encouraged the public to seek early intervention for symptoms associated with heart attack and stroke.

Another reason why the influx of patients may have increased is the expectation that all health issues can be fixed. The notion of consumerism has found its way into health care (Smith et al., 2008; O'Donnell and Entwistle, 2004; Boote et al., 2001; Beardwood et al., 1999). Some literature suggests that patients are increasingly seeing health care as a commodity and have higher expectations than can currently
be met (Elwyn et al., 1999; Lupton, 1997). As patients are becoming more informed about their conditions, particularly through advertising and the use of the Internet to self-diagnose, more see health as goods and services they are paying for, and require more value for money. Hence, not only have the demands for quantity of service increased, but there has also been an increase in the demands for quality of service. However, the discussion surrounding quality and safety in health is beyond the scope of this thesis.

2.5.3 Demand and Supply Management

In addition to a higher influx in patients, another factor of access block concerns issues of supply and demand of physical resources inside and outside the hospital. Whilst there has been an increase in demand for health services, it appears there has been a decrease in the supply of hospital beds. The ACEM (2004) argue that one of the reasons for access block is a decline in the number of inpatient beds. Cameron and Campbell (2003) concur and report that “the total number of acute hospital beds has decreased over the past two decades, with a 15% decrease in public hospital beds occurring from 1995 to 2000” (p. 99). Further, Cameron and Campbell state that “there have been concomitant decreases in inpatient length of stay, but at the same time the number of hospital admissions has increased. There are now more day procedures and day admissions” (p. 100). This decrease in the number of available beds has caused significant problems as, at the same time, the number of presentations to the ED has risen (Fatovich and Hirsch, 2003; Derlet and Richards, 1999). As well as a decrease in beds for acute patients, there has been a decrease in beds assigned to high-dependency patients. The decrease in beds for high-dependency patients has led to an increase in demand by elderly patients for
ED beds. Additionally, there has been a steady decline in the provision of nursing home resources. Thus, economic rationalist driven management strategies have significantly affected service supply capabilities, and is a major cause of hospital bed access block. Due to economic rationalism, altered funding models, such as casemix and diagnosis related groupings (DRGs), have been put in place, as discussed below.

2.5.4 Changes to the Funding Model

In New South Wales, policy documents highlight the significance of casemix on supply of service capabilities, as the casemix provides recommendations for hospital budgets. Casemix funding for inpatient services is where “the budget for a hospital is based on the number and type of patients treated in the hospital” (Duckett, 1998). The development of diagnosis-related groups (DRGs) are clinical and resource homogeneous categories for inpatients, which provide a means of grouping types of patients treated and are used for payment purposes. The budgets of hospitals “are thus determined primarily on performance or output, rather than negotiation, history or politics” (Duckett, 1998; p.169). However, it would be naive to assume that casemix funding eliminates the need for hospital management to engage in politicking. Coupled with the notion of consumerism is the reality that hospitals are behaving more like businesses, with an emphasis on generating their own additional income.

It is financially more beneficial for a hospital to conduct elective surgery, as elective surgery is an income generator unlike emergency medicine, which is costly to the hospital. As discussed above, reduced funding and cost shifting further impel the
justification by hospitals to reduce the number of beds available. Such debate has also led the previous Federal Liberal Government to argue that the Federal government should have responsibility for the entire health system (Buckmaster and Pratt, 2005, 2020 Summit, 2008). This continued debate about funding for the public hospital systems means that there is added pressure for decision makers about bed resource allocation.

In addition, changes to the bulk billing practices have resulted in an increase of patients to ED (Hopkins and Speed, 2005; ACEM, 2004; Griggs and Atkins, 2004; Ford, 2002). Under the current Medicare agreement, Australian citizens and residents can received free treatment at any public hospital in Australia. The treatment that patients receive is bulk billed through Medicare, and is therefore free for Medicare holders. The rate of bulk billing by General Practitioners has steadily decreased since the mid 1990s. The Australian Medical Association (AMA) and the Government have conflicting views as to why this decrease has occurred. The AMA argues that “because the scheduled fee has not kept pace with either the cost of running a practice or the Consumer Price Index, rates of bulk billing are declining as doctors increasingly charge above the rebate level” (Parliamentary Library, 2002; Brief Number 3). Hopkins and Speed (2005) concur that part of the decline in bulk billing is because of failing to index rebates appropriately. That is, as costs increase, people are paying more for their health services. Therefore, because of concerns over being adequately reimbursed for their services, General Practitioners increasingly choose to no longer bulk bill. As a result, more patients are presenting to the ED with general practice related medical problems, thereby placing further
pressure on the hospital system (Hopkins and Speed, 2005; Griggs and Atkins, 2004; Ford, 2002).

Whilst the ED presentations have increased and the bed numbers have reduced, it seems logical an increase in bed resources would fix the problem. However, there are other factors which further compound the issue. There is no point in increasing the physical number of beds if there are no nurses to look after the patient, wards people to move to the patient, and corporate services people to clean the area. Hence, the funding system cannot solely be blamed for bed shortages for ED patients. For example, chronic labour shortages cannot be fixed by pouring more money into the system alone. There are other issues that need to be considered such as working conditions, access to education and professional development opportunities.

2.5.5 Changing workforce

Other contributors to access block include issues surrounding a changing workforce. As the general population in Australia continues to age, so does the clinical population (Buchan, 2002; p. 751-2). There is a considerable shortage in the health workforce, with an acute shortage of nurses (Duckett, 2007; ACEM, 2004; Cowin and Jacobsson, 2003; Klein, 2003; Duffield and O'Brien-Pallas, 2002; Hawthorne, 2001). The consideration of adequate staffing is a concern for hospital managers due to the ageing population of nurses coupled with the apparent difficulty of recruiting and retaining nurses. Therefore, the concerns are not only about recruitment and retention of nurses, but also the planning associated with the inevitable retirement of nurses and a loss of organisational knowledge. This thesis
argues that the dependence upon informal social networking will increase as a result of these impending changes to the workforce in a climate of increasing constraints. That is, if staff are constrained by these impending changes, they may need to rely on their relationships with other staff to get things done. The needs and effects of using social capital as a solution to systemic problems will be further discussed in Chapter 3.

The issue of access block is complicated and there are many reasons for the occurrence. As outlined above, the reasons for access block vary according to the different stakeholders who have written extensively about the issue. In response, NSW Health has introduced some initiatives in an attempt to limit the instances of access block for patients. These initiatives are discussed in the following section.

### 2.6 Combating Access Block

In an attempt to reduce the occurrence of access block, two initiatives have been implemented by NSW Health. These include: 1) The establishment of Patient Flow Units, and 2) the transformation of the NSW Health Ambulance System into the Emergency Department Network Access (EDNA) system.

#### 2.6.1 Establishment of Patient Flow Units

Traditionally, the allocation of beds to patients in the emergency department was carried out by the Assistant Director of Nursing or the After Hours Manager of a hospital. Patient Flow management as a special managerial function has since been
recognised formally with the introduction of Patient Flow Units (PFU) in NSW in 2004.

The PFU is a centralised unit that executes the management of patient flow throughout a hospital. Patient flow includes bed allocation to patients who are admitted via the emergency department, transferred from another hospital, or are awaiting surgery (elective/non-elective). The staff of the PFUs work closely with all departments in the hospital to allocate beds for patients. PFU staff work especially closely with the Emergency Department to reduce access block. For example, The Royal Prince Alfred Hospital’s (RPA) introduction of a Patient Flow Governance Structure was able to reduce access block from “over 50% in February to 15% by April 2006” (ARCHI, 2008). This was achieved by working with all staff, particularly the ED staff, to make changes to the existing ED models. For example, the RPA developed a discharge delay reporting system.

It is important to note the initiatives being developed by the individual hospitals to deal with patient flow issues such as access block. Different strategies work for different hospitals depending on the size and layout of the hospital, the type of staff, and the type of patients presenting. However, these initiatives may conflict with the mandatory initiatives decreed by the overarching Area Health Service management in the search for a standardised systems approach across all hospitals. Therefore, if there is a mismatch between what the Area Health Services decrees and what the local managers of each hospital prefers, stakeholders may use other avenues (such as informal networks and alliances) to achieve the outcomes desired by the Area Health Services, in a way that placates hospital stakeholders. Such dynamics
between local and Area Health Service are, as described by Glouberman and Mintzberg (2001), part of a “vertical gap”. This gap will be discussed in detail in Chapter 3.

### 2.6.2 Ambulances, EDNA and Patient Flow

In addition to the establishment of Patient Flow Units, there have been improvements to the Ambulance Service, which has resulted in an increase of information sharing between the Ambulance Service and hospitals. The current Emergency Department Network Access (EDNA) System is an electronic ambulance distribution system. In each NSW Ambulance, Mobile Data Terminals use software that assists ambulance officers in allocating ambulance patients to hospitals. Once ambulance officers have triaged a patient, the officers enter the patient’s information, including symptoms and demographics, directly into the data terminal in the ambulance vehicle. The system outlines which hospitals in a close geographical position have the resources to treat the patient, approximately how long it will take the ambulance to get to the hospital, and how many ambulances are waiting at the hospital. The hospital is notified of the estimated time of arrival of the patient, and receives information on the patient’s condition.

The introduction of this system has, theoretically, allowed hospital managers to gain a clearer retrospective picture of the availability of ward beds to plan for future peak periods. It also allows other managers from different hospitals (within the same Area Health Service) to monitor how they compare to other hospitals and provides a benchmark. However, whilst in theory the system allows for a more transparent overview of available beds and the time it takes to treat a patient in the ED, there are
still ways around the system. For example, during the observation phase of this research, one flow manager pointed out that different hospitals may enter a patient into the system as soon as they walk into the emergency department whilst others may wait until the patient has been triaged. Delaying the time a patient is entered into the system may mean that the hospital is less likely to breach the benchmark standards. Therefore, this manager was indicating that although there are formal mechanisms in place for monitoring and reporting bed utilisation, there are functions of the system, such as when data is entered, that allow for a manipulation of patient treatment times. Several participants reported that there are often ways around bureaucratic systems, especially when the systems are perceived to be ineffective by those who need to achieve hospital goals.

2.6.3 Emergency Medicine Units, Rapid Emergency Assessment Teams, and Aged Care Service Emergency Teams

As well as the introduction of PFUs and improvements to the EDNA System, NSW has introduced another four (4) key initiatives in its attempt to relieve the pressure of Emergency Departments. These initiatives have been implemented across selected public hospitals across NSW as a trial. They include:

1) *Emergency Medicine Units (EMUs)*. These units provide short term observation and treatment which means that less acute patients can be treated quickly and discharged, thereby improving the likelihood of a bed for patients with more serious conditions. 2) *The Rapid Emergency Assessment Teams (REATs)* allows specialist nurses to order certain tests and administer pain relief whilst a patient is waiting to be seen by a medical team. This reduces the overall wait time for the patient because by the time the patient is seen by a medical team, they do not have to wait
again for these tests to be ordered and executed. 3) **Clinical Initiatives Nurses (CINs)** liaise with the triage nurse so that the CIN is able to treat waiting room patients. The CIN hands over care of the patient to other nurses once initial treatment and investigation is complete (Cashin et al, 2007). 4) Multidisciplinary **Aged Care Services Emergency Teams (ASETs)** are responsible for the early detection of patients who may benefit from specialised care. This means that the patient is treated for the initial medical condition they attended the ED for, as well as any other conditions the team may identify. This helps reduce the likelihood that these patients will revisit the ED on multiple occasions for different illnesses that may be preventable if detected earlier.

### 2.6.4 Reporting Mechanisms - Bed Boards

Previously, NSW Hospitals had various ways of tracking patients flow in and out of the emergency department. All NSW hospitals now use Bed Boards as a way of monitoring patient flow. The Bed Board is an electronic predictive date tool that demonstrates the capacity and demands of a hospital at a specific time (Berry, 2006; BSH Conference). Bed boards are an initiative to improve the information flow within a hospital and across other hospitals in the same Area Health Service. The Patient Flow Bed Board System was first introduced to NSW Hospitals in January 2005 and subsequently rolled out throughout 2005. NSW Health provided the project funding and in 2004 a development team was formed to manage the process. Refer to Figure 2.1 for a visual representation of a bed board.
All NSW Hospitals use Bed Boards to report on the admissions to the emergency department. It allows bed managers an opportunity to gain a clearer picture of which beds in the hospital and Area Health Service are available and plan patient admissions and transfer accordingly. The System displays information about occupancy status, ED Profile, Pre Admissions, number of additions to the elective theatre list and unexpected theatre cases. The system also holds historical data, can do projections and display inter hospital transfers, estimated discharges, request for a transfer, and a ward level platform of planned and actual available beds. The system can generate management reports, including a capacity demand analysis.

The system is valuable in that it allows hospital managers to use real time information systems to gain an overview of what is happening across all the

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**Figure 2.1: NSW Hospital Bed Board**
(Source: Maureen Berry BSH Conference 2006)
hospitals in the Area Health Service. However, the system is limited as it is not used to its full potential. The system only uses selected data and does not take into account other factors such as corporate services cleaners and wards people availability. It also does not take into account the human factor such as dealing with staffing issues on the ward. For example, convincing staff to take on extra shifts during busy periods is a skill that needs to be negotiated by managers and cannot be achieved with a Bed Board system.

2.6.5 Emergency Department or Diagnostic Unit

In addition to supply and demand issues, the role of the emergency department has changed from a place where patients receive urgent treatment, to a diagnostic unit. This change has severely impacted upon patient flow in the department. Patients are not “ready” to be admitted until the medical decision is made and a patient can be admitted to a specific specialty/specialist doctor. Hence patients are staying longer in EDs to first await the decision to admit, then to set in motion the flow to a ward bed. What used to be one seamless integrated system is in effect now a series of separate processes, each moderated by different people of different status. Transitions between these processes can be problematic. Transition requires people with specific skills to negotiate difficulties encountered as a result of bureaucratic processes. In this research it was observed that such people take advantage of their informal networks to “get things done”. However, not everyone has the ability to form the ‘right’ networks or use the networks in a way that will allow them to expedite the flow of patients. Those people who are able to use their skills to expedite patient flow through their informal networks are pivotal to the patient flow process. It is therefore important to consider the context when considering interactions between people.
Understanding the culture of an organisation is therefore a requirement in understanding the context.

### 2.7 Summary

The above review of the NSW Health context drives research on relationships within hospitals. There has been an increase in demand for the services of the emergency department, for a number of reasons. One reason is that there has been an increase in demand for service issues as a result of higher influx of patients due to demographical changes, changing patient conditions, such as an increase in mental health patients and longer length of stay, and as a result of a better informed community. There are also issues with demand and supply combined as a result of managing physical resources inside hospital and outside the hospital. Further, there are issues as a direct result of funding mechanisms by governmental/control at a strategic level through casemix/DRG funding. Furthermore, there are issues with the supply of service as a result of changing workforce. Some initiatives have been introduced to combat the increase of presentations, such as the introduction of the nurse practitioner and the development of emergency medical units.

System changes implemented to deal with access block are not enough to prevent it from occurring. What is needed is an understanding of the required characteristics, skills, knowledge and attitudes of hospital staff, which may in fact be detrimental to the quest for the improvement of patient flow. It is not clear who the stakeholders are when making decisions about bed allocation or how these decisions are made. Further, it is not clear who provides information to the stakeholders responsible for
making decisions about bed allocation, and what the relationship is to existing organisational theory.

The implementation of Patient Flow Units has significantly altered stakeholder relations when managing flow. The management of flow is now centralised under the perception that a centralised flow would be more efficient. However, this perception may not be accurate. This research will not only investigate the role of the unit in administering beds, but also the personal influence exercised by pivotal people. Therefore, it is important to establish who the stakeholders are and what characteristics they need to have to enable the initiative of the Patient Flow Unit to its fullest potential. In other words, just taking the initiative is not enough. It is the realisation of individual attitudes, skills, and knowledge that determines success of initiatives, because stakeholder magnitude/strength of relationships between the stakeholders is essential.

The following chapter (Chapter Three) will explore the current literature about organisational culture in an effort to better understand how the environmental influences guide the actions of various stakeholders involved in decision making about bed allocation. Stakeholder Theory is also explored so that the pivotal people in decision making about bed allocation can be identified. In addition, alliances and networks are explored as a way for pivotal people in organisations to influence decision making about bed allocation.
3 Organisational Culture
3.3 Introduction

In order to understand the way hospitals function, it is important to understand the behaviour of people within the hospital and the environment in which they operate. Having a greater understanding of the organisational behaviour, and in particular an organisation’s culture, assists in the unravelling of the ways in which a hospital is and can be run.

This chapter critically analyses current literature on organisational culture. First, it gives a comprehensive rationale for employing organisational cultural perspectives when investigating interactions between professional groups in hospitals. Second, a range of organisational cultural definitions are explored and adapted for use in this research. Lastly, Martin’s three perspective theory (2002) is applied to the context described in Chapter Two.

3.4 Rationale for the use of Organisational Culture theory as a foundation

Organisational cultural theory, as an element of organisational behaviour theory, lends itself to this kind of research because organisational cultural research allows us to interpret human interactions from both an insider and an outsider point of view. That is, cultural research allows us to use both meaningful and neutral approaches to make sense of the behaviour of stakeholders when making decisions about resource allocation.
In order to investigate the diversity of values and beliefs between occupational and professional groupings, an organisational culture perspective allows full exploration of cultural forms both material and ideational, and allows emergence of the data for the researcher to make sense of data. Weick’s sensemaking theory (1995) is useful in that it propels the researcher to look at the way that people see things, rather looking at formal policies and organisational structures. The researcher will look at both formal and informal practices in an attempt to gain a better understanding of hospitals’ organisational cultures.

This thesis is built on a theoretical foundation that uses a multi-perspective approach of integration, differentiation and ambiguity, which is also referred to as the three perspective approach (Martin, 2002). Martin argues that all three approaches to view organisational culture should be used simultaneously to understand an organisation’s culture because a single approach will not give an accurate, holistic view.

Now that the use of organisational cultural theory as a foundation for this thesis has been outlined, an array of definitions will be explored. The next section outlines the adopted definition of organisational culture as applied to this research. It also features a discussion of the different approaches to understanding organisational culture research.
3.5 Definition of Organisational Culture

Defining organisational culture has proven to be somewhat difficult, as demonstrated by the bewildering array of available and diverse definitions (Adkins and Caldwell, 2004; Fitzgerald, 2002; Sorensen, 2002; Schein, 1996; Barely and Kunda, 1992; Hofstede et al. 1990; Meyerson and Martin, 1987; Frost et al., 1985; Geertz, 1973; Kroeber and Kluckhohn, 1952).

Because of the difficulty in defining the term culture, most researchers use some form of description of attitudes internalised and expressed by organisational actors. For example, Kroeber and Kluckhohn (1952) believe that “culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values” (p. 327).

Other researchers describe organisational culture in terms of how it may be experienced and observed by others. For example, according to Hofstede et al “organisational culture is 1) holistic, 2) historically determined, 3) referred to anthropological concepts, 4) socially constructed, 5) soft, and 6) difficult to change” (Hofstede, et al. 1990: p. 286). Kunda (1992, in Alvesson, 2002) combines the internal and external descriptions and states that culture is a collection of “shared rules governing cognitive and affective aspects in an organization, and the means whereby they are shaped and expressed” (p. 3).
Further, Schein (1996) attempts to simplify the definition of culture and simply states that culture is the sum of “shared norms, values, and assumptions” (p. 229). Collectively, organisational culture researchers seem to agree that organisational culture is a set of socially constructed ideas, values, and norms that are embedded within an organisation.

The organisational culture literature demonstrates that the culture of an organisation is a set of collective values and beliefs that are common to all organisational members, as well as exclusive to that particular organisation. A critical review of the literature reveals two commonalities when defining organisational culture: organisational culture is both ‘shared’ and ‘unique’. However, exactly what is shared or unique is difficult to define.

Discussions about defining organisational culture are ongoing. For example, some researchers think the term *shared* is inaccurate, due to the existence of subcultures (Schein, 2004; Martin 2002; Lok and Crawford 2001; Schultz 1995; Meyerson and Martin, 1987; Louis 1985). Whilst some values, beliefs, and norms of an organisation’s culture can be considered shared, the existence of subcultures means that other values, beliefs, and norms are shared by specific groups. Hence, whilst culture must be shared, the level of involvement in whatever is shared may differ and can assist with the construction of organisational (sub) cultures. These researchers argue that an overarching organisational culture cannot be defined as being fully shared because more often than not there is more than one organisational culture in each organisation. Moreover, when some element of an organisation’s culture is not shared, or rejected, this can be considered a sub- or counter culture.
Uniqueness as a descriptor of culture is also contested by some researchers. It is difficult to prove empirically that an organisation’s culture is unique (Martin, 2002; De Laine, 1997; Louis, 1985; Schein, 1985; Smircich, 1983). For example, many companies state that their objective is to achieve quality in service, implying they have implemented a culture of service quality. Quality in service is an objective that is not distinct to any one organisation and therefore having quality in service as an underlying theme does not make an organisation unique on this basis (Van Maanen and Barely 1985; Trice and Beyer 1984). Nevertheless, descriptors of a common philosophy, that sets itself apart from others, would indicate an organisational culture shared by its members, and recognised by its members as typically theirs.

Hence, it is evident that there are inconsistencies amongst the definitions presented above and that the use of the terms ‘shared’ and ‘unique’, when defining organisational culture, is contestable. However, it is clear that elements of sharedness and uniqueness exist at both the overarching organisational level, as well as within the subcultural groupings in the organisation.

In an attempt to include descriptors of integration as well as recognising subculture formation, for the purpose of this research the following definition of organisational culture is adopted:

organisational culture includes cultural manifestations that are unique to that particular organisation to the point that these manifestations are recognised by organisational members as typical of their organisation.
This definition indicates that cultural manifestations are shared by members at both the integration (overall cultural) level, as well as the differentiation (sub-cultural) levels. Although an organisation’s culture is unique and shared, internal differences between individuals and groups (ambiguity) will create constant, intermittent patterns of behaviour and behaviours that are not patterned at all. This required the researcher to adopt an extension to the above definition by adding:

In addition, individual and group conflicts of cultural manifestations are innate forces evident in organisational cultures that will on occasion create sustained patterns as well as unsustained patterns of integration.

Manifestations of culture include “rituals, stories, humour, jargon, physical arrangements, and formal structures and policies, as well as informal norms and practices” (Martin, 2004; p. 55). Cultural overt or material manifestations can include office space allocations, the physical environment of a building, outwardly expressed relationships between people and groups, brands used by a company, and different levels of security access to different employees. In this thesis, material manifestations, such as nurses wearing uniforms, doctors with stethoscopes around their necks, and managers wearing suits were identified. The latent and ideational manifestations are much harder to recognise as these reflect the values and beliefs of employees individually and collectively. These may include the atmosphere of the working environment and the rapport between different people (Martin, 2002). In this thesis an example of ideational manifestations, would be that despite some
differences, when there is an emergency, all know exactly what to do because their values and beliefs are ultimately about ensuring patient care.

The above extended definition is adapted from Martin’s three perspective theory. This theory proposes the adoption of at least three perspectives when assessing an organisation’s culture. Investigations that adopt such a multi-perspective view are more complete because this allows for alternative, complementary and thorough assessments. A closer look at these diverse perspectives follows in the next section.

3.6 Cultural Perspectives

Martin (2002) argues that organisational culture should be studied from at least three cultural perspectives to gain a holistic understanding. These three perspectives include the integration perspective, the differentiation perspective, and the ambiguity perspective. The three perspectives were first introduced by Meyerson and Martin (1987) and Martin and Meyerson (1988). Meyerson and Martin (1987) argued for the need to think about and enact culture and cultural change from different perspectives to avoid “blind spots” associated with looking at culture from a single perspective (p. 643). Since their foundational work on the three perspective theory, Martin and Meyerson’s work has been cited by well over 500 scholars all over the world (Google Scholar, 2009), thus indicating its widespread usage/understanding/something.

3.6.1 Integration Perspective

Many cultural studies have been researched from an integration point of view (Schein 1985 in Hansen, 2007; Martin, 2004; Ribiere, 2003; Martin, 2002; Schein,
The integration perspective of organisation culture is referred to interchangeably as functionalist, managerial, and normative perspectives (Martin, 2002). Supporters of the integration perspective believe that organisational culture is a variable that can be used to predict outcomes (Martin, 2002; Schein, 1992; Scott, 1992; Louis, 1985). For example, leadership training focused on a step-wise prescriptive model for changing the organisation’s culture. It seems that the ability to change culture rapidly was tied to leadership success.

Martin (2002) defines the integration perspective as focusing on “those manifestations of a culture that have mutually consistent interpretations… ambiguity is excluded” (p. 94). That is, culture is viewed by all members of an organisation in the same way. Sathe (1985, in Martin, 2002, p. 99), a proponent of the integration perspective, argues that in order to maintain a normative feel, employees should seek cultures that fit their own values, and that “if fundamental and irreconcilable misfits between the individual and the organization are apparent, it may be best for the individual to leave” (p. 140). This shows that in Sathe’s opinion, one unified culture is desirable and that weeding out individuals, who do not conform to the one unified culture, is necessary. It demonstrates that, according to integrationists, there is a belief that one unified culture is both desirable and achievable.

Furthermore, some proponents of the integration perspective have developed arguments that outline how to ‘deal’ with subcultures (Kotter and Heskett, 1992;
Collins and Porras, 1994; Schein, 1999). Some authors believe that “if subcultures are acknowledged to exist, training and performance appraisals, motivational speeches, and clarification of an organisation's strategy may be ways for management of an organisation to reign in pockets of resistance created by such subcultures” (Kotter and Heskett, 1992; Collins and Porras, 1994; Schein, 1999, in Martin, 2002, p. 99). This confirms that integrationists believe that culture is a variable that can be manipulated, and that subcultures are undesirable.

Martin (2002) also noted that for researchers who are working from the integration perspective only, “ambiguity regarding some issue might be recognized, but it would be described in negative terms, for example, as a stressor, resulting in emotional strain and performance decrements” (p. 98). This validates some sort of intervention by managers so that future ambiguity is ruled out, in order for one unified organisational culture to continue to exist. In fact, such ambiguity is deemed unacceptable.

In summary, the integration view offers an arguably simplified and anticipatory approach of organisational culture. Notwithstanding the amount of research undertaken from a functionalist perspective, an increasing amount of research on organisational culture is being conducted from alternative perspectives, including the differentiation and ambiguity perspectives. Contrary to a view of one unified organisational culture, some researchers support the view that several organisational cultures, or subcultures, within one organisation exist. This is known as the differentiation perspective.
3.6.2 Differentiation Perspective

Proponents of the differentiation perspective argue that subcultures exist because of inconsistent cultural manifestations. Subcultures can be defined as small work groups that have their own shared set of beliefs, values and attributes (Lok and Crawford, 2001; Martin, 1992). This means that subcultures within organisations can exist on any basis including age, gender, occupation, department, physical location, and ethnic background. Additionally, subcultures exist as a result of common underlying values and beliefs. This is confirmed by Boisnier and Chatman (2003) and Adkins and Caldwell (2004), who argue for the notion of commonality of espoused values. Adkins and Caldwell (2004) articulate this by stating “subcultures within an organization are based on both the pivotal values that define the culture of the organization and a set of peripheral values that are not shared throughout the organization” (p. 970).

Organisational Culture researchers with a tendency to view cultural aspects from a differentiation perspective generally view differences, including material and ideational inconsistencies, as “inescapable and desirable, both descriptively and normatively” (Martin, 2002, p. 102). Therefore, diversity created by groups within one organisation is deemed inevitable.

It is possible for people to belong to more than one subculture. Martin (2002) believes that subcultural differences may be based along functional or hierarchical lines, networks of work relationships, or demographics (p. 103). And although there may be a formation of subcultures due to such differences, it cannot be assumed that one particular source of difference is more likely to create a subculture. For
example, it is not enough to assume that a nurse belongs to a particular subculture just because of his or her profession. Other factors such as being a male nurse, or being a manager may contribute to a particular nurse being part of multiple subcultures within the nursing profession in one particular organisation.

Although stakeholders within an organisation can belong to multiple groups, they tend to operate in specific ‘worlds’ working toward a superordinate organisational goal, but from different perspectives. This is also recognised in the general health management literature. For example, Glouberman and Mintzberg (2001), claim the existence of four ‘worlds’ within a hospital including care, cure, control, and community world views. These worlds are occupied by different professions within the hospital, who operate from different perspectives. This notion of occupational and professional differentiation, or ‘worlds’, will be applied in detail in Chapters Seven and Eight as part of the discussion for this study.

When researching the existence of subcultures, there is no single formula for understanding the formation and development of subcultures. Each organisation may be unique, but the formations of subcultures within these organisations are varied. Van Maanen and Barley propose that the “group level of analysis… is where people discover, create, and use culture, and it is against this background that they judge the organization of which they are a part” (1985, p. 51). This requirement of group level of analysis is common amongst differentiation researchers of organisational culture especially when exploring the possibility of several strong organisational cultures rather than just one. The investigation of different cultures within an organisation is important as it helps researchers understand the different
professional identities of various stakeholder groups, and allows an insight into the workings of an organisation. Further, such understanding will indicate what cultural manifestations are shared at a smaller group level, and how people get things done at a more direct level.

The formation of subcultures may introduce possible divergences between members of different subcultures, but this typically remains latent until a definite course of events occurs (Van Maanen and Barley, 1985; Becker and Geer, 1960). For example, the surgical and medical department may coexist peacefully until there is a small pool of resources which both departments must fight over.

Subcultures emerge for a number of reasons. Fitzgerald (2002) includes “differential interaction, similar personal characteristics, and social cohesion as a basis for subculture formation, and these can include diversity in educational background and professional identity” (p. 30). Employees may feel drawn to one another because of similar experiences due to positions they hold or may have held in the past. For example, a former manager of a health unit may be better able to interact with a current manager of a health organisation, even if they have not worked together before, because they are able to ‘speak the same language’, or have the same world views. Such common characteristics may facilitate the relationship between the managers because they share aspects of a professional identity unique to health managers. This concept is explored in detail in the discursive literature, particularly presented by Foucault from 1966 to 1984.
The degree to which a subgroup is considered *central* by other subgroups is important as is the degree to which they are seen as *incomparable* by other subgroups (Van Maanen and Barley, 1985; Hickson et al., 1971; Crozier, 1964). Indeed, access to resources may be different depending on the power/importance of a subgroup (Alvesson and Berg, 1992; Turner, 1990; Van Maanen and Barley, 1985). Furthermore, “a subculture should also not be considered smaller than the culture of a society, even though the subgroup is much smaller numerically than its encompassing collective” (Van Maanen and Barley, 1985, p. 36). This is evident when noting the power of the Nurses’ Union in the health system. Although Nurses individually have little power in accessing resources, many changes have been implemented in the health system due to the campaigning of the nurses’ union.

In summary, the differentiation view of organisational culture explores the potential differences that arise between the subcultures. These differences exist in values, beliefs and attitudes. The differentiation perspective allows for assessment of culture from a consistent inconsistency viewpoint. Therefore, when looking at interactions between and within occupational groups in a hospital, a cultural study from a differentiation perspective is warranted. However, in addition to the unified culture that the *integration* perspective presents, and the separate (yet unified within themselves) subcultures that the *differentiation* perspective presents, another perspective argues that organisational culture is ambiguous. This is known as the ambiguity perspective.
3.6.3 Ambiguity Perspective

The ambiguity perspective outlines that acceptance of uncertainty in the external environment is necessary to compete in a globalised world. Cultural manifestations are thought to be in constant flux, ambiguity and multiplicity (Martin, 2002; Fitzgerald, 2002; Eljiz, 2004). Multiple views are thought to exist about any one issue and are encouraged (Martin, 2002; Martin and Frost, 1995, Dunford, 1992). The ambiguity perspective “encompasses the complications that the clear oppositions of dichotomous thinking omit” (Martin, 2002, p. 104). However, very few companies are comfortable with uncertainty. This perspective is based on the notion that there cannot be clear groups because individuals vary greatly and constantly develop. For example, task definitions between professions, such as doctors and nurses, are not always clear cut. A doctor may believe they are the only ones with the authority to cure as articulated in their professional history; however nurses may believe that they also have a role in the curing of a patient.

Therefore, proponents of the ambiguity perspective are “more likely to view ambiguity as a normal, salient, and inescapable part of organizational functioning in the contemporary world” (Martin, 2002, p. 105). This is confirmed by Fitzgerald (2002), who stated “lack of consistency and consensus, and, above all ambiguity, are the principles of the ambiguity perspective” (p. 32). She goes on to say that the level of ambiguity in an organisation is what makes the organisation unique. These principles are in direct contrast to the integration perspective and the differentiation perspective.
The ambiguity perspective is more reflective of the complexities in an organisational cultural study in hospitals. Organisational actors are inconsistently inconsistent in their expression of underlying values and beliefs. For example, even within the same ‘world’, members who share a distinct professional identity, may view themselves from a different perspective depending on the situation they are in at that moment in time. For instance, doctors, who are also managers (or hybrid doctor-managers) may introduce themselves in some situations as a doctor, whilst in other situations they may introduce themselves as a manager (Kippist, 2006). This would suggest that delineation within the same profession is also context driven, complicating the assessment of an organisational culture even further.

It is interesting to note that belonging to several subcultures within one organisation may represent inner struggles of identity and loyalty. That is, if there is a disagreement between two subgroups (where one person is a member of both) it would be important to see what factors would make that individual side with one group over another (if at all and at what times). This is important because knowing how people view themselves as individuals and amongst groups gives researchers an insight into the overall organisational culture,. This is just as important as considering what binds the organisational members together and comprises the uniqueness of an organisation.

Therefore, some organisational culture researchers prefer to investigate from a three-perspective theory, rather than just a single theory, when analysing an organisation’s culture (Fitzgerald, 2002; Martin, 2002). Equally, the complexities in health organisations warrants a multi-perspective investigation of the organisation’s
culture to consider members’ values and beliefs through different lenses to gain a more complete understanding of the organisational culture in the three hospitals under study.

### 3.7 Organisational Culture and Managing Patient Flow

This thesis looks at the interactions between managers and clinicians from a managerial point of view, reflecting the integration perspective, as well as from the clinician’s (doctors nurses and other clinical staff) point of view, reflecting an ambiguity perspective. In addition, this thesis also assesses views from professional groupings’ point of view, reflecting a differentiation perspective. This multi-perspective view gives a more complete picture of the interactions between occupational groups when making decisions that affect patient flow and access block.

#### 3.7.1 Three Perspective Theory

There have been some researchers who argue for the need to take all three perspectives into account (Martin, 2002: 1998: 1992; Fitzgerald, 2002; Frost et al. 1985). Although it may be argued that an organisation’s culture can never be understood completely, a multi-perspective theory can assist a researcher in further understanding elements of an organisation’s culture through the behaviour of organisational members. Organisations are made up of diverse individuals and groups which exist in open systems making it impossible to track and understand each element in those open systems. Although it is impossible to fully understand an organisation’s culture, it is important to study an organisation’s culture from all three perspectives.
perspectives. Just as it is simplistic to assume that an organisation’s culture can be completely understood, it would be simplistic to assume that an organisation’s culture can be understood from a single integration or managerial point of view, a differentiation or subculture point of view, or an ambiguity point of view alone. Using these perspectives in isolation will result in an incomplete picture of a highly complex system with complex interactions between individuals and between and within groups.

Researchers attempting to undertake social science field research must first understand the environment being studied. By gaining an understanding of the environment, albeit an understanding which is limited due to being an “outsider” to the organisation, researchers are better able to consider how the values and beliefs of individuals and groups have shaped, and in turn are shaped by the organisation. In order to identify the various stakeholders involved in the decision making of patient flow in a hospital, having an understanding of the environment is essential. It is therefore necessary to undertake a cultural snapshot of the organisations under study and compare them for differences. The cultural snapshot was employed in this study to three different sized hospitals, via a survey questionnaire to individual hospitals workers, as discussed in detail in the methodology chapter, Chapter Five.

The above analysis of the three separate perspectives provides examples of how researchers have examined particular organisations from one perspective and developed theories. However, by looking at the different facets of an organisation with different lenses, several theories and attempts of understanding organisational culture can be combined to gather a more complete picture for researchers.
interested in how an organisation works and how people within an organisation ‘get things done’. Using different lenses to examine what appears to be the same thing is important particularly because of the different professional and occupational groups within an organisation. These occupational groups have distinct professional cultures, and this shapes and is shaped by their professional identity. Thus it is essential to investigate the interactions within and between these groups in order to understand the dynamics in relation to patient flow.

The multi perspective approach is also employed when looking at patient flow issues from several professional perspectives. For example, a medical perspective can be interpreted as an integration perspective because of its historically anchored strong boundaries around their expressions of power, urgency, and legitimacy (Mitchell, et al., 1997). Notwithstanding, a nurse’s perspective can be likened to the ambiguity perspective of organisational culture where processes are more organic, fluid, less constrained, and largely inconsistent. The recognition that different professional groups can be likened to tribes (Braithwaite, 2005; Meyerson and Martin, 1987) would also indicate that a multi perspective of culture is a powerful way of examining interactions between professional groups and professional identities. Acknowledging points of similarity and differences within a large group (integration), within smaller sub groups (differentiation), and by individuals (ambiguity) will allow the researcher to employ different methods in understanding inter-occupational and professional dynamics in the context of managing patient flow.
Consequently, in order to understand occupational and professional dynamics when managing patient flow from an organisational culture perspective, the following questions have been developed:

1) How can the organisational culture be described in:
   a) small hospital
   b) medium hospital
   c) large hospital

2) Do subcultures exist within these hospitals, and if so, how can they be differentiated?

Conducting the research as a cultural study underpins the theoretical framework to be outlined in the following Chapter.

3.8 Summary

This chapter critically analysed the current literature on organisational culture, and gave reasons as to why the researcher will use an organisational culture perspective for the thesis. Different organisational culture perspectives were investigated, and the following definition of organisational culture was given; “organisational culture includes cultural manifestations that are unique to that particular organisation to point that these manifestations are recognised by organisational members as typical of their organisation. The researcher established that a three perspective theory will be used to better understand the organisational cultures of the hospitals under investigation, for the reason that the three perspective theory allows the researcher to understand an organisation’s culture from multiple paradigms. Furthermore, the researcher discussed the use of an organisational cultural perspective to be able to better interpret human interactions from both an insider and an outsider point of view.
4 Theoretical Framework
4.1 Introduction

In order to understand the behaviour of people within the hospital and the environment they operate in, researchers need to look at roles of these people and the groups within which they undertake these roles. This understanding of the roles that people have, and the characteristics that are considered common, then assists in determining the ways that people and groups interact with each other to achieve outcomes.

This chapter critically analyses current literature on professional identities and roles, networks and alliances, social capital, and stakeholder theory. First, it gives a comprehensive outline of professional identity and the characteristics considered common for professionals within certain roles. Second, the chapter analyses the way in which people with diverse roles form alliances and networks to achieve outcomes. Third, the chapter looks the formation of social capital as a result of the alliances and networks formed. Next, stakeholder theory is used to investigate the formal power, legitimacy, and urgency given to stakeholder claims. Lastly, the chapter explores the concept of ‘deep smarts’. It then outlines how using ‘deep smarts’ characteristics can be used to identify people who have additional qualities to formal power, urgency, and legitimacy. This then relates back to the current study which examines this concept in light of the research question: how do these qualities assist the flow of patients from the emergency department to ward beds?
4.2 Professional Identity and Role Theory

The various professional groups in an organisation have distinct characteristics. These characteristics combined are essential components of professional groups’ cultural identities. Fitzgerald (2002) draws upon a vast range of research to discern the identities of medical and nursing professions in terms of values and beliefs, such as functional autonomy, professional boundary, reaction to reform, cultural spectrum, societal spectrum, dominance and authority, and professional privileges (See Table 4.1).

Table 4.1 - Differences in Professional Identity
Source: Fitzgerald 2002 p. 52

<table>
<thead>
<tr>
<th></th>
<th>Medical Identity</th>
<th>Nursing Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Autonomy</strong></td>
<td>Independent, self-evaluated, if any</td>
<td>Independent, exposed to external and internal evaluation Following directives</td>
</tr>
<tr>
<td></td>
<td>In position of authority</td>
<td></td>
</tr>
<tr>
<td><strong>Professional Boundary</strong></td>
<td>Impermeable and thick</td>
<td>Flexible</td>
</tr>
<tr>
<td><strong>Reaction to Reform</strong></td>
<td>Mechanistic, change averse, preferring status quo</td>
<td>Much more organic, going with the flow</td>
</tr>
<tr>
<td><strong>Cultural Spectrum</strong></td>
<td>Largely fragmented, some differentiation (specialities) and outward integration, tightly coupled</td>
<td>Largely integrated, associated with hierarchical structure, with pockets of differentiation and fragmentation, loosely coupled</td>
</tr>
<tr>
<td><strong>Societal Spectrum</strong></td>
<td>Unreserved communal acceptance of knowing what is right</td>
<td>Communal admiration for hard work, but much lower knowledge application</td>
</tr>
<tr>
<td><strong>Dominance and Authority</strong></td>
<td>Sustained dominance</td>
<td>Sustained subordination</td>
</tr>
<tr>
<td><strong>Professional Privileges</strong></td>
<td>Prescribes what is right to cure</td>
<td>Prescribes what is right to care</td>
</tr>
</tbody>
</table>

Such distinctions are helpful because they explain differences of behaviour between professionals, when they are confronted with making decisions about resource allocation in hospitals both in terms of control, but also in terms of task allocations. Such differences have existed for some time. For example, Friedson (1988) asserted that the division of labour of the medical profession is different to the division of
labour of the nursing profession. Therefore how tasks are divided amongst professionals is a consideration. He argues “one is autonomous, and the other is not; one gives orders and takes orders from none, while the other gives orders to some and takes orders from others” (p. 70). Further, the differences in professional status, roles division, and boundaries are magnified given the differences in values, beliefs, and attitudes between the two groups as outlined in Table 1.

Fitzgerald (2002) argues that professional identity is not static. Professional identity is closely linked to the environment; within a context of health reform, professional identity has also evolved. Allen (1997) discusses the changing division of labour between doctors and nurses by putting forth the notion of the Negotiated Order Perspective (NOP). The NOP is a social theory that asserts that “the negotiated order on any given day could be conceived of as the sum total of the organization's rules and policies, along with whatever agreements, understandings, pacts, contracts, and other working arrangements currently obtained” (Strauss, 1978: 5-6). Therefore, according to the researchers adopting a NOP, professional identity is adaptable and constantly evolving.

A Negotiated Order Perspective (NOP), as a social theory used in health, relates to formal inter-occupational negotiations about clinical work between doctors and nurses (Allen, 1997). Additionally, the NOP relates to boundaries, and the changing division of labour between doctors and nurses. The NOP is helpful in that it allows researchers to look at traditional roles of nurses and doctors, as well as the shifting boundaries in relation to division of labour. In fact, it clarifies roles and responsibilities and simplifies relationship norms. As the NOP suggests, it is
important to understand the formal roles of those involved in decision making about patient flow (Allen, 1997). This is because, on the surface, the various stakeholder claims are clearly outlined in tangible roles.

In addition to understanding the formal cure role of doctors (diagnosing and treating patients), the formal care role of nurses (continued treatment of patients), and the formal control role of managers (administer procedures and rules), the informal role of these stakeholders cannot be ignored. However, the NOP theory only looks at formal relationships and how these are negotiated, and as such is criticised in other contexts (Modell, 2006; Day and Day, 1977, 1978; Benson, 1977, 1978). Allen’s (1997) theory lacks discussion about informal roles that doctors and nurses may have in addition to formal division of labour. This is because although doctors, nurses, and managers have a distinct divisions of labour and set roles, there are unspoken roles that also dictate the way that an organisation functions. Whilst nurses are inheriting more medical duties, as seen by the introduction of the Nurse Practitioner Role (refer to Chapter Two), they also have informal roles where networking is seen as beneficial for the organisation’s climate and the flow of patients. For example, it was observed that nurses and managers engage in informal practices whereby having good relationships with other organisational members may help the flow of patients from the emergency department into a ward bed. These informal relationships are discussed in detail in Chapters Six, Seven, and Eight.

In summary, the NOP assists with understanding the dynamics between social order and formal rules, which is necessary in the context of this research. However, it lacks comprehensiveness by ignoring the influence of informality when trying to achieve
desired results. In fact it is the premise of this research that work cannot be completed without a great deal of informality. This informality is developed and maintained by the formation of formal and informal networks, as well as the formation of formal and informal alliances. As such, this research builds on the Negotiated Order Theory by answering the question of how informal social networking affects the way that decisions are made about resource allocation in hospitals.

4.3 Networks

Organisational culture encompasses an understanding of the environment and the people that work in the environment. A key way of understanding an organisation’s culture is by looking at the similarities and differences between its subcultures (Martin, 2001). By examining the networks of work relationships, researchers can begin to gain an understanding of the overall culture. There are many different types of networks that may exist within an organisation. These may include social networks, such as a work social club, informal networks, including knowing who to call when a form needs to be processed quickly without red tape, and alliances, including forming groups to influence management decision making. Social networks, informal networks, and alliances are discussed below, in order to advance the understanding of the complex issues embedded in the research question (or something).
4.4 Social Networks

Observing Interactions between stakeholders assists researchers in understanding the way an organisation functions. Stakeholder theory is discussed later in the chapter. These interactions are important because they assist in explaining the way that stakeholders interface in the organisational environment. The interactions between stakeholders may be through formal meetings. Or, stakeholders may engage through informal interactions, such as being part of a group or network that play golf on a regular basis, or a group of smokers who meet outside the building. For example, doctors often meet for coffee and lunch during work hours, whilst nurses organise social events outside of work hours, thus forming social networks.

Social networks, as defined by Liebeskind, Oliver and Brewer (1996), are “a collectivity of individuals among whom exchanges take place that are supported only by shared norms or trustworthy behaviour” (p. 430) As such, they form a part of an organisation’s culture and may present themselves as either dominant or smaller subcultures. This research is conducted within an organisational culture perspective, and as such an examination of groups and networks are an essential requirement of understanding how organisations function. Gulati and Gargiulo (1999) argue that sociologists have seldom examined how social networks originate. However, there is considerable research describing the phenomena of social networks by way of case study. Social networks are a significant way in which people form the connections that make up social capital. A collectivity of individuals may occur for different reasons, one of which is that people have similar interests and therefore attribute a shared meaning to certain things (Gulati and Gargiulo, 1999). A reason why people with similar interests congregate can be explained by the concept of homophily.
4.4.1 Homophily

Lazarsfield and Merton (in McPherson, Smith-Lovin and Cook, 2001) coined the term of homophily by summarising the concept and using the expression “birds of a feather flock together”. McPherson, Smith-Lovin and Cook define the theory of homophily as “contact between similar people, which occurs at a rate higher than among dissimilar people” (2001: p. 416). This may be a reason why social networks or social relationships are formed, as well as why these social connections can be maintained.

According to McPherson et al. (2001) two types of homophily are evident. These include status homophily and value homophily. Status homophily is where “similarity is based on informal, formal, or ascribed status” (p. 419). Similarity may be based upon a range of characteristics including age, race, religion, or occupation. Value homophily, is based on “values, attitudes, and beliefs” (p. 419). Both types of homophily are based on individuals who share something in common. Commonalities in value homophily may exist due to attitudes, beliefs, attributes and aspirations (McPherson et al., 2001: Louch, 2000: Wright, 1997: Yamaguchi, 1990: Marsden, 1987-88). After family ties, organisational ties, such as work relations, provide the majority of links between people.

These work relations assist researchers in their consideration of the way an organisation works. Podolny and Baron (1997; p. 673) believe that “even in the most bureaucratic settings, informal social relations provide an important source of task advice” (Blau, 1995; Dalton, 1959; Kanter, 1977), can affect the content and quality of decision making (Crozier, 1964; Hickson et al., 1971), and often become valued
personal relationships for many workers (Roethlisberger and Dickson, 1946; Warner and Low, 1947). In fact, it can be argued that there is a need for informal social relations between people within a bureaucratic organisation so that people have a basis for both value and status homophily, or in other words; a basis for similarities. Commonalities between employees will help with shared norms and trustworthy systems of behaviour. Studying informal social relations will also help a researcher understand how people group themselves and how others group them depending on their shared systems of belief.

However, typically, “when networks within organizations or small communities are studied, they often display a core-periphery pattern, with a central group of closely interconnected people and a larger group of people who are less densely connected to the core and to each other” (McPherson et al., 2001; p. 427). This central group of closely interconnected people often form the focal point for much of the social activity and are usually more extensively connected to other people within the organisation than others not directly a part of the central group. It is important to note that “while homophily on structural similarity has focused almost exclusively on influence and comparison processes, the core-periphery pattern that networks often show may indicate that other types of advice, friendship and association respond to this basis of homophily as well” (McPherson et al., 2001; p. 428).

Therefore, it is clear that the connections that people form at a social level at work can be just as important as those formed based upon formal attributes such as structure and position. The collectivity of individuals, or the central group closely interconnected plays an important role in the development of the organisations
overall norms, beliefs and attitudes. This influence may be through formal decision making authority and may relate to decisions about which departments get the most money. Or it may be through informal networks that organise trivia nights and the location of the organisation’s annual gathering. These add to “the way we do things around here”, that is, the organisation’s culture. For example, in some hospitals, some of the permanent staff organise events through social clubs for the staff. The discussion above looks at the positive linkages between people as well as the negative symmetry and how this may explain the formation of cultural groupings in hospitals.

In addition, a collectivity of individuals is often characterised by one central person of the network whom others within the network are drawn towards. This concept is known as centrality. Sparrowe et al. (2001) define centrality as the “extent to which a given individual is connected to others in a network” (p. 316). This central actor has a certain persona that mirrors others’ values, attitudes and beliefs, as well as a status that is attractive to other members of the network. The central actor is a connection for members of a social network who may wish to access other members, and is then able to use the accumulated knowledge to generate workable solutions to task-related problems (Baldwin et al., 1997). This form of connecting can be accomplished by the use of informal networks. Understanding the way that informal networks operate in an environment is important in gaining a more complete picture of the organisation’s culture. This is because understanding informal networks helps researchers gain a better understanding of the various subcultures that may exists within an organisation’s culture. The three perspective theory allows researchers to look at networks within the organisation (integration), smaller yet still discernible
networks (differentiation), and difficult to spot alliances and networks between individuals with points of similarity that are not clear to others (ambiguity).

4.5 Informal Networks

Organisational networks are constructed when individuals in organisations interact (Tolbert, Salancik, Krackhardt and Andrews, 1995). Networks can take any form and vary from formal arrangements between individuals or group, to informal networks. Whereas formal networks are based upon directed work relations, informal networks are developed “outside of the formal structure of organizations and often describe the relationships of friendship networks, advice networks, trust networks, and communication networks” (Pappas et al., 2004: p. 10). Krachhardt and Hanson (1993) define the informal organisation as “the networks of relationships that employees form across functions and divisions to accomplish tasks fast” (p. 104). They argue that managers should use network analysis to “translate relationships” (p. 105). The need to translate relationships is essential for people who may wish to gain access to an organisation since understanding (or attempting to understand) an environment, gives a researcher more information about an organisation’s culture.

According to Krackhardt and Hanson (1993), these network relationships include the advice network, the trust network, and the communication network. The advice network shows the “prominent players in an organization on whom others depend to solve problems and provide technical information” (p. 105). Sparrowe et al. (2001) state that advice networks are “comprised of relations through which individuals share resources such as information, assistance and guidance that are related to the
completion of their work” (p. 317). This relates to the concept of centrality, which was previously discussed in the social networks section of this review. Organisational members are drawn to prominent players who are considered central to the entire network. Considering who these central players are, is essential to understanding why some people are able to “get things done”, whilst others are not.

Contrary to the advice network, which is built upon those with technical knowledge, the trust network “tells which employees share delicate political information and back one another in a crisis” (Krackhardt and Hanson, 1993: p. 105). A social network map would help others see who the central person within a trust network would be. The trust network is said to be able to “often reveal the cause of non-routine problems such as poor performance by temporary teams. Companies should examine trust networks when implementing a major change or experiencing a crisis” (Krackhardt and Hanson, 1993: p.106). Understanding trust networks is important for a researcher studying an organisation, because trust networks help build social capital, which allows researcher to better understand how connections are made and why people are able to work with some and not with others.

The communication network “reveals the employees who talk about work-related matters on a regular basis” (Krackhardt and Hanson, 1993: p. 105). Again, if a social network map was drawn, there would be a central or a couple of central people that other employees would talk to regularly about work related matters. In a study of communication networks, Krackhardt and Hanson (1993) found that “more communication ties did not distinguish the most profitable branches; the quality of communication determined their success. Non-hierarchical branches, those with two-
way communication between people of all levels, were 70% more profitable than branches with one-way communication patterns between “superiors” and staff” (1993: p. 109). A person who is considered central to a network would be able to access more people and would likely be capable of a higher quality of communication due to expected reciprocity and goodwill generated from this.

The advice network, the trust network, and the communication network, are also interlinked and by examining which people interact with each other, a central person or persons can be determined as being most important to the informal network being examined. Thus social capital is a resource and the result of social networking, which occurs through a mechanism of homophily and for the purpose of establishing social connectivity. As discussed in the previous section, social connectivity is conducive for the development of social capital as resource. One of the areas of informal social networking rarely researched involves intraorganisational alliances.

4.6 Alliances

Whereas networks are formed for future unspecified purposes, alliances are formed for specific purposes. For example, a network may consist of a group of people who regularly meet as friends who catch up on what is going on in the organisation. However, an alliance may be formed between two people who meet to form a strategy for a specific purpose, and then do not continue to meet once the purpose has been achieved, Alliances range from formal written contracts to verbal communication. Hergert and Morris (1988) concluded that since 1980 the number of interorganisational alliances, that is alliances between organisations, has “virtually exploded”. However, much of the literature about alliances is about alliances with
other organisations (Harrigan, 1986; Gulati, 1995; Gulati and Singh, 1999; Gulati and Gargiulo, 1999), rather than alliances within the same organisation. Indeed, the research clearly indicates that when organisations decide to form new alliances they do so by depending on the information generated from existing interorganisational alliances (Macaulay, 1963; Grannovetter, 1985; Ring and Van de Ven, 1992; Powell and Smith-Doerr, 1994; Doz, 1996; Lincoln, Gerlach and Ahmadjian, 1996; Gulati, 1998).

Whereas networks are formed for future unspecified relations, alliances are formed for specific outcomes. Both alliances and networks, as applied to the three hospitals studied, are discussed in Chapter Seven and Eight. Since most literature on alliances is about linking organisations as whole entities, this research is novel. In this research, alliances are studies within the one organisation, a phenomenon not readily identified in existing literature. This is probably because alliance theory has not been linked with organisational culture theory as yet. This research examines alliances within the same organisation, and as such adds to existing literature about intraorganisational alliances.

There are three types of alliances: direct alliances, indirect alliances to a common party/group, and reputation, which is based on who the group wants to have an alliance with. Gulati and Gargiulo (1999) have termed these alliances relational, structural, and positional. Most of the research about alliances has been focused on alliances across different organisations rather than alliances within the same organisation. There is no research that directly links how and why people form these types of alliances in order to influence decision making to gain access to resources,
and if the organisational culture directly or indirectly propels employees to form such alliances ‘to get things done’. This research examines the formation and use of alliances to get things done.

Additionally, there is little research that examines the strength or the magnitude of these individuals’ relationships. For the purpose of this research, these individuals in organisations will be referred to as stakeholders. They are referred to as stakeholders because they have a say in the way that decisions are made about resource allocation. These stakeholders are investigated because the researcher is interested in examining how individuals and groups within organisations affect decision making about resource allocation. Stakeholder theory is discussed in the later sections of this chapter.

Networks and alliances are created for various reasons. However, the common theme is that people form these relationships as a way of achieving shared objectives. Developing relationships with work colleagues often creates beneficial exchanges, which may lead to the sharing of resources (from intellectual to material). On one hand, these alliances are shared. However, the more that is shared, the greater the divide between competing stakeholder groups from different worlds, such as doctors from a cure world, nurses from a care world, and managers from a control world (Glouberman and Mintzberg; 2001). This investment in social relationships as a resource is known as social capital, which is discussed in the following paragraphs/section.
4.7 Social Capital

Understanding the way social relationships are formed and why they are formed is necessary for researchers who aspire to understand the connections between people. Connections between people included social and informal networks. Social networks differ from other types of informal networks as the emphasis is on relationships formed for social purposes such as social clubs. One reason why organisational members aspire to develop connections is that these connections may assist with getting things done, such as expediting patient flow. This is considered social capital. Understanding the networks and relationships that people have in organisations allows researchers to seek patterns of behaviour, both overt and latent, that exist when stakeholders make decisions, such as, in the context of the present study, in the process of admitting a patient from the emergency department (ED) to the ward. An analysis of inter and intra professional interactions may assist with improving efficiencies within the admission process and, as such, may have implication for combating access block.

Putnam argues that social capital is one of the “features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives” (1995, p. 24). Bourdieu (1986) defines social capital as “the set of resources that inheres in the structure of relations between individual actors”. Oh, Chung and Labianca (2004) expand this definition: “people and groups of people are connected to certain others, and this creates a network of interdependent social exchanges where certain people become trusted exchange partners and can be called upon for resources and support” (p. 3). Such resources may refer to material and/or human resources.
Onyx and Bullen (2000) argue that “all uses of the concept [social capital] refer to more or less dense interlocking networks of relationships between individuals and actors” (p. 24). The significance of relationships between people in a professional environment is evident particularly when the formal channels needed to gain access to resources are ineffective (Podolny and Baron, 1997). For example, a staff member attempting to order stationery may be able to bypass several forms if they have a good relationship with the administration person in charge of stationery orders. Therefore investment (by all levels of employees) in social capital, or networks of interdependent social exchanges, is critical. As well as interlocking networks of relationships within a social structure, there are other themes indicative of social capital.

Reciprocity and trust are also common themes of social capital (Onyx and Bullen 2002). These themes are essential to an organisation’s culture because reciprocity and trust (for whatever reason) forms the basis of many relationships in organisations. Reciprocity occurs when “the individual provides a service to others, or acts for the benefit of others at a personal cost, but in the general expectation that this kindness will be returned at some undefined time in the future in case of need” (Onyx and Bullen, 2004: p. 24). Indeed, by providing services to others at a personal cost, a kind of goodwill is built that helps with the interdependent social exchanges needed to build strong social capital. For example, a nurse may work through his/her lunch hour during a busy period with the understanding that if a family emergency arises at another time, they will be allowed to leave one hour earlier. In this example, there is no formal agreement that leaving early at another time will happen, however
there is a basis of trust between the nurse and the manager that implies that the nurse will be looked after. This implies that there is a strong link between reciprocity and trust where the former cannot exist without the latter.

Fukuyama (1995) defines trust as “the expectation that arises within a community of regular, honest and cooperative behaviour, based on common shared norms, on the part of other members of that community. Those shared norms (in relation to cultural integration) can be about deep “value” questions like the nature of God or justice, but they also encompass secular norms like professional standards and codes of behaviour” (Fukuyama, 1995: p. 26). Exploring such integrative norms helps a researcher understand the culture of an organisation, as the researcher begins to understand why behaviours are occurring by exploring the attitudes and beliefs of those employees behaviours. Exploring how norms are based on trust also helps in the understanding of various subcultures that may exist within the organisation being examined. As well as exploring norms to understand social capital, a researcher must examine the conditions of social capital. In summary, social capital theory argues that the connections that people form assist with achieving goals and outcomes. However, it is not clear how the development and maintenance of social capital may assist with the flow of patients from the emergency department to a ward bed.

In an effort to link social capital to cultural theory, the work of Nahapiet and Ghoshal may be useful. Nahapiet and Ghoshal (1998) and Tsai and Ghoshal (1998) argue that there are three conditions of social capital which are interrelated. These include the structural dimension, the cognitive dimension, and the relational dimension.
The structural dimension refers to the “overall pattern of connections between actors…who you reach and how you reach them” (Nahapiet and Ghoshal, 1998: p. 244). This could be considered a map of the entire organisation where there are lines joining certain people and not others. As part of the map, numerous and thick lines may mean that a person is reaching others more frequently and that they are central to an organisation’s social structure. An example of a map of connections is depicted in Figure 4.1. These are sometimes referred to as sociograms (Hogan, 2007).

![Figure 4.1: Example of a Sociogram](image)

Furthermore, “the location of an actor’s contacts in a social structure of interactions provides certain advantages for the actor. People can use their personal contacts to get jobs, to obtain information, or to access specific resources” (Tsai and Ghoshal, 1998: p. 465). The more central (influential) a person is within the social structure of
an organisation, the more leverage they hold to access information and resources. This central person may be known as a definitive stakeholder in Mitchell et al’s (1997) stakeholder theory. Stakeholder Theory is discussed in the latter part of this chapter. The structural dimension of social capital is similar to cultural integration where the researchers are interested in the overall lines of connection.

The second condition of social capital is the cognitive dimension. The cognitive dimension refers to “those assets created and leveraged through relationships and among the key facets in this cluster are trust and trustworthiness” (Tsai and Ghoshal, 1998: p. 244). As discussed previously, trust about norms such as professional standards and codes of behaviour help determine the social capital of an organisation. By understating how people view such norms within an organisation, a researcher can gain a better understanding of the intricate relationships between people. “Trust can act as a governance mechanism for embedded relationships (Uzzi, 1996 in Tsai and Ghoshal, 1998: p. 465). Moreover, although “trust is an attribute of a relationship…trustworthiness is an attribute of an individual actor involved in the relationship” (Barney and Hansen in Tsai and Ghoshal, 1998: p. 465). Therefore, the theme of trust within a relationship is an outcome of that relationship, trustworthiness is a characteristic of each individual within the relationship and as such will vary from individual to individual. Trust is the collective outcome of individual’s trustworthiness. Lack of trust, for instance, maybe a reason why a department in a hospital does not get on with another department. It may be because of previous dealings, or it may be because of historical reasons. It is these types of subcultural differences that the researcher aims to examine. Therefore, the
The cognitive dimension of social capital is related to the differentiation perspective of organisational culture.

The third condition of social capital is the relational dimension. The relational dimension refers to “those resources providing shared representations, interpretations, and systems of meaning among parties” (p. 244). Interpretation of shared systems of meaning is important to researchers who wish to understand the collective or the organisation holistically, as well as understanding the shared systems of meaning between smaller subgroups. The shared codes or paradigms of the relational dimension of social capital can be likened to the ambiguity perspective of organisational culture, where there are sporadic yet sometimes discernable patterns of similarity based upon shared representations and interactions.

Hence social capital theory is a strong framework for the investigation of interpersonal and intra professional dynamics because it allows researchers to look at the structural, cognitive, and relational dimensions of social capital from a three perspective foundation of culture. In addition, the Nahapiet, Tsai and Ghoshal framework has close synergies with the foundation of this thesis, which is a cultural perspective, and as such warrants investigation of the social capital of various stakeholder relationships in an organisation.

Whilst social capital theory and network theory explain why people come together to get things done, these theories alone will not give a clear picture on who matters and to what extent they matter, when making decisions about patient flow in emergency department. For this, stakeholder theory as per Mitchell et al. (1997) was adopted as
a frame for indentifying individuals and groups with a stake in patient flow decision making.

4.8 Stakeholder Saliency

Freeman (1994) defines stakeholders as “any group of individuals who can affect or are affected by the organisation or firm, including its investors, suppliers, employees, customers, competitors, local communities in which it operates, regulatory agencies” (Barringer and Harrison, 2000). Mitchell et al. (1997) developed a stakeholder model to assist managers deal with multiple stakeholder issues effectively. The model consists of three factors used to determine the salience (the degree to which the manager takes the stakeholder's power, legitimacy and urgency into account), or the timeliness required to meet certain stakeholders' issues. The model is useful to researchers studying stakeholder interests and the impact of stakeholders on organisations, in that researchers can use attributes which help them flag influential organisational members. These attributes are discussed in the following subsection.

4.8.1 Stakeholder Attributes

The three attributes of Mitchell et al.’s (1997) stakeholder theory include power, legitimacy, and urgency (see Figure 4.1). The first stakeholder attribute, power, is the ability to influence decisions. The second attribute is legitimacy, and is the verification to use the ability to influence decisions. Legitimacy is also known as the authority. The third stakeholder attribute urgency, includes time sensitivity and criticality, and is about how essential it is for a decision to be made. Mitchell et al. claim that “power by itself does not guarantee high salience in a stakeholder-
manager relationship. Power gains authority through legitimacy, and it gains exercise through urgency” (Mitchell, et al. 1997: pp 865-6). Mitchell et al’s model claims that when all three attribute can be found in a stakeholder class, managers will take their stake more seriously. However, the model does not deal with the magnitude or strength of the existence of all three attributes. Stakeholders are assessed according to the three attributes, power, legitimacy and urgency, and placed into seven classes of stakeholders, which are then categorised into three groups according to the number of attributes they possess. An eighth class exists which are non-stakeholders or these can be potential stakeholders (refer to Figure 4.2).

![Stakeholder Categories and Classes](image)

**Figure 4.2: Stakeholder Categories and Classes**

Source: Adapted from Mitchell et al. (1997: 874)

Whilst the stakeholder theory according to Mitchell et al (1997) may appear an ideal way of assessing an organisation’s stakeholders salience, the model is somewhat simplistic. Barringer and Harrison (2000) argue that stakeholder theory in general,
tends to look at organisations heuristics at more of a micro level than a macro level and is more descriptive rather than prescriptive. The stakeholder model is unrealistic as it would be impossible to assess multinational corporation’s stakeholders, which may exceed hundreds and even thousands. Furthermore, according to Barringer and Harrison (2000), “stakeholder models often lead to the conclusion that alliances can facilitate goal congruence among a group of stakeholders, but they do not provide much in the way of advice with regard to the form alliances should take” (p. 374). They extend their assessment and argue that “due to a lack of empirical testing, much of the wisdom emanating from stakeholder theory is accepted on faith, or because of moral correctness” (p. 374).

However, Mitchell et al. concede there is a lack of empirical research and urge researches to test the model. The model is useful in that it can explain and retrospectively justify how researchers of decision making theory identify and classify stakeholders. However, the model does not account for personal informal relationships or magnitude or (thickness) of interactions when making decisions about class. That is, the researchers focus on formal relationships and ignore informal relationships when deciding upon the attributes which will be used to classify stakeholders into one of the eight classes. Whilst this researcher will use the stakeholder attributes to help determine formal decision making ability in the hospitals studied, the researcher will also look at informal relationships, such as alliances and networks, to gain a more complete picture of how decisions are made when diverse stakeholders are involved in the decision making process.
Notwithstanding the criticisms, stakeholder theory is useful to evaluate the power, legitimacy, and urgency, and combination thereof that determines salience of managers and of employees in an organisation. However, the model fails to address how the same stakeholder, that is the employee, who has power, legitimacy, and urgency would be assessed compared to another employee with the same level of power, legitimacy, and urgency. That is, if employee A and employee B are grouped as sharing the same class, how is salience exercised? There may be a need for a ‘rule of thumb’ that managers use as a result of their experience. Therefore, salience is about individual judgement, where the main stakeholder is the manager him/her self. Using social capital theory and network theory helps understand why people come together to get things done, whilst stakeholder theory assists with explaining, through formal signposts, which of these people matter when making decisions about patient flow.

Salience through individual judgement can be recognised in organisational members with certain skills and characteristics. Connecting with and reaching people, trust and trustworthiness, and shared meaning between people, interlink to form social capital and helps to determine who a researcher may need to connect with to gain access into an organisation. Some organisational members have a high level of tacit knowledge, which allows them to recognise patterns others cannot see and make wise decisions that lead to a good outcome. This special insight based on expertise built on organisational experience has been referred to by Leonard and Swap (2005) as “Deep Smarts”. It is argued that keeping Deep Smart people in organisations add to an organisation’s social capital. In order to understand the way that decisions are made by stakeholders, it is important to identify those stakeholders that are pivotal to
the way an organisation is run. These stakeholders possess certain skills and attributes that allow them to use their expertise in making decisions. Essentially, it can be argued that these stakeholders possess “deep smarts”.

The researcher discusses these deep smart attributes in the following section. However, it should be noted that these attributes help identify individuals with special characteristics that assist in organisational conduciveness. Therefore, deep smarts is not a theory as much as it is a tool that assists researchers in recognising people with particular skills.

4.9  **Deep Smarts**

Leonard and Swap (2005) define deep smarts as “the knowledge that provides a distinctive advantage, both for organizations and for managers as individuals” (p. 2). They further describe deep smarts as “a potent form of expertise, based on first-hand life experiences, providing insights drawn from tacit knowledge, shaped by beliefs and social forces” (Leonard, 2007; p. 3). Pivotal people within organisations are said to possess deep smarts based on a number of characteristics or attributes. Deep smarts can be recognised by looking at the ladder of expertise.

There are four levels of the “ladder of expertise” (2005; p. 8). These include (1) the Master (virtuoso); (2) the Journeyman (advanced); (3) the Apprentice (advanced beginner; intermediate); and (4) the Novice (beginner). They argue that “the process of specifically building and transferring deep smarts aims to address knowledge gaps in the organization. A knowledge gap is, quite simply, the difference between what
someone knows (and knows that she knows) and what she needs to know in order to accomplish some task with competence, if not expertise” (p. 7).

Leonard and Swap warn against classifying people in organisations under the two extremes of novice or expert and argue that “the world is not divided between the two extremes of novices and experts. The cognitive territory between the two is occupied by intermediate levels of expertise. Whether to label a coach an “expert” or a “journeyman,” or a start-up entrepreneur a “novice or “apprentice”, is usually a subjective decision” (p. 8). They further argue that “Attaining true deep smarts takes time as well as effort, and it would be misleading to assume that knowledge gaps between the extremes (novice and expert) can always be filled. All of us at some times in our lives assume the role of novice, and if we preserve in accumulating experience and knowledge, we may also have the privilege of taking the master’s role” (p. 9). Understanding the different levels of the ladder of expertise is essential in understanding how deep smarts occur in organisations, as well as the characteristics of deep smarts.

4.9.1 Characteristics of Deep Smarts

According to Leonard and Swap (2005), there are several characteristics of deep smarts. The original seven dimensions of deep smarts include: (1) skills and know-how; (2) systems thinking; (3) separation of signal from noise; (4) swift, wise decision-making; (5) ability to take context into account; (6) networks; and (7) pattern recognition.
Leonard (2007) states that staff who possess “skills and know how are essential to the organisation. These are people who have deep smarts are the GO-TO employees, the ones who have the answers” (p. 3). For example in the hospital, such pivotal persons are the most resourceful. They are often very experienced and have tacit and explicit knowledge of organisational matters that is beneficial to others.

Persons who employ systems thinking apply “knowledge of big picture to details; interactions and consequences” (p. 16). For example, in the hospital most system thinkers would be at a more senior level. These managers can oversee the interconnections between parts of a system that can otherwise be blurred by a separation of individual wards. Additionally, a senior manager may employ some contingency plans during a point of crisis and will use other contingency plans at other points of crisis based upon the current situation.

Leonard (2007) goes on to say that deep smarts people have “the ability to separate signal from noise by focusing on relevant data and behaviors” (p. 16). For example, a manager in a hospital may be able to recognise that staff are unhappy about additional patients being admitted to their ward, and identify possible barriers that the staff may engage in to delay the arrival of the patients.

Further, deep smarts people are able to engage in swift, wise decision making. These experts are able to “determine quickly what facts are relevant in a particular context, allowing them to focus their attention on just the information that is currently pertinent. This combination of pattern recognition, abstraction, and focusing on only
the relevant dimensions of the problem results in a highly efficient, fluent decision process in complex tasks – a process that is largely tacit” (p. 53).

Additionally, staff with the ability to take context into account are experts who “integrate the experience-based patterns they have built up with information about the context, resulting in a superior choice of action because it is contingent on variations in the situation” (p. 53). For example a manager may recognise that there will be a busy night and take action to transfer less acute patients to other departments to make room for incoming acute patients, even if the manager does not know the exact number of patients that will be incoming.

People with strong networks are able to engage with others who provide access to essential knowledge assets” (p. 86). For example, a manager at a hospital may use their networks to encourage casual staff to work during busy nights.

Lastly, according to Leonard and Swap (2005), people with deep smarts characteristics have an eye for pattern recognition. When “knowledge is fragmented, they aggregate it, make sense of it, see the relevant patterns, and act on it” (p. 58).

In addition to the seven original dimensions of deep smarts introduced in 2005, Leonard (2007) proposes two supplementary dimensions of deep smarts. These include; (8) ability to deal with novelty; and (9) enthusiasm/passion for the knowledge domain.
People with deep smarts have the ability to deal with novelty. They are "open-minded enough to allow questioning of own assumptions" (p. 42). For example, whilst routines are well settled in the work of most hospital workers, deep smarts will reflect regularly on own, often ingrained, suppositions and will analyse problems from different perspectives to make a balanced decision.

Furthermore, deep smarts have passion for the knowledge domain, which "speaks to their motivation which affects the ability to continually learn" (2007; p. 42). This would indicate that according to Leonard (2007), passionate staff have the innate volition and enthusiasm to learn from their experiences and this adds to the growth of individuals.

To date, the concept of deep smarts has only been examined looking at individuals that possess some or all of the characteristics. There is no research to indicate if a team can be considered as displaying deep smarts characteristics. Members of teams, and subgroups, have a high level of interdependence with one another. There is also no research that indicates if the size of an organisation has an effect on the degree to which deep smarts characteristics are discernible at both the individual level as well as the team level. This also ties into organisational culture and stakeholder theory.

Stakeholder Theory assists researchers in attempting to examine different issues managers in organisations face when making decisions when various stakeholders are involved. Researchers of organisational culture are interested in how decisions are made. The emphasis of this study will be upon the identification/consideration of
stakeholders. From a management point of view, there is a considerable amount of research about stakeholders (Hillman and Keim, 2001; Jones, 1999; Mitchell and Agle, 1999; Mitchell, Agle, and Wood, 1997; Rowely, 1997; Donaldson and Preston, 1995; Freeman, 1994:1992). However, there is little research that considers how stakeholders use their social relationships as a resource for influencing decision making. Therefore, this research is important because it articulates how people use their informal social relationships to influence decision making about patient flow.

4.10 Summary

The above critical review of professional identity and roles, networks and alliances, social capital, deep smarts, and stakeholder theory reveals an area about the consideration of informal attributes to determine who matters when making decisions, which has not as yet been fully investigated. Essentially, the individual, or individuals, we call ‘deep smarts’ can be likened to cultural leaders. These cultural leaders can be considered definitive stakeholders, which are central to the organisation.

The researcher has discussed how there can be multiple definitive stakeholders within an organisation. The question remains, who really matters? Are all definitive stakeholders equally definitive or are there patterns of behaviour identifiable consistently or inconsistently? Answering these questions may have implications for the management of patient flow in the emergency department. Therefore, in order to understand stakeholder influence in decision making, the following questions have been developed:
3) (i) How are alliances created and boundaries crossed between stakeholders from different organisational cultural backgrounds?

(ii) How do stakeholders with diverse subcultures make decisions about resource allocation?

4) Does the magnitude/thickness of the stakeholder-managerial relationship influence whatever decision is going to be made, and if so how?

This chapter outlined the theoretical framework for the research by reviewing studies of professional identity and roles, networks and alliances, social capital, stakeholder theory, and deep smarts in relation to decision making about resource allocation. The researcher discussed the identification of professional identities and the formal roles of stakeholders in hospitals according to Allen’s Negotiated Order Perspective. The concept of social capital and homophily were considered as a framework to obtain better understanding of the formation of subcultures and networks and alliances within health organisations. The use of networks and alliances in organisations was discussed in relation to understanding subcultures and boundaries within an organisation’s culture. The boundaries created and enforced by networks and alliances were considered as in the recognition of stakeholders with formal power, urgency, and legitimacy as well as the informal power of stakeholder groups to influences decision making about resource allocation. The recognition of powerful individuals with discernable characteristics (deep smarts) was also discussed. However, the researcher argued for the need to look at informal attributes to distinguish how powerful a stakeholder claim can be considered, particularly when stakeholders are affiliated with diverse subcultures and professional groups. The following chapter will outline the methodological framework of the study.
5 Methodology
5.1 Introduction

This chapter outlines the school of thought that underpins the methodological structure for this research. The chapter consists of three sections.

In Section One, the researcher will explain the underpinnings of the knowledge that is being created and a justification of the mixed methods approach. In Section Two, the researcher will explain the tools used to gather the data. Due to the complex nature of hospital labour, multiple methods were used to gather the data. A survey questionnaire was used to gain a snapshot of the organisational culture of each of the three (3) hospitals examined in the study. Semi-structured interviews, observation and a review of the formal rules and procedures were used to understand why particular cultural manifestations were occurring in each of the hospitals. In addition, section two outlines how the data was analysed using quantitative and qualitative methods of analysis. The researcher used principles of triangulation to deal with the complexities of the research.

In Section Three, the researcher discusses the considerations and limitations of the research undertaken. The researcher’s and participant biases are outlined, as are the strategies used to combat such biases. In addition, ethical issues are considered.
5.2 Section One – The Foundation of Knowledge Creation

Social science field research was used for the purpose of this research. Social science field research is a multi perspective approach that allows both emic and etic perspectives, commonly used in cultural research. A mixed methods methodology was used as a framework for the research. An overview of previous as well as current practices for the use of a mixed methodology guided the researcher in determining how to mix the methods.

5.3 Social Science Field Research

To place this research in an ontological and epistemological space, this research can be categorized as social science field research (Strauss and Corbin, 1990; Giddens, 2006; Perecman and Curran, 2006). Social science fieldwork encompasses several complementary methods of data gathering and analysis, where the researcher enhances insights and perspectives about a specific context to build a stronger social scientific understanding of people and events within that context. In this research, a mixed methods approach was used by undertaking a cultural assessment via survey questionnaire, complemented by observations of interactions between organisational actors, including formal semi-structured interviews and reflections of many hours of observation. This research design required the adoption of both an emic and etic approach.

The researcher identifies with both a constructivist approach and pragmatist approach to create knowledge. The researcher agrees with Crotty’s definition of constructivism in that “there is no objective truth waiting for us to discover it. Truth, or
meaning, comes into existence in and out of our engagement with the realities in our world” (Crotty, 2003; 1998, p. 8). That is, “different people may construct meaning in different ways, even in relation to the same phenomenon” (Crotty, 2003; p. 9). Meaning in this study is understood to be constructed by the participants in the study, as well as the interpretation of these meanings by the researcher.

Further, pragmatism is “knowledge that works in practice or is working in practice” (Hayes, 2008). In the epistemology of pragmatism “knowledge is not the reproduction of reality but an instrument for dealing with it successfully. The semantics of pragmatism locates the meaning of concepts in the practical consequences for action resulting from their use or their difference from other concepts” (Joas, 2002; p. 578). For example, a pragmatic ontology would allow the researcher to make recommendations about the formation of networks, as well as the management practices of the teams within those networks to the benefit of the hospital system.

5.4 Emic/Etic Research

The organisational culture literature outlines two types of approaches that can be used to study an organisation’s culture; the emic approach and the etic approach. The emic approach is “the inside perspective of ethnographers, who strive to describe a particular culture in its own terms” (Morris et al, 1999; p. 781). Adopting an emic approach would mean that the researcher had to emerge herself in the context and gather field notes from an insider perspective. This was not entirely possible as the researcher was not an employee of the hospital. Nevertheless, the researcher ensured that she was very close to what was really going on. The
researcher did this by being unobtrusive. For example, the researcher ensured that she conducted the observations by working with the staff the same hours they did, and taking lunch breaks and coffee breaks at the same time.

The aim of this research was to describe the organisational cultures of the hospitals being studied and make generalisations within those organisations cultures, rather than attempting to make generalisations about all hospital cultures. However, this research is not purely etic either, as the researcher immersed herself in the organisations under study, created a relationship with organisational actors and as such likely influenced those observed.

The etic approach is “the outside perspective of comparativist researchers, who attempt to describe differences across cultures in terms of a general, external standard” (Morris et al, 1999; p. 781). The researcher used an etic approach to be able to make generalisations, based on her observations, about the organisational cultures studied.

These definitions would indicate that research is either emic or etic. However, this research adopted a mixed approach where the emic/etic mix is seen more as a fulcrum to balance the two approaches. Although the researcher was not a part of the environment, she was able to use her lived experiences to give a personal interpretation of the organisation’s culture (Spiers, 2000 p. 715). The researcher conducted the study as an outsider (etic), however spending shifts observing and building relationships allowed her to have a more personal understanding of the hospital environment. Using emic and etic approaches, the researcher was able to
minimise the limitations associated with using only one of the approaches. Hence, the researcher concurs with Hofstede that “emic-etic approaches are complimentary” (1998; p. 19). The advantages of using a mix of emic/etic approaches is one of the justifications for using a mixed methods approach.

5.5 Mixing Methods for Completeness

There are several terms used for research that employs multiple methods of data collection. These terms include multi methods, mixed methods, multi-strategy, blended, convergence, integrated, combined, (Creswell, 2003; p. 16), and also hybrid (Martin, 2002; p. 207). For the purpose of this research, the term that will be used is that of multi methods research.

Whilst quantitative approaches to research have been used by social and human scientists since the foundational stages of business research, and qualitative approaches have gained more prominence in the last four decades, multi methods approaches are relatively new (Creswell, 2003).

There have been strong discussions about using a quantitative or a qualitative approach in attempting to gain an understanding of organisational cultures (Martin, 2002). Whilst qualitative approaches classically dominated cultural research, quantitative approaches became more popular in the late 1980s and early 1990s as some researchers felt that by using quantitative methods they could “use cultural variables to predict performance, commitment, and turnover” (Martin, 2002; p. 213). Still, others argued that using quantitative approaches for cultural research are “a
sign of the deterioration of the richness and innovation of early cultural research” (Martin, 2002; p. 213).

On the other hand, in general business research, at the second half of the last century, it was more common that quantitative studies were accepted in respected journals such as the Administrative Science Quarterly (Daft, 1980; p. 629 in Martin, 2002; p. 212). As such, qualitative researchers, including organisational anthropologists found it more difficult to get their work published, particularly in North America. This is because “qualitative case studies of organizations were heavily criticised” (Martin, 2002; p. 212).

However, in Europe and Japan, some researchers expressed their dissatisfaction that quantitative research was considered superior to qualitative research (Martin, 2002). Coupled with an interest in post-modernist theory, some business researchers began to use more qualitative approaches and adopted principles of organisational culture research, in the hope that “cultural research would offer a place where the strengths of qualitative methods would be appreciated and legitimated” (Martin, 2002; p. 213). This movement led to fierce debates about the use of qualitative versus quantitative methods.

However, some researchers believe that any research that is not traditionally scientific (such as physics) can be placed anywhere along a continuum indicating the extent of quantitative and qualitative research. This is confirmed by Newman and Benz (1998 in Creswell, 2003) who state: “the situation today is less quantitative versus qualitative and more how research practices lie somewhere on a continuum
between the two” (p. 4). Such debate has led researchers to consider the use of a multi methods approach to research (Martin, 2002; Rousseau, 1990).

Multi methods are valuable in research as “different types of data provide cross-data validity checks” (Patton, 2002; p. 248). Using multiple methods allows investigation into a research question with an array of methods that do not have overlapping weaknesses and complementary strengths (Brewer and Hunter, 1989; in Patton, 2002). Therefore, undertaking an organisational behaviour study in three hospitals, within a multi-perspective cultural frame, where data is gathered by several complementary means, provides for a holistic view of interactions between organisational actors when making decisions that affect patient flow. Hence, adopting a multi methods approach for the conduct of this enquiry is clearly justified.

5.5.1 Multi Methods Research

Adopting a multi methods approach allowed a more in-depth understanding of the organisations being examined. Researchers justify their use of a multi methods approach by explaining that it allows for a richer collection of information, thereby increasing the validity and rigour of the research. Such an approach is “essential not only to determine the scientific validity of our research in a formal sense but also to determine and eliminate any substantive social biases that might be introduced by the overuse of a single type of method (Brewer and Hunter, 2006; p. 185). It is apparent that using a range of qualitative methods to collect and analyse data supports the notion that multi methods can help a researcher to gain a more extensive understanding of the many facets of an organisation. As such, a “diversity of methods implies rich opportunities for cross-validating and cross-fertilizing
research procedures, findings and theories” (Brewer and Hunter, 2006; p. 1). This ‘fits’ with the belief that a multi methods approach to the study of culture is advantageous since “if a problem has been addressed from one cluster of methods, theories, and interests, then attacking the problem from a different set of methods, theories, and interests might well yield new insights” (McGrath, Martin and Kulka, 1982 in Martin, 2002; p. 235). Furthermore, a multi methods approach “integrates, at the very concrete level of individual studies and research programs, the various empirical implications of a theory by combining the research methods that are best adapted for studying each empirical implication” (Brewer and Hunter, 2006; p. 35). The multi methods approach used included the distribution of a survey questionnaire, conducting semi structured interviews, undertaking extensive and comprehensive document analysis and field observations.

To combine these diverse data sets, triangulation techniques were employed. Triangulation is achieved when different methods used yield clearer similar results. Triangulation of the methods employed is discussed in more depth in the latter part of this chapter. However, it should be noted that even by using a multi methods approach for collecting and analysing data, biases are inevitable and will be part of any social science research. Therefore, reflexivity, was used as a method in this research to discuss “the preferences and opinions of an author…as it is particularly important in cultural studies, in which so many divergent assumptions are often left unsaid or asserted as truth” (Martin, 2002; pp 7-8). Reflexivity, and its centrality in this study, will be discussed further in this chapter.
5.6 Research Questions

The overarching research question “How does informal social networking interact with decision making about resources, and how can this be explained from an organisational culture perspective?” is answered by four sub questions:

1) How can the organisational culture be described in:
   - Small Hospital
   - Medium Hospital
   - Large Hospital

2) Do subcultures exist within these hospitals, and if so, how can they be differentiated?

3) (i) How are alliances created and boundaries crossed between stakeholders from different organisational cultural backgrounds?
   (ii) How are decisions about resource allocation (i.e. material resources) made when stakeholders are affiliated with diverse subcultures?

4) Does the magnitude/thickness of the stakeholder-managerial relationship influence whatever decision is going to be made, and if so how?

The first two sub questions will mainly be answered by the analysis of the survey questionnaire (Appendix 2). The latter two questions will mainly be answered by conducting semi-structured interviews (Appendix 3) and by observation. The exact methods employed are detailed in the Section Two.
5.7 Section Two – Gathering and analysing data

This social science field research adopted a multi methods approach using survey questionnaire, semi-structured interviews and observation of a range of cultural manifestations, including employee interaction and physical space such as office layouts, work activity and routines. In addition, document analysis of the formal rules and procedures of the hospitals was undertaken. In addition to discussing the research protocol, these methods for data gathering will be discussed and justified, and the concept of triangulation will be introduced.

5.8 Survey Questionnaire

There are advantages and disadvantages to using a survey questionnaire in social science research. Some of the advantages include the low cost involved, rapid data collection, anonymity for participants, and accessibility of participants (Cooper and Schindler, 2006; p. 253). According to Bryman, some disadvantages of a survey questionnaire include “problem of meaning, problem of omission, problem of memory, social desirability effect, question threat, interviewer characteristics, and a gap between stated and actual behaviour” (2004; p. 165). The researcher took steps to minimise the risk of incurring these disadvantages by choosing a previously validated survey questionnaire, and piloting the survey questionnaire with academic and industry professionals. Parts of the survey questionnaire were validated by the original authors across various hospitals throughout Australia and the United Kingdom.

The survey questionnaire (Appendix 2) was constructed from two previously validated survey questionnaires. The first survey questionnaire was the Professional
sub-cultures and hospital reform, employed by Degeling et al (1998). Section A (organisational assessment) allowed respondents to assess the organisation’s managerial characteristics by answering questions about respondents feelings and beliefs about the organisation. For example, this section contained statements such as “at this organisation, managers treat staff as their equals”. Section B (material resource allocation) allowed respondents to express their opinions about how resources within the organisation were allocated as well as how they should be allocated. For example, in this section, the respondents were asked to consider statements such as “resource issues have no place in clinical decision-making”. Section D (work values) allowed respondents to express their views about the work values they held and about social relationships within the organisation. For example, this section included statements such as “ones work and private life should never mix”. Participants were then asked to give their opinions a choosing a number in a 7 point Likert scale where “1” meant strongly disagree and “7” meant strongly agree.

This survey questionnaire was selected as it has been used successfully in other studies (E.g. Eljiz, 2004; Fitzgerald, 2002). The original survey questionnaire was devised using organisational culture theory and was piloted throughout various hospitals across Australia. These items of the study were devised by Holt and Kabanoff (1995, cited in Degeling, et al. 1998), and seek respondents’ opinions about organisational commitment, managerial role characteristics, organisational goals, and work values when choosing a job. Therefore, the researcher determined that the Degeling et al. survey questionnaire was the best way of gaining a snapshot of the different hospitals in this study.
The second survey questionnaire adopted for this research was the *Global Leaders 2000 Questionnaire* by Mitchell and Agle, (1999). This survey was selected to assist the researcher in determining how stakeholder theory can be used to group hospital staff in stakeholder roles. The survey is central to the Stakeholder theory presented by Mitchell et al. 1997. This survey questionnaire was selected, because stakeholder theory, as outlined by Mitchell and Agle (1999), formed an important element of the literature review and consequent framework for analysis. Section C of the survey questionnaire asks respondents about their views on interactions with various occupational groups. For example, on a likert scale from 1-7, where 1 indicated strongly disagree and 7 indicated strongly agree, respondents were asked to consider statements such as “this occupational group has the ability to apply coercive force when making decisions”. For a copy of the final survey questionnaire, refer to Appendix (2).

5.8.1 Likert scale

The original survey questionnaire developed by Degeling et al (1998) used a five (5) point Likert scale. The original survey questionnaire developed by Mitchell and Agle (1999) used a seven (7) point Likert scale. The researcher used a seven (7) point Likert scale because “researchers have found that a larger number of items for each attitude object improve the reliability of the scale” (Cooper and Schindler, 2006; P. 340). Also, by increasing Likert scales, the researcher is able to reduce the distance between the measuring points. In addition to descriptive data, the researcher was interested in the degree of variance of responses to assist her in identifying similarities and differences between the various occupational groups. Larger Likert
scales improve data reliability and allow for analysis such as ANOVA, which would normally only be used for categorical data.

5.8.2 Pilot

The survey questionnaire was distributed to managers, health academics and industry people (from both academia and health related institutions). The researcher received forty completed survey questionnaires with comments about content, structure, and wording. The majority of comments indicated that the questionnaire was too long and that some sections were repetitive. As a result, the final survey questionnaire was condensed substantially. The researcher excluded the items in the survey that were not related to the areas of theory being examined in this study, and were therefore considered not necessary for inclusion. For example, the researcher excluded the questions from the original survey questionnaire about clinical autonomy, as these questions did not relate to the areas of decision making being investigated in this study.

5.8.3 Population and Sample

The population consisted of health services staff who can influence decision making about resources allocation. In particular, those staff who influence directly the process of transferring a patient from the emergency department to a ward bed were the intended population (or something). The sample was obtained using convenience sampling of those hospitals who agreed to participate in the study. A key assumption of the research is that the size of hospital matters when investigating organisational culture. Therefore, three hospitals: one small, one medium, and one
large were chosen. These hospitals are defined by size according to the peer group definitions of NSW Health (NSW, 2008).

5.8.4 Distribution protocol

No one particular occupational group was targeted. This was due to the fact that hospitals are busy environments, and the researcher could not justify interrupting staff who were involved with patients. Therefore, leaving a number of surveys with each department team leader was the most appropriate method of distribution.

The survey questionnaire was printed and included with a participant information letter (Appendix 4). The survey questionnaire and participant information statement were included in an A4 envelope. Also included was an A5 reply paid envelope for participants to return completed questionnaires to the researcher. The survey questionnaires were printed rather than online due to the poor response rate of online survey questionnaires (Veal, 2005; Bryman, 2004; Sheehan, 2001, Tse, 1998).

The survey questionnaires were distributed to each department within each of the three (3) hospitals. The researcher selected a key person from each ward (e.g. duty manager) and left some questionnaires with that person, asking them to ask staff to complete a survey questionnaire and return it via the pre paid enclosed envelope to the researcher. The researcher also attended the departments and made herself available to clarify any questions. The researcher revisited each department and asked the duty manager to remind staff about the survey questionnaires.
The researcher had placed an identifying number on the reply paid envelope so that she could keep track of how many surveys were returned from each department. This identifier did not affect the ethical merits of the study as the intent was to identify if departments within each hospital differed in their answers. As the survey questionnaire packages were left in easily accessible areas, such as the nurses’ station and tea rooms, the researcher had no way of identifying individuals, thus ensuring their anonymity. Return of the questionnaire indicated implied consent.

5.8.5 Response rate

It is difficult to determine the exact number of the staff in each of the hospitals due to the nature of the hospital context. There are many staff working in hospitals who are casuals, seconded to different positions, and/or work across various hospitals within the same area health service. However, information from each hospital’s public information records allowed the researcher to determine the following: the population of staff and volunteers in the small hospital consists of around 700 people. The population of full-time equivalent staff in the medium sized hospital consists of close to 1200 people. The researcher was unable to determine the population of the large hospital based on the public information available, but would estimate it to be in the range of 2500 to 3500 full-time equivalent staff.

The researcher distributed different quantities of surveys depending on the size of the hospital. A total of three hundred and fifty (350) surveys were distributed to the small sized hospital and fifty-two (52) were returned indicating a response rate of 14.86%. A total of six hundred (600) survey questionnaire packages were distributed to the medium sized hospital and seventy-one (71) were returned indicating a
response rate of 11.83%. A total of eight hundred (800) surveys were distributed to the large sized hospital and sixty-six (66) were returned indicating a response rate of 8.25%. These response rates are adequate considering the long length of the survey questionnaire (Roth and BeVier, 1998).

5.9 Quantitative Analysis

The statistical analysis of survey responses included descriptive statistics, testing of internal consistency via Cronbach’s alpha, testing of construct validity via principal components analysis, and analysis of differences in means via ANOVA and t-tests (Hair, et al., 2006; Polit and Hungler, 2001). These methods of analysis are described next.

5.9.1 Reliability testing

This research made use of the coefficient alpha or Cronbach’s Alpha to indicate the homogeneity or internal consistency of survey questions. This estimates the extent to which different parts of an instrument are equivalent in terms of measuring the critical attribute (Hair et al, 2006). For example, Question Two asked about different approaches to management in the hospital. A reliability test was performed to ensure all items represent the overall characteristic of the questions. When item 7 and 9 were removed from the analysis, the reliability increased, indicating a good relationship between individual items and the overall characteristic of the scale. Therefore, item 7 and item 9 were not used for further analysis. The reliability tests on other survey items will be presented in Chapter Five.
All scales demonstrated an alpha score greater than $\alpha = 0.70$. Hair et al. (2006) indicate that a score of $\alpha = 0.70$ or greater signifies a degree of internal consistency that is considered acceptable in social science research. The internal consistency or reliability of responses suggests the respondents are able to understand the questions and give consistent answers to related items.

### 5.9.2 Validity testing

In terms of validity, the principal component analysis for the stakeholder analysis sample supported the three factor structure (power, urgency, and legitimacy) purported to underpin the questionnaire by Mitchell et al. (1997). Additionally, the norms for the descriptive statistics of the total population were representative of the professional and functional groups in NSW Hospitals. For example, the ratio of males and females, and the ratio of doctors and nurses in the sample were characteristic of those of workers in NSW Health.

Section C of the survey questionnaire included questions from the original Agle et al. (1997) survey questionnaire. Agle used factor analysis to group the questions into three factors. In this research, factor analysis was used to group the questions resulting in the three factors of legitimacy, power, and urgency. Respondents were asked to answer questions about these factors in relation to three professional constituencies, or stakeholder groups. These stakeholder groups are “Doctors”, “Nurses”, and “Others” (people who are not doctors or nurses). Factor analysis was used to reduce the data and to investigate the possibility of underlying constructs which would help the researcher understand the complexity of stakeholder groups and culture in the organisations examined.


5.9.3 Analysis of Variance (ANOVA) and T Testing

The Analysis of Variance (ANOVA) technique was used to explore the variance between the means of groups of respondents for each question. For example, the researcher was interested comparing the variance in mean responses between doctors, nurses, and others in relation to questions about intrinsic and extrinsic factors in the organisational assessment section. The ANOVA assisted the researcher in understanding if there were similarities and/or differences in overall organisational culture, and if subcultures existed in the hospitals. T Testing was used for the small sized hospital because there were not enough doctors to conduct an adequate ANOVA. Therefore, inferences were made on the differences between nurses and others.

These quantitative methods tested the proposition that diverse subcultures exist within the hospitals studied. However, the categorising of different professional and functional groups as subcultures does not define the culture of an organisation. The relationships within and between professional and functional groups, as well the boundaries, give more of an indication of an organisation’s culture. Using only a survey questionnaire to quantitatively measure an organisation’s culture and subcultures gives an inadequate and incomplete understanding of ‘the way we do things around here’. Therefore, semi-structured interviews, observations, and conversations with organisational members were conducted in addition to the survey questionnaire. Using qualitative methods assisted the researcher in gaining a more in depth understanding of the social construction of relationships and networks.
between interprofessional groups, as well as the boundaries and alliances within and between groups, during the patient flow decision making process.

5.10 Interviews and Observation

Semi structured interviews allow the researcher “some latitude in how questions are asked, and in what order, but it is still the case that all interviewees are asked the same basic questions” (Shank, 2006: p. 50). Semi structured interviews were used as the questions contained both open and closed ended questions (See Appendix 3). This was so that the researcher could compare information, such as demographic information, collected from the different staff. It also allowed the researcher to compare the way that each participant viewed the same process, such as bed allocation.

Semi structured interviews allowed the researcher the scope to explore answers by having a list of shared topics with recommended questions that were expanded to include others depending on the flow of the interview. Other advantages of semi structured interviews include the following: “participants can provide historical information, and they allow the researcher ‘control’ over the line of questioning” (Creswell, 2003: p. 186). Disadvantages of semi structured interviews include the concern that they “provide ‘indirect’ information filtered through the views of interviewees, provide information in a designated place rather than the natural field setting, researchers presence may bias responses, people are not equally articulate and perceptive” (Creswell, 2003: p. 186). The researcher responded to such potential disadvantages by conducting the interviews in each of the hospitals where
the staff worked, and confirming as well as extending elements of the interview with the interviewees when she saw them on future occasions.

5.10.1 Population and sample

Selection of interviewees was based on purposive (or purposeful or judgement) sampling (Creswell, 2003), where the researcher selected those people she considered to be rich sources of information. The researcher determined potential participants as rich sources of information if they were a decision making stakeholder who could influence the allocation of space to patients who required admission to a hospital bed.

Through purposive sampling, the researcher selected “a sample to serve a specific purpose, even if this makes the sample less than representative” (Zikmund, 2003: p. 382) so that the researcher could get information from the appropriate sources. The specific type of purposive sampling used was that of snowball (or chain) sampling. Patton (2002) argues that snowball sampling is “an approach for locating information-rich key informants or critical cases. The process begins by asking well situated people: ‘Who knows a lot about? Whom should I talk to?’ By asking a number of people who else to talk with, the snowball gets bigger and bigger as you accumulate new information-rich cases” (2002; p. 237).

Examples of stakeholder groups interviewed included the hospital/divisional manager, patient flow manager, emergency department managers, nurse unit managers/coordinators, admitting doctors, and emergency services. Stake (in Denzin and Lincoln, 2005), argues that in “larger collective case studies, the sample
size is usually much too small to warrant random selection. For qualitative fieldwork, we draw a purposive sampling, building in variety and acknowledging opportunities for intensive study” (p. 451).

A total of eighteen (18) staff were interviewed from all three hospitals. Four (4) staff were interviewed from the small sized hospital, six (6) staff were interviewed from the medium sized hospital, and eight (8) staff were interviewed from the large sized hospital. The time needed to interview each person ranged from 45 – 90 minutes.

Table 5.1 outlines the stakeholder groups the researcher conducted semi-structured interviews with. All participants involved in the semi-structured interviews had formal decision making authority for their areas within the hospital.

<table>
<thead>
<tr>
<th>Table 5.1 - Professional Group Breakdown of Interview Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/ Manager</td>
</tr>
<tr>
<td>Small Hospital</td>
</tr>
<tr>
<td>Medium Hospital</td>
</tr>
<tr>
<td>Large Hospital</td>
</tr>
</tbody>
</table>

5.10.2 Recruitment

The participants were recruited using purposive or snowball sampling starting with management staff from the emergency department. The emergency department was selected as a starting point because the process of allocating beds started at the emergency department. Middle managers and senior managers from around the hospital were also recruited using purposive snowball sampling. During interviews,
the researcher asked interviewees to identify people in the hospital they thought central to the organisation and good at networking. The researcher then contacted those staff and informed them of her research and asked if they would participate. In some instances, interviewees introduced the researcher to prospective participants. The number of interviews was expanded if the interviews revealed that richer data would require more detail from more interviews. Consent was sought before the interview with the researcher asking the participant to sign a form of consent (Appendix 5). Both the researcher and the participant were provided with an original, signed consent form. Due to the fast-paced nature of hospitals, the researcher was unable to conduct semi-structured interviews with some individuals who had expressed an interest in participating in the research.

5.10.3 Interviews/Questions

The questions that were asked were related to the themes of organisational culture and subcultures, stakeholder relationships, alliances and networks and decision making surrounding resources (See Appendix 6). These themes were identified as important during an extensive review of the literature about organisational culture and stakeholder theory (discussed in Chapters Three and Four). The themes the questions were based upon related to the themes outlined in the sub questions of this study, where the theory mentioned led to the formation of these questions.

The questions asked during the interviews were about informal relationships, the strength of interdepartmental relationships, advantages of these, disadvantages of these relationships, and questions that indicated the relationship between social networking and resource allocation.
5.10.4 Observations and Conversations

Fieldwork also included observing patterns of interactions between staff members. There are several advantages of observing behaviours. Some advantages include: the “researcher has a first hand experience with participants, the researcher can record information as it is revealed, … aspects can be noticed during observation, and useful in exploring topics that may be uncomfortable for participants to discuss” (Creswell, 2003: p. 186). According to Creswell (2003), the disadvantages of observation include the possibility that the researcher “may be seen as intrusive, ‘private’ information may be observed that the researcher cannot report, the researcher may not have good attending and observing skills, and certain participants (e.g. children) may present special problems in gaining rapport” (p.186).

The researcher was able to build a rapport with most of the staff she spoke with by having other people she had developed rapport with introduce her and tell other staff what she was doing. This led to discussions with many staff the researcher would not otherwise have been exposed to. Information that was deemed private does not appear in the research report, but assisted the researcher in gaining a better understanding of the hospital cultures. The researcher also attended various training seminars to assist her with her observation skills and used this in conjunction with her previous research experience that had required her to observe environments.

The researcher also collected data by observing different interactions between people in each hospital. The result of using the observation method of data collection allowed the researcher to collect diary entries, a reflective journal, notes about
behaviour and conversations, the layout of offices/facilities available to different people, and other content themes.

As this study is social science field research, the researcher did not set boundaries as to the types of observation and conversations that were reported on. By keeping an open mind and letting the data speak for itself, the researcher allowed the themes to emerge. The comparative method allowed the researcher to look at the similarities and differences of the data collected, using triangulation to have a more robust understanding of the findings. A total of thirteen (13) days of observation were spent at the three hospitals. The researcher spent three (3) days of observation at the small sized hospital, four (4) days at the medium sized hospital, and (6) days at the large sized hospital. The researcher also visited each hospital on several occasions to distribute and collect the survey questionnaires. This provided the researcher an opportunity for further discussion with staff, and provided an opportunity to ask staff if they would like to take part in a semi-structured interview.

The researcher asked for managers’ consent to report upon observations about cultural manifestations within the environment. Staff were informed about the research via the participant information sheet (Appendix 4). The researcher attempted to be as unobtrusive as possible, so that conclusions could be drawn from behavioural patterns. The researcher visited meetings and public areas, such as a tearoom.

The researcher visited the Emergency Department (ED) of all the three hospitals on several occasion to discuss her research with the staff and observe patterns of
behaviour. The researcher spent several days with staff from the Patient Flow Unit at each of the three (3) hospitals. This allowed her access to the different wards and a chance to observe the environments and actions of the people involved in making decisions about resource allocations. Some time was also spent visiting the wards and offices of the hospitals to gain an understanding of the culture, or “the way we do things around here”.

It is also important to note that whilst only eighteen (18) staff in total were interviewed across all three hospitals via semi structured interviews, the researcher conducted countless conversations with staff from various occupational groups across the hospitals. In this way, the researcher was able to collect valuable data about each hospital’s organisational culture.

When employee behaviour was observed, specific names of employees are not used in any of the research. The researcher identified herself to the staff at each of the wards and informed them of her research. It also allowed the researcher a chance to speak to staff from all levels of the organisation.

5.11 Analysis and Interpretation of Qualitative data

Both Leximancer and QSR NVivo software packages were used to assist the researcher in the analysis of interview data, observational data, and data collected from conversations.

Leximancer allowed the researcher to identify strong concepts and construct themes by looking at the frequency of words and how often the words travelled
together. For example, the words nurse and nurses could be treated as a main theme or concept because cross checking of quotes revealed that respondents were discussing the same thing in relation to the two words. However, hours and time could not be treated as the same theme because respondents spoke about hours in relation to current work, and time in relation to previous work and management of the hospital. The themes and concepts from Leximancer were used as a guide in conjunction with the concepts from the theoretical framework such as organisational culture, professional identity and roles, social capital, stakeholder theory, networks and alliances, and deep smarts. Some of the themes and concepts that emerged from Leximancer included time, patient, nurses, doctors, roles, culture, management, bed, and people.

The concepts were then collated as themes where the researcher used the themes to organise the qualitative data into QSR NVivo. Once the data was sorted according to the newly created themes in QSR NVivo, the researcher was able to use comparative analysis methods to integrate the research material (Lambert and McKevitt, 2002), and understand the concepts generated from Leximancer, in order to make sense of the large amount of data. The researcher read each of the interviews and then compared the interviews to reveal commonalities and differences.

This researcher used narratives from the field to identify similarities and differences and to develop and test theory (Blaikie, 2000). The use of comparative analysis prompts the researcher to engage with a process of reflection. This process is important as it allowed the researcher to systematically think about the linkages and
interconnections between players in the hospital fields studied (Kleining and Witt, 2000). These linkages and interconnections were revealed through looking at the themes and concepts in the interviews and relating these to the literature. For example, the researcher spoke to several different participants about an incident that occurred and was able to compare the responses based on the different narratives.

During the data collection phase, the researcher refined the questions asked of the respondents to reflect the emerging themes. The researcher began by asking general questions about the patient flow process and bed allocation, and then focused on specific themes such as alliances and networks. Based upon the themes that emerged from Leximancer, the researcher used the terminology from the theoretical framework to come up with the final themes. These themes included people, work, care, culture, stakeholder theory, deep smarts, alliance, dominance, influence, and other important themes. Refer to Appendix 6 for a list of the themes and related concepts used for the data categorisation.

Using a reflective, iterative process, the researcher cross-examined theme content to explore relationships between and within the themes. The themes that emerged from the interviews were compared across the data sources. This enabled the researcher to engage in a systematic analysis that was open to alternative explanations of the findings (Creswell, 1998). For example, the researcher looked at the same incident using different theories to make sense of what participants recounted, as well as what the researcher observed.
The researcher used the themes and concepts when reading through the transcripts. The transcripts were read in their entirety and quotes were labelled with the identified themes and concepts using QSR NVivo. The researcher’s supervisors also read the transcripts and helped modify the themes and concepts identified from 200 themes to 13 themes with related concepts. The use of supervisors in the data analysis was evident, as more than one analyst increases the consistency and reliability of the analysis (Pope and May, 2000).

5.11.1 Review of Documents

The advantages of document collection include the fact that it “enables a researcher to obtain the language and words of participants, can be accessed at a time convenient to the researcher – an unobtrusive source of information, represents data that are thoughtful, in that participants have given attention to compiling, and, as written evidence, it saves a researcher the time and expense of transcribing” (Creswell, 2003: p. 187). Some of the disadvantages of document review are that it “may be protected information unavailable to public or private access, requires the researcher to search out the information in hard-to-find places, requires transcribing or optically scanning for computer entry, materials may be incomplete, and the documents may not be authentic or accurate” (Creswell, 2003: p. 186). The researcher combated these possible disadvantages by asking staff in the organisation where she could find the documents required, and asking them to introduce her to the managers who were the gatekeepers of that information.

The researcher asked for manager’s consent to access the Corporate Policy and Procedures Manual. Minutes of departmental meetings were also collected from the
relevant managerial staff of each hospital. By viewing these documents, the researcher was able to gain an understanding of the formal rules and procedures. This then helped the researcher formulate additional questions to ask staff in the semi-structured interviews. For example, the researcher was able to question staff about bed procedures, which vary from one hospital to another, particularly across different area health services.

5.12 Triangulation

The start of this chapter outlined the underpinning of the knowledge that is being created and a justification of the mixed methods philosophy. A mixed methodology was deemed most appropriate to answer the research questions.

There are different types of multi methods procedures, including concurrent, transformative and sequential procedures. *Concurrent* procedures are where the “researcher converges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem” (Creswell, 2003; p. 16). *Transformative* procedures are where the “researcher uses a theoretical lens as an overarching perspective within a design that contains both quantitative and qualitative data” (Creswell, 2003; p. 16). *Sequential* procedures, are where the researcher “seeks to elaborate on or expand the findings of one method with another method…the study may begin with a quantitative method in which theories or concepts are tested, to be followed by a qualitative method involving detailed exploration with a few cases or individuals” (Creswell, 2003; p. 16). This sequential procedure requires triangulation.
Triangulation is defined in many different ways: “[a] process of converging upon a particular finding by using different sorts of data and data gathering strategies” (Shank, 2006: p. 113); attempting to “pinpoint the values of a phenomenon more accurately by sighting in on it from different methodological viewpoints” (Brewer and Hunter, 1989; p. 17); and, “no single method ever adequately solves the problem of rival causal factors. Because each method reveals different aspects of empirical reality, multiple methods of observations must be employed. This is termed triangulation” (Denzin, 1978; p.28).

Triangulation enabled the researcher to use qualitative methods to overcome the weaknesses of the quantitative methods and vice versa. Using the quantitative method of a survey questionnaire, the researcher was able to get a wide sample of respondents to answer questions that would allow her to determine a cultural footprint of the hospital environments. Conversely, using the qualitative methods of semi structured interviews, observations and conversation, the researcher was able to gain a more in depth understanding of the cultural environments of the hospitals.

5.12.1 Reflexivity

Reflexivity is a central notion in multi methods research. It has been argued that reflection is necessary in cultural studies, as “so many divergent assumptions are often left unsaid, or asserted as truth (Martin, 2002; p. 8). Reflexivity allows a researcher to distinguish between what others have said and what a researcher believes, as indicated by what he or she is stating. The researcher is young, not from within the industry and is educated in business management and marketing. Therefore, these factors were taken into account during discussions between the
researcher and her supervisors. The researcher had regular meetings with her supervisors after interviewing and observing, and discussed her perceptions in an effort to make sense of what was occurring.

At the end of each day of distributing survey questionnaires, the researcher recorded her thoughts and reflections as to incidents that may have occurred, such as staff reactions to being asked to fill in a survey questionnaire, or the layout of a tea room where survey questionnaires were left for staff to take. Similarly, after each interview, the researcher recorded her thoughts and observations. The recordings were later listened to and the researcher was able to distinguish her own opinions from those she had been critiquing in her literature review. The use of the diary assisted the researcher with data triangulation, as it allowed the researcher to be conscious of how her feelings and thoughts could have impacted what she observed.

5.13 Section Three – Methodological considerations

There are several considerations which have an impact on the study. These include the quantitative and qualitative limitations of the methodology, limitations of time and context, researcher and participant bias, and ethical considerations.

Most importantly, this research may not be generalisable. The research is limited by a small sample size of three hospitals and a particular focus on the emergency department. Therefore, the generalisations made here are only applicable to the hospitals examined as part of this study. Nevertheless, this research is valuable because of the unique insights, from an emic and etic perspective, into organisational culture and decision making efforts of relevant emergency department
and other hospital staff. The inter- and intra-professional dynamics when making decisions about resources illuminated issues that can be recognized in a broader sense. Despite limitations of the methodology discussed next, this thesis helps explain some of the dynamics in an effort to better understand the interplay between hospital workers when combating emergency department access block.

5.14 Limitations of the Methodology

The survey questionnaire was used as a tool to attempt to gain a cultural footprint of each of the hospitals. It is impossible to gain a complete understanding of an organisation’s culture, particularly as an outsider, using a survey questionnaire. This is because the questions asked were in relation to only a small component of the organisation. The number of responses across the different subcultural groups was inconsistent. However, the researcher attempted to offset this limitation by discussing the issues presented in the survey, to as many staff as possible from the different occupational groups.

The nature of the hospital environment meant that the researcher only had a limited amount of time to ask questions as all staff involved were on call as part of their job requirements. The researcher is aware that her presence may have caused staff in the hospitals to behave in a different manner to what they normally would (Hawthorn effect). The researcher visited the different departments several times and spoke to staff on different occasions to minimise this effect.
5.14.1 Researcher Bias

The researcher is aware that her biases may have affected the research process and outcome. As with any research, the researcher’s preconceived judgments, personal feelings and beliefs, and expectations were all possible biases. The researcher entered the hospital environments with preconceived notions about these environments. The researcher also became aware of her biases during her observation of the hospitals, particularly in relation to the different people and their personalities. The researcher had to take steps to ensure that her biases had as little impact as possible on the research journey. The researcher examined her own biases during the analysis of the results from observations, conversations and semi-structured formal interviews by reflecting upon what she heard and observed.

Steps taken to minimise biases included discussing her research and research methods with her colleagues in academe as well as within industry. The researcher had the benefit of discussing what she thought she observed and why incidents may have occurred with her primary supervisor, who has worked in the hospital environment for over twenty (20) years. To avoid the likelihood of this increasing bias, the researcher also frequently met with other researchers of her centre who had either worked in the health care industry/and or were researching the health environment. Therefore, the researcher was able to have several different opinions which helped her make sense of a foreign environment.

The researcher also kept a reflective digital audio diary, which she listened to when transcribing and analysing the data to recall how/why she felt a particular way about a participant or observation she had made. The researcher is relatively
inexperienced in work experience, and life, so she was able to take a fresh approach to the analysis of the data and organisation.

The constant comparison nature of this research, and triangulating different data sets, required much reflection and thought about how much the researcher influenced the research. Whilst bias itself is accepted in subjectivist paradigms, minimisation of bias was achieved by discussing the data collected with colleagues and keeping a reflective diary recording thoughts and feelings.

5.14.2 Participant Bias

In addition to researcher bias, there is also the likelihood of participant bias. Cooper and Schindler (2006) identify two types of participant bias: response bias and social desirability bias (p. 252). Response bias occurs when participants cause error by “responding in such a way as to unconsciously or consciously misinterpret their actual behavior, attitudes, preferences, motivations, or interpretations” (p. 252). Social desirability bias occurs when “participants create response bias when they modify their responses to be socially acceptable or to save face or reputation with the interviewer” (p. 252).

The researcher took steps to try to reduce participant biases. Time spent during observation and conversations with participants helped the researcher clarify if what was said by the participants during interviews was what actually occurred on a day to day basis. Observing participants in different environments assisted the researcher in understanding statements made by the participants.
5.15 Ethical Issues

An ethics application was submitted and approved by each Area Health Service as well as the university. Initially, there were some ethical issues including the de-identification of participants, consent to participate in the research, data storage, and the likelihood of the research causing participants (and non-participants) harm. Both the name of the person being interviewed and their position are known to the researcher, however both have been de-identified. Participants’ names and positions were not made available to either the hospitals involved or in any publications. For example, when talking about managers, the researcher referred to them as senior manager, middle manager or lower level manager. The positions referred to were left as general as possible.

Consent was required at all levels of the research. An information letter (see Appendix 4) was included with all questionnaire packages. Participant consent was demonstrated upon return of the survey questionnaire. The researcher asked for the emergency department manager’s consent, as well as ED employees during staff meetings to report upon observations about cultural manifestations.

All data collected is stored at the UWS Archives with a General Disposal Authority (GDA) to destroy the data after a seven (7) year period from publication of the thesis. This includes completed questionnaires, consent forms, interview transcripts and electronic interview recordings. Only the researcher and her supervisors have access to the data during this period so they may be used for future publications.
Throughout the research process, the researcher consulted the National Statement on Ethical Conduct in Research Involving Humans to ensure that she understood the espoused values including, research merit and integrity, justice, beneficence, and respect (National Statement on Ethical Conduct in Research Involving Humans, 2007) for all parties involved.

5.16 Conclusion

This research adopted a mixed methods approach to social science field research. Central to its success is the reflexivity employed at all phases of the research protocol. Adopting a constructivist and pragmatic approach to organisational cultural research was necessary because each organisation’s culture is unique and meanings about cultural manifestations differ across as well as within cultures. Meaning in this study is understood to be constructed by the participants. Also, that meaning will have practical implications for health managers.

Further, the research protocol allowed the gathering of data from different sources. Amongst these sources was a survey questionnaire, which provided a snapshot of the cultural environment of each of the three hospitals. Semi structured interviews were used to understand more about why, from the point of view of the participants, manifestations in the environment were happening. Observation and conversations with staff also allowed the researcher to gain a greater insight into the culture of each of the hospitals. Analysis of documents gave the researcher a better understanding of the formal rules and procedures of each hospital.
In addition, this chapter outlined the limitations of the research methodology used. However these were largely overcome by bringing to the fore the possible researcher and participant biases. Possible researcher biases included the researcher’s preconceived judgments, personal feelings and beliefs, and expectations. Researcher bias was reduced through the practice of reflexivity. Possible participant biases included response bias and social desirability bias. Participant bias was reduced by conversing with and observing participants in different environments.

The nature of qualitative research is that is limited in espousing truth. This research gives a clear overview of organisational footprint and the authentication of values and beliefs that are contextualised to three hospitals in NSW, at a short timeframe in 2007.

The next chapter will commence by presenting the findings from survey data in three hospitals and an analysis of the organisational culture as measured by the survey questionnaire. Subsequent chapters will bring in the observational and interview data to authenticate what “is really going on” in the hospitals as constructed by the organisational actors. Implications from these findings for organisations and its managers will be presented and area for further research will be proposed.
6 Quantitative Analysis
6.1 Introduction

This thesis has employed a mixed methods approach, which allows for cross checking of the data, to assist with gaining a better understanding of hospital environments. This chapter reports on the quantitative findings and analysis of the research and answers the following questions:

(1) How does informal social networking interact with decision making about resources and,

(2) How can this be explained from an organisational culture perspective?

These questions have been selected to gain an understanding of the organisational cultures of the hospitals studied, so that the researcher can explain how informal social networking interacts with decision making about patient flow from an organisational perspective. Using a survey questionnaire (see Appendix 2), the researcher was able to obtain a wide sample of respondents to answer questions that allowed her to determine a cultural footprint of the environments of the hospitals participating in the study.

In this chapter, first, the overall or cumulative culture in three hospitals will be depicted. Second, the cultures in each of the three hospitals will be described separately, looking for commonalities and differences between them. Third, cultural patterns between professions (doctors, nurses, and others) as well as differences between functional levels (managers and clinicians) will be investigated.
Specifically, the following sub questions will be answered:

1. How can the organisational culture in hospitals be described, and how can hospital culture be described in a small, a medium, and a large hospital?

2. Do professional and functional subcultures exist within these hospitals, and if so, how can they be differentiated?

These explorations are necessary to answer the questions about saliency of decision-makers when negotiating resource allocation issues, such as admission of a patient from the emergency department to a ward.

The aims of this chapter are then to 1) obtain a snapshot of organisational culture; and 2) obtain a greater understanding of organisational cultural effects effect on stakeholder saliency when making decisions. In the first part (survey questions 1-4), the survey questionnaire takes an organisational cultural snapshot, assessing the value basis of managerial and organisational practice by investigating four cultural constructs which are then discussed in this chapter:

1. **A sense of organisational commitment.** This is an assessment of how staff are bonded to the organisation. This construct allows conclusions to be drawn about participants’ feelings of affiliation and commitment as being strong versus weak.

2. **Perceptions of managerial role characteristics.** This construct assesses the extent to which the respondents perceive their hospital as being mechanistic as opposed to organic.

3. **Perceptions of currently pursued organisational goals.** This construct contains a ranking of organisational goals being currently pursued by the hospital.
4. **Perceptions of orientation to work values when choosing a job.** This construct is a ranking of the work values that are considered when choosing a job.

In the second part (survey question 5), the survey questionnaire assesses respondents’ perceptions about stakeholder saliency when making decisions, and in particular the depth or magnitude of the significance of the stakeholder in making decisions. As described in Chapter Three, organisational culture in hospitals is considered a vehicle or conduit for decision-making and may be influenced by staff perceptions of ‘who really matters’. The survey questionnaire tested if perceptions of salience were influenced by demographic differences such as hospital size, functional level of respondents (manager or clinician) or professional background of respondents (doctor, nurse, or other). This was achieved by adapting questions from previous research done on stakeholder saliency by Mitchell and Agle (1999). For the purpose of this research, data was gathered using questions relating to the construct:

5. **Interactions with Various Professional Constituencies.** This question considers interactions with other professional groups to determine the level of influence on decision making by other professional groups. That is, it investigates the saliency of stakeholders. This is measured by investigating perceptions of the *power, urgency,* and *legitimacy* of the stakeholder groups.

In analysing the material, assessments were conducted at the organisational level, the professional level, and the functional level. The organisational level includes one small hospital, one medium hospital, and one large hospital. The professional level
includes doctors, nurses, and others (participants who are not doctors or nurses). The functional level divides the cohort into managers and clinicians. The label “managers” includes medical managers, nurse managers and other managers; and the label “clinicians” includes medical and non-medical clinicians, such as nurses. Table 6.1 indicates the number (n) of participants in each of the levels of assessment.

<table>
<thead>
<tr>
<th>Table 6.1 - Number of Participants According to Professional and Functional Groupings per size of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Small</strong></td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>Professional (n=189)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Functional (n=136)</td>
</tr>
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<td></td>
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</tbody>
</table>

6.2 Demographic Data

Demographic data was collected to analyse the composition of the types of staff who responded to the survey questionnaire. A total of three hundred and fifty (350) surveys were distributed to the small sized hospital and fifty-two (52) were returned indicating a response rate of 14.86%. A total of six hundred (600) survey questionnaire packages were distributed to the medium sized hospital and seventy-one (71) were returned indicating a response rate of 11.83%. A total of eight hundred (800) surveys were distributed to the large sized hospital and sixty-six (66) were returned indicating a response rate of 8.25%. The total number of responses is n = 189. Table 6.2 shows the breakdown of responses represented in percentages for each hospital in relation to gender, age group, and professional group.
Table 6.2 - Demographic Data of Respondents Gender, Age Groups, and Professional Groups

<table>
<thead>
<tr>
<th>Gender</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>24%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Female</td>
<td>76%</td>
<td>78%</td>
<td>76%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>8%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>30-39</td>
<td>29%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>40-49</td>
<td>32%</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>50-59</td>
<td>28%</td>
<td>31%</td>
<td>39%</td>
</tr>
<tr>
<td>60+</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>2%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Doctor</td>
<td>6%</td>
<td>6%</td>
<td>18%</td>
</tr>
<tr>
<td>Nurse</td>
<td>62%</td>
<td>47%</td>
<td>41%</td>
</tr>
<tr>
<td>Administration Management</td>
<td>0%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Doctor Management</td>
<td>0%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Nurse Management</td>
<td>26%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal Area of Practice</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>n = 44</td>
<td>n = 50</td>
<td>n = 50</td>
</tr>
<tr>
<td>Administration/Management</td>
<td>n = 9</td>
<td>n = 22</td>
<td>n = 15</td>
</tr>
<tr>
<td>Education</td>
<td>n = 5</td>
<td>n = 7</td>
<td>n = 6</td>
</tr>
<tr>
<td>Other</td>
<td>n = 3</td>
<td>n = 5</td>
<td>n = 5</td>
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</tbody>
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<thead>
<tr>
<th>Percentage of Time Spent on: Patient Care</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>n = 5</td>
<td>n = 12</td>
<td>n = 8</td>
</tr>
<tr>
<td>1-10%</td>
<td>n = 2</td>
<td>n = 8</td>
<td>n = 3</td>
</tr>
<tr>
<td>11-49%</td>
<td>n = 6</td>
<td>n = 5</td>
<td>n = 6</td>
</tr>
<tr>
<td>50+%</td>
<td>n = 35</td>
<td>n = 43</td>
<td>n = 34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Time Spent on: Administration/Management</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>n = 27</td>
<td>n = 34</td>
<td>n = 15</td>
</tr>
<tr>
<td>1-10%</td>
<td>n = 8</td>
<td>n = 8</td>
<td>n = 7</td>
</tr>
<tr>
<td>11-49%</td>
<td>n = 8</td>
<td>n = 7</td>
<td>n = 18</td>
</tr>
<tr>
<td>50+%</td>
<td>n = 7</td>
<td>n = 19</td>
<td>n = 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Time Spent on: Education</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>n = 27</td>
<td>n = 40</td>
<td>n = 28</td>
</tr>
<tr>
<td>1-10%</td>
<td>n = 12</td>
<td>n = 18</td>
<td>n = 18</td>
</tr>
<tr>
<td>11-49%</td>
<td>n = 8</td>
<td>n = 7</td>
<td>n = 10</td>
</tr>
<tr>
<td>50+%</td>
<td>n = 1</td>
<td>n = 3</td>
<td>n = 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Time Spent on: Other</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>n = 42</td>
<td>n = 54</td>
<td>n = 40</td>
</tr>
<tr>
<td>1-10%</td>
<td>n = 5</td>
<td>n = 5</td>
<td>n = 9</td>
</tr>
</tbody>
</table>
The following outlines the relevant demographics for the thesis.

6.2.1 Gender

Demographic data shows that 22% of respondents are male and 78% of respondents are female. According to the data obtained from the various NSW Area Health Services, of the total number of hospital staff, approximately 25% are male and 75% are female. This indicates that the gender breakdown of respondents is representative of Area Health Services staff profiles (Sydney South West Health Annual Report, 2006-2007; South Eastern Sydney Illawarra Health Annual Report 2006-2007).

6.2.2 Age Group

Figure 6.1 shows the breakdown of the age groups of the respondents. It indicates that almost two thirds (62%) of respondents are older than 40 years. The Nursing and Midwifery Labour Force (2005; p. 9) reports the average age of nurses is 45.1 years and that nearly 25% of nurses are over 50 years. The Medical Labour Force (2005; p. 7) reports the average age of medical clinicians is 45 years. This is what is
expected as other studies also report that hospitals in Australia have an ageing workforce (e.g. Duckett, 2007).

6.2.3 Professional Group

The survey found that 8% of respondents are in clerical roles, 15% of respondents are in nurse management roles, and 11% of respondents have other roles (other includes security, ward staff, allied health etc). This reflects the fact that the nursing professional group is the largest category of employees in hospitals (Duckett, 2007; p.160). Figure 6.2 shows the breakdown of the professional groups in terms of their positions. It indicates that approximately two thirds of respondents (65%) work as nurses (50%) and nurse managers (15%). Figure 6.2 also indicates that 10% of respondents are doctors, and 2% are doctor managers.

![Figure 6.1: Summary of Respondents Age Groups](image-url)
6.2.4 Principal Area of Practice

Of the 189 respondents, 21% reported that their principal area of practice is management, 65% have a principal area of direct patient care, 8% are involved in education, and 6% in other areas (i.e. research).

6.2.5 Terms of Employment

Of the respondents, 72% reported to be employed as full-time salaried staff, 25% are employed as part-time salaried staff, and the remaining 3% are employed as other (i.e. casual staff, contract staff).

6.2.6 Length of Employment with Organisation

11% of respondents reported to have worked for their organisation less than 2 years and 41% have worked for their organisation for 10 years or more.

In summary, respondents collectively are representative of staffing profiles in several Area Health Services in NSW. The response rate was relatively higher in the smaller
hospitals than it was in the large hospital. Overall there are indications of an ageing workforce with 35% of respondents being over the age of 50. Most respondents are involved with direct patient care and are salaried. Almost half of the respondents have worked in the organisation for more than 10 years. Therefore, the sample is representative and the results may be generalisable.

6.3 Sense of Organisational Commitment

As stated above, a sense of organisational commitment is an assessment of how staff are bonded to the organisation. This allows conclusions to be drawn about participants’ feelings of affiliation and commitment as being strong or weak. The 9 item question used to assess this (Table 6.3) tests the cultural construct of “commitment” in small, medium and large hospitals, and tests if these feelings of affiliation differ between professional and functional subgroups. The questions are taken from Degeling et al. (1998) which was an adaptation from Holt and Kabanoff’s (1995) Survey of Organisational Values.

Table 6.3: Respondents Feelings and Beliefs about their Organisation

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  I tell my friends this organisation is a great organisation to work for</td>
<td>4.39</td>
<td>1.672</td>
</tr>
<tr>
<td>2  If the values of this organisation were any different than what they are, I would not want to be attached to this organisation</td>
<td>4.22</td>
<td>1.615</td>
</tr>
<tr>
<td>3  Since working for this organisation, my personal values and those of the organisation have become more similar</td>
<td>3.48</td>
<td>1.553</td>
</tr>
<tr>
<td>4  My private views about this organisation are different to those I express publicly</td>
<td>3.55</td>
<td>1.866</td>
</tr>
<tr>
<td>5  The reason I prefer this organisation to other organisations’ because of what it stands for, its values</td>
<td>3.70</td>
<td>1.651</td>
</tr>
<tr>
<td>6  I feel a sense of &quot;ownership&quot; for this organisation</td>
<td>3.88</td>
<td>1.793</td>
</tr>
<tr>
<td>7  Staying with this organisation is a matter of necessity</td>
<td>4.19</td>
<td>1.900</td>
</tr>
<tr>
<td>8  What the organisation stands for is important to me</td>
<td>4.99</td>
<td>1.527</td>
</tr>
<tr>
<td>9  Leaving the organisation at this time would disrupt my life too much</td>
<td>4.74</td>
<td>1.907</td>
</tr>
</tbody>
</table>
6.3.1 Combined Hospitals Responses

Before analysing the result of the three hospitals individually, an analysis of the combined data set was undertaken. The organisational assessment investigates respondents’ feelings and beliefs about the organisation. Respondents were asked to indicate the extent to which they agreed or disagreed with the statements in Table 3. A response of “1” indicated that they strongly disagreed with the statement, and a response of “7” indicated that they strongly agreed with the statement.

6.3.2 Reliability

Table 3 presents the statements asked about how organisational members feel about their organisation. The Cronbach’s alpha for this group of statements was found to be 0.739, indicating a degree of reliability that is considered acceptable in social research (Hair et al, 2006). Table 3 also depicts the means and standard deviations of the respondents from the entire cohort (n=189) from all three hospitals. This gives a broad indication of the respondents’ overall assessment. However, the 9-items included in the overall assessment indicates a large distribution with clustering around the mean. It is therefore indicated to investigate by combining the items into factors to give a more meaningful picture of how people are bonded to the organisation.

The data from Table 6.3 was analysed using Principal Components Analysis. The pattern matrix is shown in Table 6.4 and shows the extraction of two factors (OAF1 or Intrinsic Factor and OAF2 or Extrinsic Factor). The KMO index, a measure of sampling adequacy, is 0.801 indicating a good commonality between the items. Together the two factors accounted for 57.619% of the variation underlying the
structure. OAF1 is correlated with statements 1, 2, 3, 5, 6, 8. These items are grouped into a factor named “Intrinsic Factor”. This factor is interpreted as telling us something about the value congruence and affiliation that people have with the hospital. The reliability test shows that the alpha for this group of questions is 0.851 indicating that OAF2 is correlated with statements 7, 9, 4. These items are grouped into a factor named “Extrinsic Factor”. This factor is interpreted as saying something about the choice or necessity employees have in staying with the hospital. The alpha for this group is 0.604. However, the alpha increases to 0.679 if statement 4 is not used in the analysis. Therefore, statement 4 has been removed from further analysis.

The newly created intrinsic and extrinsic factors were used for further analysis of the three professional groups (doctors, nurses, others), and two functional groups (clinicians and managers).

Table 6.4: Pattern Matrix for Organisational Commitment

<table>
<thead>
<tr>
<th>Statement Number</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>.863</td>
</tr>
<tr>
<td>1</td>
<td>.807</td>
</tr>
<tr>
<td>3</td>
<td>.721</td>
</tr>
<tr>
<td>6</td>
<td>.717</td>
</tr>
<tr>
<td>8</td>
<td>.703</td>
</tr>
<tr>
<td>2</td>
<td>.698</td>
</tr>
<tr>
<td>7</td>
<td>-.087</td>
</tr>
<tr>
<td>4</td>
<td>.216</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
Rotation Method: Oblimin with Kaiser Normalization.  
\( a \) Rotation converged in 3 iterations.
Three professional groups were used for the analysis. These were doctors, nurses, and others who are not doctors or nurses.

### 6.3.3 Difference of Organisational Commitment between Professional Groups

An Analysis of Variance (ANOVA) was carried out to explore the differences between the means of the three (3) groups of respondents in relation to the hypothesis posed. The first step is to determine if any pair of means is unequal.

Table 6.5 indicates that the homogeneity assumption has not been violated for either factor. Therefore, the Levene’s test for homogeneity of variance is not significant and indicates that the population variances for each group are approximately equal. This adds to the reliability of statistical analysis.

**Table 6.5: Levene's Test for ANOVA in Organisational Commitment between Professional Groups**

<table>
<thead>
<tr>
<th></th>
<th>Levene Statistic</th>
<th>df1</th>
<th>df2</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Factor</td>
<td>.663</td>
<td>2</td>
<td>168</td>
<td>.517</td>
</tr>
<tr>
<td>Extrinsic Factor</td>
<td>.878</td>
<td>2</td>
<td>171</td>
<td>.417</td>
</tr>
</tbody>
</table>

The next step investigates if there are significant differences between doctors nurses and others in terms of their affiliation with the hospital (Intrinsic Factor).

**H0#1 There is no difference between professional groups in terms of affiliation with the hospital**
This was investigated by utilising the analysis of variance (ANOVA). Table 6.6 indicates there is no significant difference between the professional groups’ feelings and beliefs about the organisation.

Table 6.6: ANOVA between Professional Group Feelings and Beliefs about their Organisation

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrinsic Factor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>.524</td>
<td>2</td>
<td>.262</td>
<td>.181</td>
<td>.835</td>
</tr>
<tr>
<td>Within Groups</td>
<td>243.637</td>
<td>168</td>
<td>1.450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>244.161</td>
<td>170</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extrinsic Factor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>3.799</td>
<td>2</td>
<td>1.899</td>
<td>1.108</td>
<td>.333</td>
</tr>
<tr>
<td>Within Groups</td>
<td>293.161</td>
<td>171</td>
<td>1.714</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>296.960</td>
<td>173</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hence, the feelings and beliefs null-hypothesis “There is no difference between professional groups in terms of affiliation with the hospital” cannot be rejected, thus is accepted for all variables. It is interesting to note that the intrinsic factor is 0.835, which is high but not significant. However, this may be a possible area for future research.

6.3.4 Functional Groups in all hospitals

Next, the data was investigated to determine if there are significant differences between clinicians and managers terms of their affiliation with the hospital

_H0#2 There is no difference between functional groups in terms of affiliation with the hospital_
As there were only two groups, Managers and Clinicians, used for the functional analysis, Independent Groups T-Tests were used instead of ANOVA.

Tables 6.7 and 6.8 indicate there is no significant difference between managers and clinicians feelings and beliefs about the organisation.

**Table 6.7: ANOVA between Functional Groups Feelings and Beliefs about their Organisation**

<table>
<thead>
<tr>
<th>Functional Role</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>101</td>
<td>4.043</td>
<td>1.1899</td>
<td>.1184</td>
</tr>
<tr>
<td>Manager</td>
<td>36</td>
<td>4.222</td>
<td>1.4058</td>
<td>.2343</td>
</tr>
<tr>
<td>Extrinsic Factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>101</td>
<td>4.832</td>
<td>1.3459</td>
<td>.1339</td>
</tr>
<tr>
<td>Manager</td>
<td>38</td>
<td>4.711</td>
<td>1.3588</td>
<td>.2204</td>
</tr>
</tbody>
</table>

**Table 6.8: Independent Groups T-Test Managers and Clinicians Affiliation**

<table>
<thead>
<tr>
<th></th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Intrinsic Factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances</td>
<td>1.937</td>
<td>.166</td>
</tr>
<tr>
<td>not assumed</td>
<td>- .683</td>
<td>53.928</td>
</tr>
<tr>
<td>Extrinsic Factor</td>
<td>.055</td>
<td>.814</td>
</tr>
<tr>
<td>Equal variances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not assumed</td>
<td>.470</td>
<td>66.027</td>
</tr>
</tbody>
</table>

Hence, the null-hypothesis “There is no difference between functional groups in terms of affiliation with the hospital” cannot be rejected for all variables. This means that there is no significant difference between functional groups’ opinions about feelings and beliefs in relation to their health organisations overall. This differs from
earlier work done by Fitzgerald (2002), where Fitzgerald reported that managers have a higher sense of necessity to stay with the hospital compared to clinicians (p. 116). While there may be some difference, a significant difference was not found in this study.

6.4 Perceptions of Managerial Role Characteristics

To test the perceptions of Managerial Role Characteristics, a 20 item question adapted from Degeling et al. (1998), was used to assess the extent to which the respondents perceive their hospital as being mechanistic or organic. These items were devised by Holt and Kabanoff (1995, cited in Degeling, et al. 1998), and seek respondents’ opinion about four management approaches that characterises the hospitals' managerial role as collegial, meritocratic, employing leadership, or elite.

A Collegial Hospital is one where “managers treat staff as equals” (Degeling, 1998; p. 21). Disputes are resolved so that they do not threaten relationships. Staff support the overall mission because they believe in it. Freedom is given to individuals to determine their own activities.

A Meritocratic Hospital is one where “managers encourage staff to compete in meeting organisational goals and objectives” (Degeling, et al., 1995; p. 21). Although managers encourage staff to get on with one another, competition is also encouraged so that increased performance is achieved. A fair degree of freedom is given to staff to decide how goals and objectives will be met.
A **Leadership Hospital** is one where “managers develop a sense of loyalty and group spirit among subordinates” (Degeling, 1995; p. 21). Managers are expected to develop their staff into strong work teams, which are controlled in a decentralised way. People feel a strong sense of belonging and loyalty to their immediate work group and managers, and are expected to support their work group when disputes occur.

An **Elite Hospital** is one where “managers ensure that staff comply with hospital requirements” (Degeling, et al., 1998; p. 21). This type of hospital relies on rules and procedures to resolve disputes. Most staff, including managers, have little choice over what they do or how they do their jobs.

The four management approaches that characterise the hospitals’ managerial role as collegial, meritocratic, employing leadership, or elite, relate to the extent of top down or bottom up authority (Degeling, 1998). The four approaches are part of the validation of the original tool, therefore the researcher could not exclude any of the approaches. The approaches assist in categorising the extent of bureaucracy of an organisations management style.

These 20 items (see Table 6.10 for the actual questions) test managerial characteristics of the hospitals according to four (4) management types. Table 9 below indicates the items that measured in a particular type and the reliability of these summations.
To increase reliability of the summated statements, as depicted in Table 6.9, statements 7 and 9 were deleted from any further analysis.

### 6.4.1 All Respondents Perceptions in three hospitals

This section asked respondents’ views about the managerial characteristics they believed their hospital exhibited. Section A from the survey questionnaire asked respondents to indicate the extent to which they agreed or disagreed about the statements in Table 6.10, with 1 indicating a strong disagreement with the statement and 7 indicating a strong agreement with the statement.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Classification</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 At this organisation, managers treat staff as their equals</td>
<td>Collegial</td>
<td>3.27</td>
<td>1.751</td>
</tr>
<tr>
<td>2 At this organisation, managers include staff in decision-making processes</td>
<td>Collegial</td>
<td>3.55</td>
<td>1.845</td>
</tr>
<tr>
<td>3 At this organisation, individual staff are given much freedom about determining their own activities</td>
<td>Collegial</td>
<td>4.01</td>
<td>1.716</td>
</tr>
<tr>
<td>4 At this organisation, being part of an organisation that values and encourages personal achievement, brings people together</td>
<td>Meritocratic</td>
<td>3.88</td>
<td>1.706</td>
</tr>
<tr>
<td>5 At this organisation, people are expected to support their managers and the members of their immediate work group when disputes arise</td>
<td>Leadership</td>
<td>4.73</td>
<td>1.490</td>
</tr>
<tr>
<td>6 Managers focus on ensuring that staff comply with the organisation’s requirements</td>
<td>Elite</td>
<td>5.41</td>
<td>1.306</td>
</tr>
<tr>
<td>7 At this organisation, most staff, including the managers, have little choice over how they do their jobs</td>
<td>Elite</td>
<td>4.31</td>
<td>1.666</td>
</tr>
<tr>
<td>8 At this organisation, managers are expected to develop their staff into strong work teams</td>
<td>Leadership</td>
<td>4.95</td>
<td>1.497</td>
</tr>
<tr>
<td>9 At this organisation, managers control their work teams in a decentralised way</td>
<td>Leadership</td>
<td>4.23</td>
<td>1.460</td>
</tr>
<tr>
<td>10 Managers focus on encouraging staff to meet organisational goals and objectives and helping them be productive</td>
<td>Meritocratic</td>
<td>4.65</td>
<td>1.581</td>
</tr>
<tr>
<td>11 At this organisation, staff support the organisation’s overall mission (purpose)</td>
<td>Collegial</td>
<td>4.93</td>
<td>1.352</td>
</tr>
<tr>
<td>12 At this organisation, people value getting on with one another</td>
<td>Meritocratic</td>
<td>5.07</td>
<td>1.426</td>
</tr>
<tr>
<td>13 Competition between people is encouraged in order to increase performance</td>
<td>Meritocratic</td>
<td>3.11</td>
<td>1.464</td>
</tr>
<tr>
<td>14 At this organisation, people tend to rely on rules and policies for resolving dispute</td>
<td>Elite</td>
<td>4.84</td>
<td>1.602</td>
</tr>
<tr>
<td>15 At this organisation, people share the view that rules have to be followed whether they personally like them or not</td>
<td>Elite</td>
<td>4.95</td>
<td>1.567</td>
</tr>
<tr>
<td>16 At this organisation, people put a strong emphasis on getting on with one another</td>
<td>Collegial</td>
<td>4.52</td>
<td>1.577</td>
</tr>
<tr>
<td>17 At this organisation, people put a strong emphasis on resolving disputes in ways that preserve their relationships</td>
<td>Elite</td>
<td>4.26</td>
<td>1.630</td>
</tr>
<tr>
<td>18 Managers focus on developing a sense of loyalty and group spirit amongst staff</td>
<td>Leadership</td>
<td>4.20</td>
<td>1.710</td>
</tr>
<tr>
<td>19 At this organisation, people feel a sense of belonging and loyalty to their particular work group</td>
<td>Leadership</td>
<td>4.63</td>
<td>1.687</td>
</tr>
<tr>
<td>20 At this organisation, people are allowed a fair degree of freedom in deciding how they can meet goals and objectives</td>
<td>Meritocratic</td>
<td>4.25</td>
<td>1.693</td>
</tr>
</tbody>
</table>
The mean and the standard deviation for all respondents when the characteristics questions are combined into collegial, meritocratic, leadership and elite styles of management are repeated in Table 6.11 below.

**Table 6.11: Descriptive Analysis of Mean Values for Organisational Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collegial Style of Management</td>
<td>186</td>
<td>4.062</td>
<td>1.1173</td>
</tr>
<tr>
<td>Meritocratic Style of Management</td>
<td>185</td>
<td>4.194</td>
<td>1.0138</td>
</tr>
<tr>
<td>Leadership Style of Management</td>
<td>187</td>
<td>4.627</td>
<td>1.1310</td>
</tr>
<tr>
<td>Elite Style of Management</td>
<td>187</td>
<td>4.865</td>
<td>1.0496</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>185</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This finding suggests that the respondents collectively characterise their organisations as first Elite, then Leadership, Meritocratic, and lastly Collegial. Respondents collectively indicate hospitals exhibit a managerial style that is characterised as Elite, and which tends to rely on rules and policies. However, this research is also about identification of subcultural differences and therefore this data was further analysed to explore differences between professional groups and functional groups in three hospitals.

**6.4.2 Professional Groups Assessment of Managerial Characteristics in All Hospitals**

The respondents were classified according to three professional groups. These groups are doctors, nurses, and others.
6.4.3 Doctors, Nurses, and Others Assessment of Managerial Characteristics

Calculation of the Levene’s statistic in Table 6.12 indicates that the homogeneity assumption has been violated (p=<0.05) in “Leadership Style of Management”. Hence we cannot assume the homogeneity of variance for the “Leadership Style of Management” variable and ANOVA should not be applied for analysis of that item. Hence this item was removed from further analysis.

Table 6.12: Levene’s Test of Homogeneity for ANOVA between Professional Groups in Assessing Organisational and Managerial Characteristics

<table>
<thead>
<tr>
<th>Test of Homogeneity of Variances</th>
<th>Levene Statistic</th>
<th>df1</th>
<th>df2</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collegial Style of Management</td>
<td>.273</td>
<td>2</td>
<td>170</td>
<td>.762</td>
</tr>
<tr>
<td>Meritocratic Style of Management</td>
<td>.056</td>
<td>2</td>
<td>169</td>
<td>.946</td>
</tr>
<tr>
<td>Leadership Style of Management</td>
<td>4.692</td>
<td>2</td>
<td>166</td>
<td>.010</td>
</tr>
<tr>
<td>Elite Style of Management</td>
<td>.061</td>
<td>2</td>
<td>171</td>
<td>.941</td>
</tr>
</tbody>
</table>

However, Table 6.12 indicates that the homogeneity assumption has not been violated for the other items. Therefore, the Levene’s test for homogeneity of variance is not significant and indicates that the population variances for each group are not significantly different. Hence, ANOVA can be applied for the items collegial, meritocratic and elite style of management.

The null-hypothesis to be tested is then,
**H0#3 There is no difference between professional groups in terms of their assessment of their organisations management characteristics**

The analysis presented in Table 6.13 indicates there are no significant differences between the professional groups’ opinions about the organisational/managerial characteristics of their organisations.

| Table 6.13: ANOVA between Professional Groups in Assessing Organisational and Managerial Characteristics |
|--------------------------------------------------------|-------------------------------------------------|-----------------|---|---|---|
| **ANOVA**                                              | **Sum of Squares**                              | **df**          | **Mean Square** | **F** | **Sig.** |
| Collegial Style of Management                          | Between Groups                                  | .214            | 2              | .107  | .084     | .919   |
|                                                       | Within Groups                                   | 216.781         | 170            | 1.275 |          |        |
|                                                       | Total                                           | 216.995         | 172            |       |          |        |
| Meritocratic Style of Management                       | Between Groups                                  | 2.139           | 2              | 1.070 | 1.059    | .349   |
|                                                       | Within Groups                                   | 170.728         | 169            | 1.010 |          |        |
|                                                       | Total                                           | 172.867         | 171            |       |          |        |
| Elite Style of Management                             | Between Groups                                  | 3.331           | 2              | 1.665 | 2.118    | .123   |
|                                                       | Within Groups                                   | 134.424         | 171            | .786  |          |        |
|                                                       | Total                                           | 137.754         | 173            |       |          |        |

Hence, the null-hypothesis “There is no difference between professional groups in terms of assessing their organisations management characteristics” cannot be rejected for all variables. That is, all three professional groups assess the organisation similarly. It is interesting to note that the Collegial factor is 0.919, which is high but not significant. However, this may be a possible area for future research.
In summary, the data on hospital characteristics show that all professional groups assess the organisational primarily as having an Elite Style of Management. This concurs with findings from Fitzgerald (2002).

6.4.4 Functional Groups in three hospitals

This section asked managers and clinicians about the managerial characteristics they believed their health organisation exhibited.

**H0#4 There is no difference between functional groups in terms of assessing their organisations management characteristics**

This was investigated by utilising the Independent Groups T-Tests. Table 6.14 indicates there is no significant difference between the functional groups views about the organisational/managerial characteristics they believe their health organisation displays.
Table 6.14: T-Test Functional Groups Assessing Management Characteristics

Group Statistics

<table>
<thead>
<tr>
<th>Functional Role</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Managers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>102</td>
<td>4.143</td>
<td>1.3033</td>
<td>.1290</td>
</tr>
<tr>
<td>Manager</td>
<td>36</td>
<td>4.478</td>
<td>1.1897</td>
<td>.1983</td>
</tr>
<tr>
<td>Provision of Direction and Coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>99</td>
<td>4.283</td>
<td>.7586</td>
<td>.0762</td>
</tr>
<tr>
<td>Manager</td>
<td>36</td>
<td>4.389</td>
<td>.7390</td>
<td>.1232</td>
</tr>
<tr>
<td>What Bind People Together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>102</td>
<td>4.647</td>
<td>1.0237</td>
<td>.1014</td>
</tr>
<tr>
<td>Manager</td>
<td>36</td>
<td>4.789</td>
<td>1.1513</td>
<td>.1919</td>
</tr>
<tr>
<td>Nature of Relationship between Managers and Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>102</td>
<td>4.325</td>
<td>.9548</td>
<td>.0945</td>
</tr>
<tr>
<td>Manager</td>
<td>37</td>
<td>4.178</td>
<td>.7315</td>
<td>.1203</td>
</tr>
</tbody>
</table>

Levene's Test for Equality of Variances vs t-test for Equality of Means

<table>
<thead>
<tr>
<th>Functional Role</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Managers</td>
<td>Equal variances assumed</td>
<td>1.200  .275  -1.354  136  .178  -.3346  .2472</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-1.414 66.773  .162  -.3346  .2366</td>
</tr>
<tr>
<td>Provision of Direction and Coordination</td>
<td>Equal variances assumed</td>
<td>.027  .869  -723  133  .471  -.1061  .1467</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-.732 63.625  .467  -.1061  .1449</td>
</tr>
<tr>
<td>What Bind People Together</td>
<td>Equal variances assumed</td>
<td>.271  .604  -691  136  .490  -.1418  .2051</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>-.654 55.754  .516  -.1418  .2170</td>
</tr>
<tr>
<td>Nature of Relationship between Managers and Staff</td>
<td>Equal variances assumed</td>
<td>3.020  .085  .850  137  .397  .1471  .1730</td>
</tr>
<tr>
<td></td>
<td>Equal variances not assumed</td>
<td>.962 82.954  .339  .1471  .1530</td>
</tr>
</tbody>
</table>
The management characteristic null-hypothesis “There is no difference between functional groups in terms of assessing their organisations management characteristic” cannot be rejected for all variables. This means that there is no significant difference between managers’ and clinicians’ opinions about feelings and beliefs in relation to management characteristics their health organisation displays.

6.5 Perceptions of Currently Pursued Organisational Goals

Thus far, analysis has been conducted to determine respondents’ commitment to their organisation, as well as respondents’ perceptions of managerial role characteristics. This section will provide an analysis of the way that respondents perceive the goals their organisation is pursuing.

6.5.1 Ranking of Organisational Goals in three hospitals by all respondents

Section A of the survey questionnaire asked respondents to rank a number of goal statements by placing number 1 next to the statement they thought was most important, number 2 next to the next most important statement and so on through to number 8 for the statement least important.

Table 6.15 shows the rank responses of all respondents from all hospitals. All respondents gave “financial viability” the highest ranking, indicating that they believe that this is the most important goal their health organisation. Staff welfare was perceived to be the least important goal the hospital is currently pursuing. This is consistent with findings reported by both Fitzgerald (2002) and Degeling et al. (1998).
Table 6.15: Ranking of Organisational Goals by Doctors, Nurses, and Others

<table>
<thead>
<tr>
<th>Goal</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial viability</td>
<td>184</td>
<td>3.50</td>
<td>2.563</td>
</tr>
<tr>
<td>Service quality</td>
<td>185</td>
<td>3.69</td>
<td>2.077</td>
</tr>
<tr>
<td>Improved productivity</td>
<td>185</td>
<td>3.69</td>
<td>2.010</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>185</td>
<td>4.05</td>
<td>2.135</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>185</td>
<td>4.38</td>
<td>1.919</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>185</td>
<td>4.43</td>
<td>2.071</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>185</td>
<td>5.65</td>
<td>2.111</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>185</td>
<td>5.68</td>
<td>2.292</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>184</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.5.2 Ranking of Organisational Goals by Professional Groups from all Three Hospitals

Table 6.16 shows the rank responses of doctors, nurses, and others. There is little variation in the way that professional groups rank the hospital’s goals. All three professional groups gave “financial viability” amongst the highest ranking, indicating that they believe that this is the most important goal their hospital is pursuing. It is also interesting to note that all three professional groups gave “staff welfare” amongst the lowest ranking. These findings are consistent with both the Fitzgerald (2002) and Degeling et al. (1998) studies which came to the same conclusion.

It is interesting to note that the others stakeholder group ranked “improved productivity” lower than doctors and nurses. Hence, the organisational goals null-hypothesis “there is no difference between professional groups in terms of their opinion about the goals currently being pursued by their organisation” cannot be rejected.
Table 6.16 Ranking of Organisational Goals by Professional Groups from all Three Hospitals

<table>
<thead>
<tr>
<th>Ranking of Organisational Goals by Doctors</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved productivity</td>
<td>23</td>
<td>3.13</td>
<td>1.456</td>
</tr>
<tr>
<td>Financial viability</td>
<td>22</td>
<td>3.23</td>
<td>2.844</td>
</tr>
<tr>
<td>Service quality</td>
<td>23</td>
<td>3.96</td>
<td>2.056</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>23</td>
<td>4.00</td>
<td>2.045</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>23</td>
<td>4.09</td>
<td>1.975</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>23</td>
<td>5.30</td>
<td>1.917</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>23</td>
<td>6.17</td>
<td>1.669</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>23</td>
<td>6.22</td>
<td>1.930</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ranking of Organisational Goals by Nurses</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial viability</td>
<td>112</td>
<td>3.59</td>
<td>2.513</td>
</tr>
<tr>
<td>Improved productivity</td>
<td>112</td>
<td>3.61</td>
<td>1.988</td>
</tr>
<tr>
<td>Service quality</td>
<td>112</td>
<td>3.74</td>
<td>2.151</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>112</td>
<td>4.13</td>
<td>2.107</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>112</td>
<td>4.29</td>
<td>1.824</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>112</td>
<td>4.39</td>
<td>2.046</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>112</td>
<td>5.62</td>
<td>2.349</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>112</td>
<td>5.74</td>
<td>2.096</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>112</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ranking of Organisational Goals by Others</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial viability</td>
<td>37</td>
<td>3.00</td>
<td>2.369</td>
</tr>
<tr>
<td>Service quality</td>
<td>37</td>
<td>3.43</td>
<td>1.951</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>37</td>
<td>4.00</td>
<td>2.309</td>
</tr>
<tr>
<td>Improved productivity</td>
<td>37</td>
<td>4.14</td>
<td>2.299</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>37</td>
<td>4.35</td>
<td>1.989</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>37</td>
<td>4.86</td>
<td>2.188</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>37</td>
<td>4.97</td>
<td>2.166</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>37</td>
<td>5.81</td>
<td>2.222</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.5.3 Ranking of Organisational Goals by Functional Groups all three Hospitals

Table 6.17 shows the rank responses of clinicians and managers. There is little variation in the way that functional groups rank the hospital’s goals. Both functional groups ranked “financial viability” in the top two, indicating that they believe that this
is the most important goal their hospital is pursuing. It is also interesting to note that both functional groups ranked “staff welfare” in the bottom two rankings. These findings are consistent with both Fitzgerald (2002) and Degeling et al. (1998) studies which came to the same conclusion.

Table 6.17: All Hospitals Ranking of Organisational Goals by Clinicians and Managers

Descriptive Statistics

<table>
<thead>
<tr>
<th>Clinicians Ranking of Organisational Goals</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial viability</td>
<td>100</td>
<td>3.47</td>
<td>2.657</td>
</tr>
<tr>
<td>Improved productivity</td>
<td>101</td>
<td>3.48</td>
<td>1.911</td>
</tr>
<tr>
<td>Service quality</td>
<td>101</td>
<td>3.92</td>
<td>2.199</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>101</td>
<td>4.20</td>
<td>2.131</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>101</td>
<td>4.40</td>
<td>1.882</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>101</td>
<td>4.51</td>
<td>2.023</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>101</td>
<td>5.66</td>
<td>2.346</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>101</td>
<td>5.67</td>
<td>2.050</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managers Ranking of Organisational Goals</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service quality</td>
<td>38</td>
<td>3.42</td>
<td>1.884</td>
</tr>
<tr>
<td>Financial viability</td>
<td>38</td>
<td>3.55</td>
<td>2.345</td>
</tr>
<tr>
<td>Improved productivity</td>
<td>38</td>
<td>3.55</td>
<td>1.927</td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td>38</td>
<td>3.87</td>
<td>2.108</td>
</tr>
<tr>
<td>Equal access for all patients</td>
<td>38</td>
<td>4.05</td>
<td>1.888</td>
</tr>
<tr>
<td>Organisational stability</td>
<td>38</td>
<td>4.68</td>
<td>1.847</td>
</tr>
<tr>
<td>Teaching and research reputation</td>
<td>38</td>
<td>6.05</td>
<td>1.972</td>
</tr>
<tr>
<td>Staff welfare</td>
<td>38</td>
<td>6.11</td>
<td>2.011</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hence, the organisational goals null-hypothesis “there is no difference between functional groups in terms of their opinion about the goals currently pursued by their organisation” is accepted.
6.6 Perceptions of Orientation to Work Values when Choosing a Job

Section D of the survey questionnaire asked respondents to rank a number of factors from 1-10 in terms of their importance when choosing a job. The respondents were asked to disregard the extent to which these factors were contained in their present job. Instead, they were asked to think of factors which would be important to an individual in an *ideal* job. Number 1 was to be placed next to the factor most important, number 2 was to be placed next to the next most important job value and so on, till number 10 was placed next to the factor considered least important in an ideal job.

6.6.1 Ranking of Work Values by all respondents in all three Hospitals

Table 6.18 is a ranking of work values by all respondents from all hospitals. It orders the work values that are important to all respondents. Table 6.18 reveals that status and recognition are less important work values when choosing a job, whilst work that gives me a sense of personal achievement is a highly important work value.
Table 6.18: Ranking of Work Values by All Respondents across all Hospitals

<table>
<thead>
<tr>
<th>Work Value</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>175</td>
<td>3.60</td>
<td>2.913</td>
</tr>
<tr>
<td>A good income level</td>
<td>174</td>
<td>4.17</td>
<td>2.784</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>174</td>
<td>4.41</td>
<td>2.433</td>
</tr>
<tr>
<td>Job security</td>
<td>174</td>
<td>4.59</td>
<td>2.999</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>173</td>
<td>4.62</td>
<td>2.331</td>
</tr>
<tr>
<td>Challenge</td>
<td>175</td>
<td>5.70</td>
<td>2.780</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>174</td>
<td>5.71</td>
<td>2.716</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>174</td>
<td>5.74</td>
<td>2.535</td>
</tr>
<tr>
<td>A career structure</td>
<td>174</td>
<td>6.10</td>
<td>2.658</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>174</td>
<td>7.96</td>
<td>2.630</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>173</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.6.2 Ranking of Work Values by professional groups in all three Hospitals

Table 19 show the rank responses of doctors, nurses, and others. There are some similarities and variations in the way that professional groups rank what factors are most important in an ideal job. All three professional groups ranked “work that gives me a sense of personal achievement” as one of the most important factors. In addition, other staff and nurses ranked “job security” as an important factor in choosing an ideal job. Further, doctors ranked “a good income level” as the most important factor in choosing a job, and “freedom to use my own approach (autonomy)” as a highly important factor. It is also interesting to note that all three professional groups gave “status and recognition” the lowest ranking. It is also interesting to note that doctors ranked “a good working relationship with a supportive supervisor” as an unimportant factor when choosing a job. Nurses ranked “friendly
co-operative co-workers” as a highly important factor when choosing a job, and others felt that “job security” was highly important.

### 6.6.3 ANOVA

Analysis of variance was conducted to determine if there were variations between perceptions of doctors, nurses and others on work values. The Levene’s statistic indicates that homogeneity is violated in statement 9 “status and recognition”. Therefore, this statement is excluded from the ANOVA between the professional groups.

Table 6.19 indicates the acceptance of the null hypothesis “there is no difference between occupational groups in terms of work values and what is important when choosing a job” for statements 1,2,4,5,6,8,10. However, Table 6.19 indicates there is a significant difference between professional groups for statement 3 “a good working relationship with a supportive supervisor” and statement 7 “job security”.

Hence, the organisational goals null-hypothesis “there is no difference between occupational groups in terms of work values and what is important when choosing a job” is rejected for statements 3 and 7. This means that there is a significant difference between professional groups’ opinions about what factors are important in choosing an ideal job, where doctors place significantly less value on having a good relationship with a supportive supervisor than nurses and others. In addition, nurses and others are significantly more concerned with job security than doctors. These results concur with findings from Fitzgerald (2002).
Table 6.19: Work Values Ranking by Doctors, Nurses, and Others

Descriptive Statistics

<table>
<thead>
<tr>
<th>Work Values Ranking by Doctors</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good income level</td>
<td>23</td>
<td>3.57</td>
<td>2.761</td>
</tr>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>23</td>
<td>3.83</td>
<td>2.790</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>23</td>
<td>4.91</td>
<td>2.661</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>23</td>
<td>4.96</td>
<td>2.531</td>
</tr>
<tr>
<td>A career structure</td>
<td>23</td>
<td>5.26</td>
<td>3.063</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>23</td>
<td>5.87</td>
<td>1.890</td>
</tr>
<tr>
<td>Job security</td>
<td>23</td>
<td>5.91</td>
<td>2.762</td>
</tr>
<tr>
<td>Challenge</td>
<td>23</td>
<td>6.17</td>
<td>2.758</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>23</td>
<td>6.22</td>
<td>2.575</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>23</td>
<td>8.30</td>
<td>2.324</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Values Ranking by Nurses</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>109</td>
<td>3.45</td>
<td>2.837</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>108</td>
<td>4.19</td>
<td>2.365</td>
</tr>
<tr>
<td>A good income level</td>
<td>108</td>
<td>4.31</td>
<td>2.886</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>107</td>
<td>4.47</td>
<td>2.169</td>
</tr>
<tr>
<td>Job security</td>
<td>108</td>
<td>4.49</td>
<td>2.953</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>108</td>
<td>5.61</td>
<td>2.572</td>
</tr>
<tr>
<td>Challenge</td>
<td>109</td>
<td>5.68</td>
<td>2.821</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>108</td>
<td>5.93</td>
<td>2.854</td>
</tr>
<tr>
<td>A career structure</td>
<td>108</td>
<td>6.17</td>
<td>2.624</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>108</td>
<td>7.93</td>
<td>2.524</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>107</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Values Ranking by Others</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>35</td>
<td>3.71</td>
<td>3.092</td>
</tr>
<tr>
<td>Job security</td>
<td>35</td>
<td>4.17</td>
<td>3.082</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>35</td>
<td>4.20</td>
<td>2.260</td>
</tr>
<tr>
<td>A good income level</td>
<td>35</td>
<td>4.23</td>
<td>2.545</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>35</td>
<td>4.51</td>
<td>2.280</td>
</tr>
<tr>
<td>Challenge</td>
<td>35</td>
<td>5.29</td>
<td>2.619</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>35</td>
<td>5.77</td>
<td>2.723</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>35</td>
<td>5.91</td>
<td>2.293</td>
</tr>
<tr>
<td>A career structure</td>
<td>35</td>
<td>6.74</td>
<td>2.477</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>35</td>
<td>8.26</td>
<td>2.904</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.6.4 Ranking of Work Values by Functional Groups in all three Hospitals

Table 6.20 shows the rank responses of clinicians and managers. There is little variation in the way that functional groups rank the hospital’s goals. Both functional groups gave “work that gives me a sense of personal achievement” the highest ranking. It is also interesting to note that both functional groups placed least importance on the value of having “status and recognition”. There are no significant differences between the rank responses of clinicians and managers about goals the organisation is pursuing. However, there is a notable difference between functional groups in relation to “freedom to use my own approach”. Managers ranked this work value more highly than doctors.

Therefore, the work values null-hypothesis “there is no difference between functional groups in terms of work values and what is important when choosing a job” is rejected for the work value “freedom to use my own approach”. This means there is a significant difference between managers and clinicians in relation to this variable. However, the work values null-hypothesis “there is no difference between functional groups in terms of work values and what is important when choosing a job” cannot be rejected for the remaining variables. This means that there is no significant difference between managers and clinicians opinions about work values and what is important when choosing a job, in the remaining variables including work that gives a sense of personal achievement, job security, a good working relationship with a supportive supervisor, a good income level, friendly, co-operative co-workers, opportunities for further professional development, and a good career structure.
Table 6.20: Clinicians and Managers Ranking of Work Values

Descriptive Statistics

<table>
<thead>
<tr>
<th>Clinicians Ranking of Work Values</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>99</td>
<td>3.66</td>
<td>2.836</td>
</tr>
<tr>
<td>A good income level</td>
<td>99</td>
<td>4.02</td>
<td>2.886</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>99</td>
<td>4.32</td>
<td>2.377</td>
</tr>
<tr>
<td>Job security</td>
<td>99</td>
<td>4.49</td>
<td>2.894</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>98</td>
<td>4.76</td>
<td>2.399</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>99</td>
<td>5.61</td>
<td>2.377</td>
</tr>
<tr>
<td>A career structure</td>
<td>99</td>
<td>5.83</td>
<td>2.800</td>
</tr>
<tr>
<td>Challenge</td>
<td>99</td>
<td>6.12</td>
<td>2.822</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>98</td>
<td>6.21</td>
<td>2.807</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>99</td>
<td>7.84</td>
<td>2.457</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>98</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managers Ranking of Work Values</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td>37</td>
<td>2.78</td>
<td>2.647</td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td>36</td>
<td>4.42</td>
<td>2.442</td>
</tr>
<tr>
<td>A good income level</td>
<td>36</td>
<td>4.50</td>
<td>2.803</td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td>37</td>
<td>4.70</td>
<td>2.504</td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td>36</td>
<td>4.75</td>
<td>1.933</td>
</tr>
<tr>
<td>Challenge</td>
<td>37</td>
<td>4.84</td>
<td>2.672</td>
</tr>
<tr>
<td>Job security</td>
<td>36</td>
<td>5.42</td>
<td>3.018</td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td>36</td>
<td>6.06</td>
<td>2.704</td>
</tr>
<tr>
<td>A career structure</td>
<td>36</td>
<td>6.58</td>
<td>2.347</td>
</tr>
<tr>
<td>Status and recognition</td>
<td>36</td>
<td>8.56</td>
<td>2.431</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>36</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.7 Professional Group Differences According to Small, Medium, and Large Size Hospitals

The analysis for the combined data set (all respondents from small, medium, large hospitals) was repeated separately for the small, medium, and large hospitals. Refer to Appendix 7 for the small hospital tests, Appendix 8 for the medium hospital tests, and Appendix 9 for the large hospital tests. Additionally, Appendix 10 shows the overall results from all three categories.
Table 6.21 outlines the variations from the small, medium, and large hospitals that were observed. Because of the small number of doctors and others recruited, a statistical analysis cannot be given. The small hospital consists of predominately nurses with mainly VMOs. The majority of others (i.e. managers/administrators) are located at different sites (i.e. head office) and the higher number of nurse respondents coupled with the lower number of doctors and others respondents in the small hospital reflects this.

Table 6.21: Professional Group Differences According to Hospital Size

<table>
<thead>
<tr>
<th>Questions</th>
<th>Professional Group Differences (Doctors, Nurses, Others)</th>
<th>Small Hospital</th>
<th>Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic, Extrinsic</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td></td>
</tr>
<tr>
<td>Collegial, Meritocratic, Leadership, Elite</td>
<td>Doctors rank hospital as (Meritocratic, Leadership, Elite, Collegial least to most) Nurses rank hospital as (Collegial, Meritocratic, Leadership, Elite least to most) Others rank hospital as (Leadership, Collegial, Meritocratic, Elite least to most)</td>
<td>Doctors rank hospital as (M, E, L, C least to most) Nurses and Others rank hospital as (C, M, L, E least to most)</td>
<td>No significant differences</td>
<td></td>
</tr>
<tr>
<td>Organisation’s Goals</td>
<td>No significant differences</td>
<td>Nurses ranked “Financial Viability” more highly than Doctors Nurses ranked “Reputation for Service Innovation and Industry Leadership” more highly than Others</td>
<td>No significant differences</td>
<td></td>
</tr>
<tr>
<td>Work Values</td>
<td>No significant differences</td>
<td>Doctors ranked “Freedom to use my own approach” more highly than Nurses and Others</td>
<td>Doctors ranked “A good income level” more highly than Nurses Others ranked “A good working relationship with a supportive superior” more highly than Doctors</td>
<td></td>
</tr>
<tr>
<td>Admin-Managers</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>Nurses believe this stakeholder group exhibits legitimacy more strongly than doctors</td>
</tr>
<tr>
<td>Power, Urgency, Legitimacy</td>
<td>Doctor Stakeholder Group</td>
<td>Doctor Stakeholder Group</td>
<td>Doctor Stakeholder Group</td>
<td>Doctor Stakeholder Group</td>
</tr>
<tr>
<td>Doctors</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
</tr>
<tr>
<td>Power, Urgency, Legitimacy</td>
<td>Nurses Stakeholder Group</td>
<td>Nurses Stakeholder Group</td>
<td>Nurses Stakeholder Group</td>
<td>Nurses Stakeholder Group</td>
</tr>
<tr>
<td>Nurses</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>Doctors and Others believe this stakeholder group exhibits power more strongly than nurses</td>
</tr>
</tbody>
</table>
The results from the table were compared with the results from the combined data. These are compared in the cultural constructs discussion section below.

### 6.8 Cultural Constructs Discussion

Thus far this thesis has tried to display a picture of the organisational culture of the hospitals that participated in the study. This picture includes cultural constructs such as feelings and beliefs about organisational commitment, organisational affiliation, perceptions about goals the hospital is currently pursuing, and work values when looking for an ideal job. There were comparisons made with findings from work done previously by Degeling et al. (1998), and Fitzgerald (2002) in the field of professional subcultures in the context of health management.

Generally, hospital culture, as measured by survey questionnaire in the domains of organisational commitment, managerial role characteristics, goals that are pursued, and work values when choosing a job, would suggest the hospitals as being integrated in nature. There is little differentiation in the respondents’ views from the three hospitals about managerial characteristics. In general, respondents believe their hospital can be described as being Elite, which tends to rely on rules and policies.

From the analysis above, whilst the different professional groups share many aspects of organisational culture, some distinct differences have emerged. This next section focuses on differences between doctors, nurses, and others. A summary of these differences is outlined in Table 6.22.
Table 6.22 Differences between Professional Groups

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Nurses</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmentally conscious</td>
<td>Environmentally conscious</td>
<td>Environmentally conscious</td>
</tr>
<tr>
<td>▪ work is generally of an</td>
<td>▪ prefer friendly, co-operative</td>
<td>▪ prefer friendly, co-operative co-workers</td>
</tr>
<tr>
<td>autonomous nature with</td>
<td>co-workers</td>
<td>▪ require support from superiors</td>
</tr>
<tr>
<td>minimal cooperation</td>
<td>▪ require support from superiors</td>
<td></td>
</tr>
<tr>
<td>Extrinsically Motivated</td>
<td>Intrinsically Motivated</td>
<td>Extrinsically Motivated</td>
</tr>
<tr>
<td>▪ income conscious</td>
<td>▪ not income conscious</td>
<td>▪ job security conscious</td>
</tr>
<tr>
<td>Independent</td>
<td>Interdependent</td>
<td>Both Interdependent and Interdependent</td>
</tr>
<tr>
<td>▪ prefer the freedom to use</td>
<td>▪ work together to deliver patient</td>
<td>▪ work together to deliver patient care</td>
</tr>
<tr>
<td>their own approach</td>
<td>care</td>
<td>▪ lead groups of people</td>
</tr>
</tbody>
</table>

There was little variation in the way that respondents from the small hospital answered. This may indicate that in this small hospital, there is a high level of integration between professional groups. The same can be said for the medium hospital. However, in the larger hospital, more differences emerged between respondents. These differences would indicate that there is greater fragmentation in the larger hospital. Divisions within the hospital may be due to the size of the hospital, the added layers of bureaucracy, and more resources to deal with. This proposition is further examined through analysis of interview data and conversations with staff discussed in Chapter Seven.

The next section looks at respondents’ perceptions about the precedence given to different stakeholder groups in relation to decision making.

6.9 Interactions with Various Professional Stakeholders

The following section examines functional groups (clinicians’ and managers’) responses to questions about stakeholder saliency. Stakeholder saliency is about
determining what level of priority is given to different stakeholder groups (Mitchell, et al, 1997). Agle et al. (1997) devised a survey questionnaire which showed that three factors were related to saliency. The three factors include legitimacy, power, and urgency. Section C of the survey questionnaire included questions from the original Agle et al. (1997) survey questionnaire. Agle used factor analysis to group the questions into three factors. In this research, factor analysis was used to group the questions according to the three factors of legitimacy, power, and urgency. Respondents were asked to answer questions about these factors in relation to three professional constituencies, or stakeholder groups. These stakeholder groups are “Doctors”, “Nurses”, and “Others” (people who are not doctors or nurses).

6.9.1 All Respondents from Three hospitals

This section asked respondents opinions about their interactions with members of three different stakeholder groups, including doctors, nurses and others. For example, a respondent (who could be a doctor, nurse or other) was asked to what degree they agree or disagree with statements made about his/her interaction when dealing with 1) Nurses, 2) doctors and 3) others. This is to assess if there are differences in opinions about interactions within their own occupational group or with the other two groups. This may say something about the magnitude of saliency, and about boundaries and boundary crossing between occupational groups when making decisions. Section C asked respondents to indicate the extent to which they agreed or disagreed about the statements. Number 1 indicated that they strongly disagreed with the statement and number 7 indicated that they strongly agreed with the statement. Table 6.23 indicates the mean and standard deviation responses by all respondents from all hospitals about all stakeholder groups. It indicates how strongly
respondents agree or disagree with statements about stakeholders’ saliency in terms of power, urgency, and legitimacy. For example, the mean response about doctors’ legitimacy, according to all respondents, is 5.096. This shows that all respondents more strongly agree that the doctors’ stakeholder group commands legitimacy.

Table 6.23: All Respondents All Hospitals Responses about all Stakeholder Groups

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legitimacy (Doctors)</td>
<td>156</td>
<td>5.096</td>
<td>1.4493</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>164</td>
<td>4.463</td>
<td>1.4072</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>158</td>
<td>5.025</td>
<td>1.4583</td>
</tr>
<tr>
<td>Power (Doctors)</td>
<td>151</td>
<td>5.157</td>
<td>1.2213</td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>159</td>
<td>3.824</td>
<td>1.3640</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>153</td>
<td>5.142</td>
<td>1.3490</td>
</tr>
<tr>
<td>Urgency (Doctors)</td>
<td>151</td>
<td>5.086</td>
<td>1.3902</td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
<td>157</td>
<td>4.968</td>
<td>1.4475</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>161</td>
<td>4.286</td>
<td>1.7008</td>
</tr>
</tbody>
</table>

Collectively, the respondents from all hospitals believe that the “Doctors” Stakeholder group is more salient, or has a higher level of influence on decision making, than the “Nurses” and “Others” groups. As can be seen from the higher mean score in Table 6.23, the legitimacy (doctors), power (doctors), and urgency (doctors) is higher than legitimacy (nurses/others), power (nurses/others), and urgency (nurses/others).

Table 6.24 summarises Professional group opinions about Doctors, Nurses, and Others Stakeholder Groups.
Table 6.24: Summary of Professional Group Opinions about “Doctors”, “Nurses” and “Others”
Stakeholder Groups

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power (Doctors)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>22</td>
<td>4.758</td>
<td>1.3961</td>
</tr>
<tr>
<td>Nurse</td>
<td>93</td>
<td>5.222</td>
<td>1.2572</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>5.133</td>
<td>.9533</td>
</tr>
<tr>
<td>Total</td>
<td>145</td>
<td>5.133</td>
<td>1.2263</td>
</tr>
<tr>
<td><strong>Urgency (Doctors)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>22</td>
<td>5.136</td>
<td>1.3903</td>
</tr>
<tr>
<td>Nurse</td>
<td>90</td>
<td>5.100</td>
<td>1.4066</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>4.967</td>
<td>1.2452</td>
</tr>
<tr>
<td>Total</td>
<td>142</td>
<td>5.077</td>
<td>1.3635</td>
</tr>
<tr>
<td><strong>Legitimacy (Doctors)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>22</td>
<td>5.000</td>
<td>1.5430</td>
</tr>
<tr>
<td>Nurse</td>
<td>96</td>
<td>5.021</td>
<td>1.5422</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>5.419</td>
<td>.9228</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>5.101</td>
<td>1.4367</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power (Nurses)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>20</td>
<td>4.350</td>
<td>1.2017</td>
</tr>
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<td>Nurse</td>
<td>102</td>
<td>3.503</td>
<td>1.4202</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>4.389</td>
<td>.9512</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>3.789</td>
<td>1.3686</td>
</tr>
<tr>
<td><strong>Urgency (Nurses)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>20</td>
<td>5.250</td>
<td>1.3328</td>
</tr>
<tr>
<td>Nurse</td>
<td>97</td>
<td>4.948</td>
<td>1.5164</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>5.000</td>
<td>1.2318</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
<td>5.000</td>
<td>1.4335</td>
</tr>
<tr>
<td><strong>Legitimacy (Nurses)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>20</td>
<td>4.550</td>
<td>1.4318</td>
</tr>
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<td>Nurse</td>
<td>105</td>
<td>4.314</td>
<td>1.5020</td>
</tr>
<tr>
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<td>31</td>
<td>4.806</td>
<td>1.0462</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>4.442</td>
<td>1.4199</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power (Others)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>20</td>
<td>5.000</td>
<td>1.3464</td>
</tr>
<tr>
<td>Nurse</td>
<td>94</td>
<td>5.234</td>
<td>1.3024</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>4.949</td>
<td>1.5301</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
<td>5.138</td>
<td>1.3587</td>
</tr>
<tr>
<td><strong>Urgency (Others)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>21</td>
<td>3.524</td>
<td>1.6917</td>
</tr>
<tr>
<td>Nurse</td>
<td>97</td>
<td>4.526</td>
<td>1.7145</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>4.152</td>
<td>1.5436</td>
</tr>
<tr>
<td>Total</td>
<td>151</td>
<td>4.305</td>
<td>1.7010</td>
</tr>
<tr>
<td><strong>Legitimacy (Others)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>20</td>
<td>4.800</td>
<td>1.5761</td>
</tr>
<tr>
<td>Nurse</td>
<td>97</td>
<td>4.990</td>
<td>1.5712</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>5.212</td>
<td>1.0535</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>5.013</td>
<td>1.4700</td>
</tr>
</tbody>
</table>

Analysis of variance was done to determine if there are significant differences between interactions with different groups to determine the level of influence on decision making by doctors, nurses, and others. Table 6.25 indicates that the homogeneity assumption has been violated (p=<0.05) for “Power” (Nurses) and
“Legitimacy” (Others). Hence we cannot assume the homogeneity of variance for the “legitimacy” variable and ANOVA cannot be applied for those items. Therefore, the legitimacy variable was not used in the analysis.

However, Table 6.25 indicates that the homogeneity assumption has not been violated for the other items. Therefore, the Levene’s test for homogeneity of variance is not significant and indicates that the population variances for each group are approximately equal.

Table 6.25: Homogeneity of Variances for Summary of Professional Group Opinions about “Doctors”, “Nurses” and “Others” Stakeholder Groups

<table>
<thead>
<tr>
<th>Test of Homogeneity of Variances</th>
<th>Levene Statistic</th>
<th>df1</th>
<th>df2</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors)</td>
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<td>2</td>
<td>142</td>
<td>.079</td>
</tr>
<tr>
<td>Urgency (Doctors)</td>
<td>.632</td>
<td>2</td>
<td>139</td>
<td>.533</td>
</tr>
<tr>
<td>Legitimacy (Doctors)</td>
<td>2.486</td>
<td>2</td>
<td>146</td>
<td>.087</td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>4.782</td>
<td>2</td>
<td>149</td>
<td>.010</td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
<td>.878</td>
<td>2</td>
<td>144</td>
<td>.418</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>2.036</td>
<td>2</td>
<td>153</td>
<td>.134</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>.525</td>
<td>2</td>
<td>144</td>
<td>.593</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>1.066</td>
<td>2</td>
<td>148</td>
<td>.347</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>3.184</td>
<td>2</td>
<td>147</td>
<td>.044</td>
</tr>
</tbody>
</table>

As demonstrated in Table 6.26, there is no difference between doctors, nurses, and others opinions about the level of influence exerted by doctors, nurses, and others, except in the construct determined by urgency. This means that according to the participants collectively, the attribute of the stakeholder-manager relationship “urgency” has a higher variability than those of legitimacy, and power. That is, all respondents more strongly agree that the “others” stakeholder group command higher urgency than the doctors and nurses stakeholder groups.
Table 6.26: ANOVA for Summary of Professional Group Opinions about “Doctors”, “Nurses” and “Others” Stakeholder Groups

ANOVA

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors) Between Groups</td>
<td>3.841</td>
<td>2</td>
<td>1.921</td>
<td>1.282</td>
<td>.281</td>
</tr>
<tr>
<td>Within Groups</td>
<td>212.692</td>
<td>142</td>
<td>1.498</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>216.533</td>
<td>144</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency (Doctors) Between Groups</td>
<td>.490</td>
<td>2</td>
<td>.245</td>
<td>.130</td>
<td>.878</td>
</tr>
<tr>
<td>Within Groups</td>
<td>261.658</td>
<td>139</td>
<td>1.882</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>262.148</td>
<td>141</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legitimacy (Doctors) Between Groups</td>
<td>3.983</td>
<td>2</td>
<td>1.992</td>
<td>.964</td>
<td>.384</td>
</tr>
<tr>
<td>Within Groups</td>
<td>301.507</td>
<td>146</td>
<td>2.065</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>305.490</td>
<td>148</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency (Nurses) Between Groups</td>
<td>1.508</td>
<td>2</td>
<td>.754</td>
<td>.364</td>
<td>.696</td>
</tr>
<tr>
<td>Within Groups</td>
<td>298.492</td>
<td>144</td>
<td>2.073</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>300.000</td>
<td>146</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legitimacy (Nurses) Between Groups</td>
<td>6.063</td>
<td>2</td>
<td>3.032</td>
<td>1.514</td>
<td>.223</td>
</tr>
<tr>
<td>Within Groups</td>
<td>306.417</td>
<td>153</td>
<td>2.003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>312.481</td>
<td>155</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power (Others) Between Groups</td>
<td>2.421</td>
<td>2</td>
<td>1.210</td>
<td>.652</td>
<td>.522</td>
</tr>
<tr>
<td>Within Groups</td>
<td>267.100</td>
<td>144</td>
<td>1.855</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>269.521</td>
<td>146</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency (Others) Between Groups</td>
<td>18.321</td>
<td>2</td>
<td>9.160</td>
<td>3.262</td>
<td>.041</td>
</tr>
<tr>
<td>Within Groups</td>
<td>415.666</td>
<td>148</td>
<td>2.809</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>433.987</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.10 Doctors opinions about interactions with “Doctors”, “Nurses”, and “Others” Stakeholder Groups

Table 6.27 displays the mean and standard deviation of responses by Doctor respondents from all hospitals about the Doctors, Nurses, and Others Stakeholder groups, with respect to legitimacy, power, and urgency in decision making.
Table 6.27: Doctors Responses about the “Doctors”, “Nurses” and “Others” Stakeholder Groups

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors)</td>
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<td>4.758</td>
<td>1.3961</td>
</tr>
<tr>
<td>Urgency (Doctors)</td>
<td>22</td>
<td>5.136</td>
<td>1.3903</td>
</tr>
<tr>
<td>Legitimacy (Doctors)</td>
<td>22</td>
<td>5.000</td>
<td>1.5430</td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>20</td>
<td>4.350</td>
<td>1.2017</td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
<td>20</td>
<td>5.250</td>
<td>1.3328</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>20</td>
<td>4.550</td>
<td>1.4318</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>20</td>
<td>5.000</td>
<td>1.3464</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>21</td>
<td>3.524</td>
<td>1.6917</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>20</td>
<td>4.800</td>
<td>1.5761</td>
</tr>
</tbody>
</table>

6.11 Nurses opinions about interactions with “Doctors”, “Nurses”, and “Others” Stakeholder Groups

Table 6.28 indicates the mean and standard deviation of responses by Nurse respondents from all hospitals about the Doctors, Nurses, and Others Stakeholder groups, with respect to legitimacy, power, and urgency in decision making.

Table 6.28: Descriptive Statistics Nurse Professional Group opinions about "Doctors" "Nurses" and "Others" Stakeholder Groups

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors)</td>
<td>93</td>
<td>5.222</td>
<td>1.2572</td>
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<tr>
<td>Urgency (Doctors)</td>
<td>90</td>
<td>5.100</td>
<td>1.4066</td>
</tr>
<tr>
<td>Legitimacy (Doctors)</td>
<td>96</td>
<td>5.021</td>
<td>1.5422</td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>102</td>
<td>3.503</td>
<td>1.4202</td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
<td>97</td>
<td>4.948</td>
<td>1.5164</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>105</td>
<td>4.314</td>
<td>1.5020</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>94</td>
<td>5.234</td>
<td>1.3024</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>97</td>
<td>4.526</td>
<td>1.7145</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>97</td>
<td>4.990</td>
<td>1.5712</td>
</tr>
</tbody>
</table>
6.12 Others opinions about interactions with “Doctors”, “Nurses”, and “Others” Stakeholder Groups

Table 6.29 indicates the mean and standard deviation responses by the “Others” professional group respondents from all hospitals about the Doctors, Nurses, and Others Stakeholder groups, with respect to legitimacy, power, and urgency in decision making.

Table 6.29: Descriptive Statistics Others Professional Group opinions about "Doctors" "Nurses" and "Others" Stakeholder Groups

<table>
<thead>
<tr>
<th>Descriptive Statistics</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors)</td>
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<tr>
<td>Urgency (Doctors)</td>
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<td>4.967</td>
<td>1.2452</td>
</tr>
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<td>Legitimacy (Doctors)</td>
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<td>5.419</td>
<td>.9228</td>
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<tr>
<td>Power (Nurses)</td>
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<td>.9512</td>
</tr>
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<td>30</td>
<td>5.000</td>
<td>1.2318</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>31</td>
<td>4.806</td>
<td>1.0462</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>33</td>
<td>4.949</td>
<td>1.5301</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>33</td>
<td>4.152</td>
<td>1.5436</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>33</td>
<td>5.212</td>
<td>1.0535</td>
</tr>
</tbody>
</table>

6.13 Professional Groups Stakeholder Discussion

Table 6.26 indicates there is a significant difference between the professional groups feelings and beliefs about “urgency”. Hence, the interactions with various occupational groups null-hypothesis “there is no difference between occupational groups in terms of their saliency” is rejected for the “urgency” variable. This means that there is a significant difference between professional groups’ opinions about the saliency of the “Others” Stakeholder group in relation to “urgency”. In relation to the “Others” Stakeholder group, Nurses tended to more strongly agree that “Others”
exhibit “urgency” compared to doctors. This means that Nurses believe Others are demanding stakeholders and Doctors believe that Others are Non-stakeholders.

However, there was no significant difference in the remaining variables. Hence, the interactions with various occupational groups null-hypothesis

\[ H0\#4 \text{ “there is no difference between occupational groups in terms of their saliency”} \]

cannot be rejected for the remaining variables. This means that there is no significant difference between professional groups opinions of saliency of the “Doctors”, “Nurses”, and “Others” Stakeholder groups in the remaining variables.

Although there were no significant statistical differences, nurses ranked their own saliency consistently lower in comparison to the ranking of saliency given to doctors and others. Both doctors and others ranked nurses saliency more highly than nurses ranked themselves. It is interesting to note that doctors and others see nurses as more salient stakeholders compared to how nurses see themselves. This is discussed in further detail in the next chapter.

6.14 Functional Group

This section asked functional group (clinicians and managers) respondents views about their interactions with various stakeholder groups. This was investigated by utilising the Independent Groups T-Tests.
Table 6.30 shows the mean and standard deviation of responses by clinicians and managers in relation to the saliency of “Doctors”, “Nurses” and “Others” stakeholder groups. The number of respondents was n = 145 because 44 respondents were not doctors, nurses, or managers.

Table 6.30: All Respondents from Functional Group opinions about Stakeholder Saliency

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power (Doctors)</td>
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<td>1.2263</td>
</tr>
<tr>
<td>Urgency (Doctors)</td>
<td>142</td>
<td>5.077</td>
<td>1.3635</td>
</tr>
<tr>
<td>Legitimacy (Doctors)</td>
<td>149</td>
<td>5.101</td>
<td>1.4367</td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>152</td>
<td>3.789</td>
<td>1.3686</td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
<td>147</td>
<td>5.000</td>
<td>1.4335</td>
</tr>
<tr>
<td>Legitimacy (Nurses)</td>
<td>156</td>
<td>4.442</td>
<td>1.4199</td>
</tr>
<tr>
<td>Power (Others)</td>
<td>147</td>
<td>5.138</td>
<td>1.3587</td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>151</td>
<td>4.305</td>
<td>1.7010</td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>150</td>
<td>5.013</td>
<td>1.4700</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>131</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6.30 indicates that all functional group respondents believe that doctors attract a high level of saliency according to the higher mean responses about the three factors or legitimacy, power, and urgency.

Table 6.31 indicates that the homogeneity assumption has not been violated in any items. Therefore, the Levene’s test for homogeneity of variance is not significant and indicates that the population variances for each group are approximately equal.

Table 6.31 also indicates there is a significant difference between the functional groups interactions with the Doctors Stakeholder group in relation to the variables “urgency” and “legitimacy”.
Table 6.31: T Test of Functional Group Responses about Stakeholder Groups

<table>
<thead>
<tr>
<th></th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td><strong>Power (Doctors)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
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<td>.263</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency (Doctors)</td>
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<td>.702</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
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<td></td>
</tr>
<tr>
<td>Legitimacy (Doctors)</td>
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<td>.095</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
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<td></td>
</tr>
<tr>
<td>Power (Nurses)</td>
<td>1.156</td>
<td>.284</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
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<td></td>
</tr>
<tr>
<td>Urgency (Nurses)</td>
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</tr>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Power (Others)</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Urgency (Others)</td>
<td>.962</td>
<td>.329</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>-.179</td>
<td></td>
</tr>
<tr>
<td>Legitimacy (Others)</td>
<td>.824</td>
<td>.366</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>-1.066</td>
<td></td>
</tr>
</tbody>
</table>

It is interesting to note that both clinicians’ and managers’ mean responses to views about doctors’ legitimacy, power, and urgency are high. This indicates that both functional groups tend to agree that doctors have a high saliency in their organisation. Both clinicians and managers also displayed high mean results for
responses about the others stakeholder group, indicating that they believe that others also have high saliency in their organisation. Interestingly, managers tended to agree more strongly than clinicians that the nurses stakeholder group exhibited urgency. This suggests that managers believe more strongly that nurses are a demanding stakeholder group. However, clinicians also had a strong mean indicating they too believed that nurses were a demanding stakeholder group, to a lesser extent than managers though. This finding is important and will be discussed in further detail in the next chapter.

Table 6.32 indicates that there is a significant difference between functional groups opinions about the saliency of the Doctors Stakeholder group in relation to the variables “urgency” and “legitimacy”. Managers also tended to more strongly agree than clinicians that “Doctors” Stakeholder group exhibited “legitimacy”. Managers attributed a higher level of importance in terms of “legitimacy” and “urgency” to doctors than clinicians. As far as stakeholder saliency is concerned this means that that there was agreement about “power” attributed to clinicians and doctors and there was less agreement in terms of “legitimacy” and “urgency” attributed to clinicians and managers. Managers believed that the “Doctors” Stakeholder group could be considered as dominant stakeholders, dangerous stakeholders, and dependent stakeholders. Refer to Chapter Four for a complete overview of all of Mitchell et al. Stakeholder Classes.
Table 6.32 - Functional Group Differences

<table>
<thead>
<tr>
<th></th>
<th>Functional Role</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power (Doctors)</strong></td>
<td>Clinician</td>
<td>84</td>
<td>5.040</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>35</td>
<td>5.371</td>
</tr>
<tr>
<td><strong>Urgency (Doctors)</strong></td>
<td>Clinician</td>
<td>81</td>
<td>4.975</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>35</td>
<td>5.514</td>
</tr>
<tr>
<td><strong>Legitimacy (Doctors)</strong></td>
<td>Clinician</td>
<td>86</td>
<td>4.849</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>36</td>
<td>5.472</td>
</tr>
<tr>
<td><strong>Power (Nurses)</strong></td>
<td>Clinician</td>
<td>90</td>
<td>3.678</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>36</td>
<td>3.704</td>
</tr>
<tr>
<td><strong>Urgency (Nurses)</strong></td>
<td>Clinician</td>
<td>85</td>
<td>4.953</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>36</td>
<td>5.222</td>
</tr>
<tr>
<td><strong>Legitimacy (Nurses)</strong></td>
<td>Clinician</td>
<td>92</td>
<td>4.435</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>37</td>
<td>4.324</td>
</tr>
<tr>
<td><strong>Power (Others)</strong></td>
<td>Clinician</td>
<td>84</td>
<td>5.202</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>34</td>
<td>5.225</td>
</tr>
<tr>
<td><strong>Urgency (Others)</strong></td>
<td>Clinician</td>
<td>88</td>
<td>4.352</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>34</td>
<td>4.412</td>
</tr>
<tr>
<td><strong>Legitimacy (Others)</strong></td>
<td>Clinician</td>
<td>86</td>
<td>4.919</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>35</td>
<td>5.229</td>
</tr>
</tbody>
</table>

However, there were no significant differences between managers and clinicians in the remaining factors. Hence, the saliency of various occupational groups null-hypothesis “there is no difference between occupational groups in terms of their ability to influence decision making about resource allocation by using social influence” cannot be rejected for the remaining variables. This means that there is no significant difference between functional groups opinions of the saliency of the “Doctors”, “Nurses” and “Others” Stakeholder group in the remaining variables.

6.15 Summary

This chapter identified professional subcultural differences by assessing the responses of three professional groups: doctors, nurses, and others. It also identified functional group differences between clinicians and managers. These differences
were examined by first analysing at all respondents views as one data set. Further differences emerged by looking at professional group differences between each of the three hospitals: a small hospital, a medium hospital, and a large hospital.

This chapter also identified differences by conducting an organisational assessment consisting of four cultural constructs. These constructs included 1) sense of organisational commitment; 2) perceptions of management work characteristics; 3) perceptions of currently pursued organisational goals; and 4) perceptions of orientation to work values when choosing a job. Further, assessment was conducted of professional groups and functional groups responses to questions about 5) stakeholder saliency. There is some variation in the homogeneity of groups, which could be explained in part by the small number of respondents from the doctor and others professional groups. The methodology was adapted from Degeling et al. (1998) and Mitchell et al (1997). The findings relating to the questions devised by Degeling et al. display some similarities. Further similarities are made with those from Fitzgerald (2002) who also utilised the Degeling et al. methodology.

The professional and functional group differences were mainly related to the size of the hospital. There was very little variation with the way that respondents from all hospitals answered questions about cultural constructs and stakeholder saliency. However, more differences emerged when respondents were assessed according to hospital size. In the small and medium sized hospitals, there was a high level of integration between groups, compared to the large hospital, which was more ambiguous. These findings are reported according to the three theory perspective of organisational culture, as proposed by Martin (2002).
Thus far, the researcher has looked at professional and functional group cultural and subcultural differences from an integration perspective. The next chapter will look at how organisational boundaries are crossed in relation to decision making. Specifically, it will examine how stakeholders negotiate these boundaries and the saliency, or level of priority, they are given by other stakeholder during this process of decision making.
7 Qualitative Analysis
7.1 Professional Interrelations when Allocating Resources

As outlined in Chapter Five, a mixed methods approach was used to investigate how formal and informal social networks, and decision making about resources in the hospital setting are related. This was viewed through an organisational cultural lens. To take a snapshot of current organisational cultures, a cultural survey was undertaken. In addition to identifying cultural similarities and differences in three hospitals, extensive observations and face to face interviews were conducted. In undertaking this qualitative part of the research, several key themes emerged around the social construction of decision making about patient flow and, in particular, about admission and moving a patient from an emergency department into a ward bed.

This chapter will report on findings from semi-structured interviews, participant observations, and conversations with doctors, nurses, and managers to investigate patient flow and illustrate decision-making stakeholder saliency at different points in time during the admission/transfer to ward process. These field illustrations demonstrate the prominence of each of the stakeholder groups (doctors, managers, and nurses) when making decisions about allocation of resources.

Analysis of the characteristics of different stakeholder groups reveals the differences between the groups in terms of work orientation, relational dynamics, and cultural orientation (see Table 7.1). Categorisation of professional groups’ attitudes towards their work helps to explain the existence of potential areas of tension between stakeholder groups when making decisions about allocation of resources, and assists with understanding the need for alternative social action to get things done in diverse environments. This is then illustrated with field examples.
This thesis investigates interpersonal associations between professional (e.g. doctors and nurses) and functional groups (e.g. clinicians and managers), when making clinical and operational decisions about patient flow by posing the following sub questions:

3) (i) How are alliances created and boundaries crossed between stakeholders from different organisational cultural backgrounds?

(ii) How are decisions about resources allocation (i.e. material resources) made when stakeholders are affiliated with diverse subcultures?

4) Does the magnitude/thickness of stakeholder relationships influence decision-making outcomes, and if so how?

This chapter reports on a thorough examination of the decision making dynamics about bed allocation in relation to three professional paradigms, namely that of cure, care, and control which is adapted from Glouberman and Mintzberg (2001). The researcher will explain how professional and functional groups’ roles change according to the stage of the patient flow process. These groups are referred to as stakeholders, and the terminology from the Mitchell et al. (1997) stakeholder model will be used. In particular, the role of each stakeholder group will be discussed. The chapter will outline how the doctors, managers, and nurses are responsible for different parts of the patient flow process (see Figure 7.1). The different stakeholder groups need to interact to progress a patient through the hospital. However, the paradigmatic diversity of the disparate stakeholder roles and objectives can cause tensions between the groups, especially when there are limited resources. Therefore, intensive fieldwork focused on how doctors, managers and nurses
interrelate during this process. In addition, the boundary crossing between the stakeholder groups and the use of intermediaries to facilitate the boundary crossing between groups were explored.

![Diagram](image)

**Figure 7.1: Definitive Stakeholders in the Process of Transferring a Patient from the ED to a Ward Bed**

The patient flow process from triage to ward admission is depicted in Figure 7.1. Upon arrival, the patient is first triaged. Triage is the process of assessing patients based on their need for medical attention. The definitive decision maker in this part of the process is a specially trained nurse. Once the patient is triaged, a doctor instigates all the necessary procedures to come to a diagnosis. The doctor is the definitive stakeholder when making decisions about medical diagnosis. Based upon the diagnosis the doctor makes the decision to discharge or admit the patient to a ward bed. The nurses in the emergency department liaise with the patient flow manager, who is also a nurse, and based on the diagnosis of the patient a bed is allocated in a ward. The patient flow manager coordinates with the nurse unit manager of the ward and organises patient transportation to the ward, where the ward nurses take charge of the patient.
7.2 The Stakeholder Divides

According to Glouberman and Mintzberg (2001), health care should not be considered as one overall system. Instead, health care is differentiated into four different worlds, also referred to as activities or mindsets: cure, care, control, and community (See Figure 7.2).

In this thesis, the cure paradigm is occupied by doctors who are interns, residents, registrars, staff doctors, or visiting medical officers. The care paradigm is occupied by clinical nurses and nurse unit managers who provide clinical leadership, but do not necessarily ‘control’ the organisation. Nurse unit managers manage at the operational and tactical levels. The control paradigm is occupied by managers of a
higher order, who manage at the strategic level. Each of these four different worlds is managed differently, resulting in a loosely connected set of systems that are attempting to function as one health care system. Hospital management involves controlling a set of several heterogenous processes disconnected from the other processes. These processes can be differentiated by identifying where management is practiced. For example, doctors and nurses who are clinicians manage primarily down directly into clinical operations, whilst administrators manage up towards those people that control and fund the institution (Glouberman and Mintzberg 2001, p.57). The result is that a hospital is not one organisation, but four different organisations, as each part structures itself in an independent way, creating two ‘cleavages” vertically and horizontally. The vertical divide investigates how closely involved with the hospital the stakeholder group is. The horizontal divide delineates those who operate clinically and those who do not.

This thesis examines boundary crossings between professional and functional divides. However, it does not investigate the fourth world “community”, because all stakeholders are part of the community. Furthermore, this thesis examines professional groups (doctors and nurses) and functional groups (clinicians and managers) who are involved in the decision making process of bed allocation as part of patient flow. Because “community” is not a professional or functional group, the fourth world is not part of this investigation. Thus, community was excluded from the analysis as it was beyond the focus of the study.
7.3 Doctors Interactions with Others: Cure Paradigm

A doctor makes the decision to admit a patient on the basis of his/her clinical assessment and with the aid of available data, such as results of investigations. This makes the doctor undoubtedly the most powerful stakeholder during the “diagnosis” phase of the patient journey (See Figure 7.1).

The doctor stakeholder group has a specific role in the patient journey. Doctors are autonomous in their clinical decision to admit, to observe or to discharge a patient from the emergency department. Glouberman and Mintzberg (2001) argue that doctors act administratively out but look clinically down. Acting ‘administratively out’ means that doctors function within their administrative hierarchy, disregarding or avoiding hospital administrative rules. Tosh (2007) states that “control over itself was part of what gave medicine its professional status” (p. 69). That is, doctors self regulate through medical boards and peer evaluation. This further enforces the professional status of doctors. By acting ‘clinically down’, this means that doctors have the power to make clinical decisions, which filter down into the organisation. These clinical decisions are in relation to admission, treatment and discharge of patients. Only doctors have the power to admit or discharge a patient. However, other stakeholder groups have different kinds of influence on the patient flow process, and this is discussed in the following paragraphs.

The following paragraphs sheds some light on the interrelations between doctors and other stakeholder groups when making decisions about a patient’s journey in the hospital, and the decision making role that doctors perform. The interrelations between doctors and others are an important consideration, as it is necessary to
understand how the cure world of the doctors functions in relation to the care world of nurses and the control world of managers. It is necessary to understand the impacts of these interrelations from a societal point of view, an environmental point of view, and a political point of view.

From a societal point of view, access block is an issue particularly when all people should have equal rights for access to hospital services. From an environmental point of view, access block causes a stressful environment, because patients are waiting for services. Furthermore, access block may be an occupational health and safety issue as well as a patient safety issue, which may lead to higher turnover of staff, further exacerbating the situation. Finally, from a political point of view, the intensified media coverage of incidents, such as the North Shore Hospital miscarriage in the emergency department bathroom, leads to a decrease in confidence of hospital situations.

The doctor's role in patient flow will be discussed in three sub-sections including comments about the organisational role of doctors, their discontinuous nature of medical interactions with patients, and medical silo's. The discussion is illustrated by the voices from the research participants when speaking with them about bed allocation and patient flow.

### 7.4 Organisational Role of Doctors

Of the three stakeholder groups discussed here (doctors, managers, and nurses), the doctor stakeholder group is the least formally committed to the hospital (Fitzgerald, 2002; Degeling et al. 1998). When the researcher spoke to several
doctors about social interactions with other staff in the hospital, most doctors spoke about how they carried out their work in the hospital and how they tended not to interact socially with other staff. Doctors reported they did not feel that their work should be affected by anything other than the need to treat patients effectively. This is what Glouberman and Mintzberg (2001) describe as “managing down”, by making a clinical diagnosis and passing on instructions to other health professionals.

During field observations, doctors also reported that they tended to rely on solving issues amongst themselves rather than using the formal systems in place for incident reporting and response. A doctor manager spoke about how he and other doctors would sort out problems amongst themselves, rather than involving the hospital administrators. The role of doctors in the hospital did not include following the formal channels for resolving conflict. He stated:

“If there’s a problem, we always talk it over at lunch, or a coffee, or something like that. In my experience, nothing has gone up to, say, for the General Manager, to intervene. Always we have tried to work it out ourselves, and it always works”.

Additionally, other stakeholders (nurses and managers) also report that doctors do not involve themselves in organisational activity in the same way that nurses or managers are (expected to). There appears to be a lesser organisational conscientiousness on behalf of doctors, which does not go unnoticed by other organisational members. For example, a senior manager commented:
“[most] doctors are not in management positions; these are clinicians. So they’re never called on even if there’s a complaint. For example, a family comes and complains about a doctor, they (clerical staff) don’t call the medical person, they call me, they’ve been told to call me”.

This different type of organisational responsibility allows doctors to be involved in the hospital at a much more superficial level than either managers or nurses. This may explain some observed tensions between professional groups that expressed themselves when making decisions about allocation of beds in wards to combat access block in the ED. For example, observations revealed that doctors did not ‘mingle’ with other staff in the hospital and preferred to work independently on their patient case load. Whereas nurses and managers were actively involved in social clubs and social gatherings, such as meeting for lunch, doctors tended to be more inaccessible in the work environment by eating their lunch in isolation.

The finding that doctors’ commitment to hospital systems is different from other organisational members has been described previously (Fitzgerald, 2002; Degeling et al., 1998). This research confirms that doctors are extrinsically, rather than intrinsically, connected to the hospital and concurs with Glouberman and Mintzberg, who state that “doctors work in the hospital rather than for the hospital” (2001; p. 59). A less intense bond with the organisation may explain some of the tensions observed. A Nurse Unit Manager told the researcher:
“They [doctors] come and do what they have to do but as far as being proactive and accepting [organisational] responsibility, they seem to be able to skip that stuff out”.

This manager believed that as a result of having a lower level of affiliation with the organisation, doctors concentrate on a specific job, without considering how isolated activities may affect a whole system or system’s operations.

It was also observed that doctors are less cognisant of hospital constraints such as budgets and human resources who work according to rosters. Upon speaking with them, doctors espoused that patients were important irrespective of other considerations such as staffing and resources. This concentration on single case management, rather than organisational process management, which was expressed by doctors themselves, was also noticed by a Senior Nurse Manager who commented:

“I mean, they [doctors] really don’t care about access block and they don’t really care about round table figures. They care about their patients”.

This quote confirms that a doctors’ view of work is more from a “project” management standpoint, where the patient is seen as a project. Their organisational responsibility is limited to treating the individual patient, notwithstanding restricted availability of resources. Such individualised and self-governing conduct could also be observed when reporting on incidents or near misses. When asked about reporting disagreements between doctors, a Senior Doctor Manager stated:
“They [doctors] are notoriously bad in sitting down and writing it. They are very good in coming and venting and whingeing about it, but they will never write it down…I don’t know. For me, personally, why I don’t write it, is because I feel that I can, instead of sitting down half an hour and writing it, I can spend that half an hour, either to prevent that incident from escalating, or to stop it”.

This senior doctor manager confirmed that, in general, doctors have a lesser affection for formal structures and tend to be more self-ruling.

Some doctors reported that in many cases it was quicker and easier to get a doctor in another ward to accept a patient if they knew each other from previous dealings. This would indicate that informal social networking when making decisions about allocation of ward beds to ED patients can be useful for improving patient flow and combating access block.

In summary, coupled with the finding that doctors seem to have a lower sense of affiliation to the hospital is the finding that doctors have lesser regard for formal structures than other organisational members. As a result of such high level of professional control, doctors place a lower emphasis on inter-professional relationships to get things done. In other words, the boundaries created by medical doctors around medical decision-making to admit and transfer a patient out of the emergency department and into the ward, are think, robust and not very permeable. This makes boundary crossing, necessary to get things done, harder to facilitate.
As discussed in Chapter Six, sovereignty and associated dominance is a medical professional boundary construct. Doctors prefer to work individually on single patient cases and are dominant in the diagnosis and admission stage of the patient flow process. However, at the same time, there is some recognition by some doctors of the need for informal social networking to get things done. Therefore, boundary crossing by doctors between cure, care and control domains in hospitals may be somewhat haphazard. Greater understanding of the boundaries may facilitate the formation of alliances necessary to smooth patient flow processes in the emergency department. Moreover, the haphazardness of boundary crossing is partly created by the discontinuous nature of medical interaction.

7.5 Discontinuous Nature of Medical Interaction

As indicated in Figure 7.1, medical interaction begins when doctors first assess the patient in the emergency department. Once the doctor makes the clinical decision to admit the patient, medical interaction ceases for a period of time. Generally, medical interaction with the patient resumes when the Visiting Medical Officer (VMO) visits them in the wards. Again, there is a pause in interaction with the patient until the next visit and up until he/she makes the decision to discharge the patient. In this sense, doctors intervene with the patient in short, often scheduled bursts (Glouberman and Mintzberg, 2001).

Contrary to the discontinuous relationship of doctors with the patient and hospital, the nursing care is provided continuously by a system of interlinked persons and processes. A Nurse Unit Manager observed:
“I guess the thing with nursing is, we’re the ones who stay put, whereas the team, the doctors all rotate, except for our staff specialists, registrars, residents, interns, all rotate… we (nurses) want the patients who are discharged to be out by 10 or 11 o’clock, but the doctors won’t come and do their work until after 12 or 1 o’clock, and so, you know, obviously their driver isn’t the same as our driver… that’s a negotiation for them, to try and get them to discharge the patients earlier”.

It was observed that the combination of professional privilege to discharge and the discontinuous nature of medical interaction with patients affects the discharge process in that often the patient waits in a bed until a doctor visits the patient and authorises that the patient can be discharged. This affects patient flow throughout the hospital as it means there are fewer beds for patients waiting in the emergency department or for patients who may need to be transferred from another health facility. Researcher observations were confirmed by a Nurse Manager, who commented:

“overnight when there are a lot of presentations, there’s a lot of backlog in the morning that needs to be sorted. People don’t get discharged till after lunch from wards. That’s because nothing happens overnight… cause you rely on the specialists to come in from their rooms and things they have clinics and things they have to go to first its not a priority for them to be at the hospital at 6 am and get people out”.
Doctors have fractured associations with patients and fractured interactions with other hospital staff members. This disassociation does not allow doctors to provide continuous care with other stakeholders in the organisation. That is, the treatment that doctors provide as part of the patient flow is discontinuous, and this may cause some bottlenecks.

Thus, in addition to strongly defined professional boundaries, the nature of medical business does not necessarily facilitate hospital processes to flow continuously. If immediate solutions to the problem are not possible, then organisational actors rely upon alternative solutions to overcome barriers impeding process flow. Some of these solutions include the formation of alliances and other boundary crossing measures including networking with those stakeholders who can influence other organisational members.

However it was noted that this is somewhat different in smaller hospitals. For example, a manager spoke about the ease of interaction between and within professional groups in smaller hospitals compared to larger hospitals:

"I think it's (interacting) just easier in a small hospital…Here, it's easier for me to just walk around to Emergency and see how things are than to pick up the phone and wait for someone to answer the phone, and do all that compared to a larger hospital".

These findings may assist to explain how decisions about resource allocation are made considering vast differences between the nature of work of different sub
cultural and professional groupings. The researcher observed that interactions in smaller hospital were much more easily facilitated than in bigger hospitals. This may be due to an integrated culture, which is accomplished relatively easily in a small hospital. However the larger hospital was dominated by an ambiguous culture and interactions were much harder to observe, more complex, and more inconsistent.

It appears that, whilst boundaries are being dismantled by the formation of alliances between individuals from inside the medical profession, and, externally, with other professional groups, there is a reformation of new boundaries. This would mean that not only is boundary crossing inconsistently consistent in line with distinct subcultural formations in a differentiation perspective of organisational culture, but boundaries around and within the profession constantly evolve, creating what was termed by participants as “medical silos”.

7.6 Medical Silos

Participants alerted the researcher that doctors tend to practice only in the area of their specialty. As such, there has been a creation of silos according to the type and level of medicine practiced by doctors. This separation within the doctor stakeholder group has led to the formation of medical tribes. A Senior Nurse Manager said:

“So you’ve got a whole lot of different professionals, who all think very differently…in Medicine, you’ve got VMOs, who really, in some sense, are consultants…and businessmen coming in. Then you’ve got staff specialists, who actually are sort of different from registrars, who are different from
residents, who are different from interns. And so, there’s that in itself, let alone when you get down to all the different departments and different wards”.

These specialised medical silos make it more difficult for ongoing communication between doctors in hospitals. Another factor that makes it difficult for communication between professional groupings is the fact that a large portion of doctors move across and to different hospitals. This movement may make it more difficult for doctors to socialise with other doctors, as well as other hospital stakeholders, such as nurses and managers. A Nurse Unit Manager commented:

“They’d socialise more in their groups...the staff specialists socialise together...Because everybody else is transient with the doctors, because they (interns) rotate every 10 weeks, so they’ve got this huge transient population”.

It can be argued that whilst their involvement with the hospital, and the staff they are working with, is intermittent, specialist care provides for some permanence of doctors. However, belonging to a speciality may further create boundaries by causing formation of sub groups based on areas of expertise. In addition to expressing this concern, hospital workers also note that these highly specialised silos have developed their own alliances that may assist them with patient flow. It was indeed observed that doctors call upon their closer aligned colleagues when they need assistance with transferring a patient. The use of informal alliances are discussed further in this chapter. The positive aspect of alliance formation is that patient flow may be expedited. However, the potentially negative side is if a doctor does not have an ‘alliance’ with the on call specialist who can give the authority to
transfer the patient out of the emergency department. A senior manager observed this happened often:

“I mean, the doctors, I’m sure, use them (alliances) all the time, if they need advice when they’re transferring patients. If they know a doctor at the other end, they’re going to ring and speak to them, and not necessarily to the one who picks up the phone that they don’t know”.

However, these alliances between doctors seem to be difficult to infiltrate. One Senior Doctor Manager spoke of their frustration at the silo mentality of doctors:

“And trying to get committees together, and work together – nursing hasn’t been so bad. But certainly the medical staff, and trying to standardise them…”

The silo mentality affects patient flow because the more groups there are to negotiate with, the more time it takes to get the patient through the system. That is, there is more cultural differentiation and less integration. The “way we do things around here” is therefore not only according to the way that doctors do things, but also according to the speciality to which the doctor belongs.

Therefore, differences in the professional group of doctors emerge according to the speciality the doctor belongs to. As doctors are the only ones that can make the decision to admit and discharge a patient, they hold a powerful position in the hospital. Glouberman and Mintzberg (2001) state that doctors are the most influential members within the hospital community. Indeed, the perceived power relationship of
doctors is dominant by their level of education and experience. The high level of influence of doctors will be discussed further in relation to the research questions.

Medical roles have been reshaped, mainly due to the introduction of highly specialised medicine. With this specialisation, the superior status of medical doctors has shifted from an inter-professional domain issue (doctors versus nurses) to an intra-professional domain issue (general versus specialist doctors) and effects of medical dominance remain an issue in patient flow matters. For example, it was observed that doctors in the emergency department who required a bed for a patient in a ward, battled with doctors from the ward to accept the patient. As stated previously, getting a patient accepted into a ward is a difficult process for doctors in the emergency department who do not have alliances with doctors in the wards. Therefore building and maintaining relationships with hospital staff, both formal and informal, is a consideration for emergency department doctors as a way of breaking down some of the barriers to quickly transfer a patient to the ward. One of those barriers is the existence of distinct medical silos preventing boundary crossing within the profession as well as between professions.

In summary, the nature of the doctors’ role in patient flow is individualised in that they work independently on patient cases. Because of their individualised nature of work, a doctor’s role delineation is tightly defined. Furthermore, because of their cure role, a doctor’s work orientation is largely project based, rather than process based. The independent nature of their work means that doctors are generally isolated from other stakeholders, and are more protective of the relational dynamics in which they
partake. Indeed, doctors tend to form alliances with other doctors, and to a lesser extent, other stakeholders who can assist them in getting their job done.

In the following section, the nurses’ care world and their role in the patient flow processes will be outlined.

7.7 Nurse Interactions with Others: Care Paradigm

As can be seen in Figure 7.1, nurses are responsible for much of the patient journey. Their involvement is apparent when the triage nurse assesses the patient, during the transfer of the patient from the ED to a ward, and whilst the patient is in the ward. Glouberman and Mintzberg (2001) state that nurses look clinically *down* but act administratively *in*. This means that nurses make some clinical support decisions, which filter down into the organisation. Administratively, nurses look to the organisation for rules and procedures that govern their work practices in the hospital.

This section reports on the interactions between nurses and professional groups when making decisions during the patient’s journey from entry into hospital to admission into ward bed. Specifically, the nurse’s role in patient flow will be discussed in three sub-sections taking into account the changing role of nurses, their connection to the institution, their role as an intermediary between stakeholder groups, and nurses as liaison officers.
7.8 The Changing Role of Nurses

Historically, nurses were viewed as being subservient to doctors (Tosh, 2007; Lockhart-Wood, 2000; Carpenter, 1995) because doctors have absolute clinical decision making power. Additionally, Glouberman and Mintzberg (2001) state that nurses are “functionally subordinate to physicians, who consider themselves solely responsible for the curing of the patient” (p. 61). However, functional subordination may be changing as a result of the changing role of nurses, which is largely driven by professionalisation of nurses as a result of higher levels of education and training at universities and technical colleges.

Higher educational standing and a changing role of nurses in health care organisation is most likely having an effect on patient flow decision making. In this investigation it was noted that nurses heavily influence formal and informal organisational decisions and use tactics to increase their decision making powers.

However, there are still some aspects of a nurse’s role that may be considered subordinate or subservient. Several nurse participants identified that the care that nurses provide contains some elements that may be considered as being supportive rather than primary. One Senior Nurse Manager stated:

“Some of what we do is subordinate, I suppose, because we’re assisting people to drink and to feed…some of the things we actually do, as a role, are quite subservient”.

The ‘supportive’ part of a nurse’s role may in fact be used as a tactic by nurses in what Fitzgerald (2002) terms a “reversal of power”. The reversal of power is used when nurses use their subordinate role as a reason for not doing something. This method was discussed by several participants, especially about the nurses from the emergency department. A Senior Nurse Manager explained how nurses responded to doctors who were discourteous to nurses:

“If people [doctors] are consistently rude, I’ll actually speak to the [senior doctor manager] and say, it’s not acceptable, and you need to say that they will get more things done. Nurses are very passive-aggressive…what they’ll do is, they won’t help the doctor”.

As discussed in previous sections, medical dominance is warranted in terms of clinical decision making. However, as noted in the professional identity literature (Illich, 1990; Friedson, 1988), the boundary from clinical importance to organisational importance is blurry. As a result, doctors appear to be unsure about exercising their power in organisational decision making. Doctors often behave in ways that expresses salience in clinical decision making by being authoritative, which often spills over to organisational decision making. Therefore, protecting professional boundaries by others, especially nurses who are managers, is necessary. This power interplay between doctors and nurses can result in a “reversal of power”, where nurses become the more powerful stakeholder.

However, nurses’ boundaries are also somewhat fuzzy. Hence the person mediating between boundaries, i.e. the conduit, or the channel of communication flow is often a
special person with a specific skill. In one situation, the Senior Nurse Manager became an intermediary between the bedside nurses and doctors, by discussing an incident with the medical manager. The nurse manager spoke with the doctor about his behaviour and explained that the nurses were upset with the way he spoke to them. The nurse manager also spoke to the nurses and convinced them to help the doctor once he apologised. In this scenario, the nurse manager used special skills to take on an intermediary role to ensure that the flow of patients was not stifled by professional boundary wars. Instead, the doctor was able to treat the patient with the assistance of the nurses, the nurses received an apology, and the patient received treatment. Therefore, the conduit for patient flow is someone who is able to move in and out of different cultural perspectives, negotiate consistent inconsistencies – such as a differentiated culture where sub cultures are formed, and allow for inconsistent inconsistencies – such as in an ambiguous culture, where patterns of behaviour are not easily identifiable. This intermediary role of some pivotal nurses is discussed further in the later part of this chapter and also in Chapter Eight.

Notwithstanding occupational cultural diversity in the emergency department, the relational distance between nurses and doctors, which may be a cause of professional boundary conflicts, seemed diminished in all three emergency departments under investigation. The closer relationship between doctors and nurses in the emergency department was also noted by a Nurse Unit Manager, who commented:

“when I worked on a ward, nurses did bow down to the doctors a little bit more than what we do down here”.

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This may be because there is a greater need for doctors and nurses to work together, just like in an Operating Theatre or the Intensive Care Unit. Nurses in other wards have much less direct contact with doctors; mainly during doctor rounds, whereas in the emergency department, doctors provide more continual care alongside the nurses, albeit for short bursts.

Social networking at a personal level both formally and informally is better facilitated when staff members work alongside one another. Such close relationships are more easily culturally integrated and are openly protected. That is, when staff in a hospital have close relationships, the networks are strong and therefore more difficult for outsiders to infiltrate.

Such influence of nurses, for example over the socialisation of doctors into hospital work, occurs mainly when new interns (doctors in their first year on practical training) enter the hospital system. One nurse exclaimed that:

"if a [new] doctor is quite nasty to a nurse or thinks that we are handmaidens, they’ll be soon set straight".

She explained that nurses may use informal tactics to alert new doctors that their behaviour is unacceptable and will not be tolerated. During observations in a large hospital, the researcher witnessed a doctor walk away from a patient to speak with a raised voice at nurses about instruments and as a result, each of the nurses walked away from the doctor. The result was that the doctor did not have anyone to hand
him the instruments needed to treat the patient until a nurse manager spoke to him about his behaviour and also encouraged the nurses to provide assistance to the doctor. Whilst this made the nurses feel rather powerful in trying to change behaviour of the doctor, they must also be aware that their stubbornness affects patient care. Such conflict may affect their willingness to make an issue with a doctor, who is being rude, especially if it means that by walking away the patient care may be delayed. A nurse manager who also witnessed the incident commented:

“I’ve told (the senior doctor manager) ‘you only have to be rude a few times and they’ll end up not being helped during their whole ten weeks’”.

The researcher spoke to several nurses and doctors about the socialisation of doctors and was told that experienced doctors often take the nurses side when shaping young doctors coming into medicine. The researcher witnessed some nurses and doctors joking about interns who had trained in other hospitals. The doctors said the nurses would soon change the ‘bad’ language and way of doing things the interns had learnt at previous hospitals to reflect the practices of the new hospital the interns were working in. The socialisation of new medical staff is an activity that can bring diverse professional subcultures together, mainly to protect an integration culture in the way “we do things around here”.

The professionalisation of nurses has undoubtedly reshaped traditional medical dominance (Fitzgerald 2002). It would be logical to think that “if a group perceives itself to be less subordinate, then the dependence on the dominant groups must diminish also” (Fitzgerald, 2002; p. 47). This change in nurses’ perception of their
subordinate role, and dependence on dominant groups, such as doctors and managers, has changed the role of nurses and affected interaction between professionals in hospitals.

The professionalisation of nurses has also allowed for an increase in nurse career paths (Duckett, 2007) that affects the responsibility of care and the authority given to nurses in relation to patients. One example of this is via the recognition of specialist trained nurses such as the Clinical Nurse Specialists (CNS) and Clinical Nurse Consultants (CNC). This expansion of nurses’ role has meant that today’s nurses have a higher level of care and cure authority than traditional nurses. A CNC spoke to the researcher about how doctors were increasingly becoming comfortable consulting with her about patient cases:

“They (doctors) give me referrals. They say, ‘can you please go and see this person. We really think you need to go and see that person. And they [nurses] will let one of the doctors know, “I think you really should get her to have a look at this person.”’ So they (doctors) do encourage the flow of traffic for me”.

However, this functional specialisation within nursing is not yet consistent and therefore cannot be compared to medical specialisation. Nevertheless, creating different layers within the profession will fracture some common boundaries and can, on the one hand, be creating barriers to communication flow within the profession. On the other hand, the introduction of highly trained specialist nurses can assist with communication flow about clinical matters between professions and as such
enhance patient flow. Therefore, it can be said that boundaries are constantly evolving, breaking down and being recreated between and within professions.

7.9 Nurses and their Affiliation to the Organisation

Earlier in this chapter, the researcher discussed doctors' affiliation with the hospital. In the quantitative chapter the researcher found that doctors are extrinsically, rather than intrinsically, connected to the hospital. This finding has also emerged in this qualitative chapter. However, nurses seem to have a different type of alignment than doctors with the hospital environment. Nurses tend to be more intrinsically connected to the hospital than doctors. The researcher discussed commitment and affiliation with some of the staff at the hospitals. Some of the nurse participants spoke about their hospital as being like a family unit that the nurses felt a sense of pride for:

“They (nurses) like working here, and it’s a place where people like to come. It’s not their home, as such, but they’re defensive of it. They’re proud of it”.

Feelings of affiliation are imperative when making connections with others, especially when networking. In conjunction with the pride that the nurses in these hospitals felt, nurses have a high level of formal commitment. Degeling et al, (1998) and Fitzgerald (2002) discuss how nurses feel more formally committed to a hospital compared to doctors. This may be due to nurses working for the hospital, compared to doctors who work in the hospital.

The difference in nurses' culture compared to doctors' culture, including affiliation and commitment, may be explained by the fact that nurses are paid directly by the
organisation and work in a contained area. They have a sense of belonging to that area, and that containment means that they must get on with their shift mates, other colleagues and get to know them on shifts and on breaks. In addition to the formal commitment that nurses have with the hospital, they also are closely associated with the institution. This may be because nurses spend the longest time with the patient during the patient flow process. For example, managers do not spend any clinical time with patients and doctors spend time with the patient intermittently. Nurses are the steady stakeholder group in the hospital for both their colleagues and their patients. A Nurse Unit Manager observed:

“The clerks tend to mix in more with the nurses. Doctors...they tend to stick together. I think the nursing staff, they’re the constant. Because of the medical (doctors) staff turnover...I think, by the time they (doctors) build a relationship up with them, it’s time for them to leave”.

Some participants spoke about the influence that nurses hold because of their constant presence in the hospital. One Nurse Unit Manager discussed how doctors were much more mobile compared to nurses:

“I guess the thing with nursing is, we’re the ones who stay put, whereas the team, the doctors all rotate, except for our staff specialists, registrars, residents, interns, all rotate, and that’s the same for every ward, and so the only person, the only people that are static, really, are the nurses, so it is kind of like, our department, play our game”.
In summary, this section of the chapter examined the interactions between nurses and others when making decisions about the patient flow process. Several of the findings that emerged seem to empirically underpin the assertions made by Glouberman and Mintzberg (2001). For example, the nurse’s role is one of support and is process oriented.

7.10 Nurses as Liaison Officers

The discussion above relating to the nurses and their care paradigm reveals some noteworthy findings. A finding of particular interest in this research was the way that nurse unit managers were being seen as “link” between clinicians and managers. This may be because the nurse unit manager is responsible for so many parts of the patient journey.

The nature of the nurse’s role is collective in that they work with other nurses and stakeholders to care for a patient. Because of their collective nature of work, a nurse’s role delineation is loosely defined. Furthermore, because of their operational role, a nurse’s work orientation is more process based, compared to the project based work orientation of doctors.

Another interesting finding was the way that nurses “juggled” the demands of different stakeholders and were part of the patient journey from the start until the end of the patient flow process. The researcher observed the patient flow managers and nurse unit managers acting as go betweens between the doctors, nurses, ward orderlies, and cleaners. The juggling of multiple stakeholder demands by nurses means that nurses relational dynamics are based on an intermediary role, where
nurses rely on networks to maintain their inter-professional relations with other organisational stakeholders. The multifaceted role of nurses is conducive for the operational role they have in patient flow.

The next section discusses the control function of managers as part of the patient flow process.

**7.11 Managers’ Interactions with Others: Control Paradigm**

The demographic data revealed that most managers in the hospital are nurses. During the patient journey, the manager stakeholder is responsible for the functioning of the entire hospital. Glouberman and Mintzberg (2001) state that managers look clinically *up* but act administratively *in*. This means that managers look to other stakeholder groups, such as doctors and nurses, for clinical decisions. Furthermore, managers operate within the same hierarchical system as the rest of the hospital. That is, managers are governed by the rules and procedures of the organisation they are working for.

This section reports on research that investigates the decision making role that managers perform during the patient’s journey in the hospital. Specifically, the managers’ role in patient flow will be discussed in three sub-sections: the formal command of hospital resources, formal authority to manage these resources, and the coordination of patient flow. These themes emerged as important matters in relation to patient flow.
7.12 Systems Resource Allocation

Whilst doctors are largely responsible for the prescription of treatment of patients, and nurses are in charge of the care of patients, managers (or administrators) are responsible for the functioning of the entire institution to support patient care. This might be a single hospital, a couple of hospitals (network), or all hospitals in the same Area Health Service. It is important to delineate these levels in order to understand the complexity of hospitals and the systems they operate within. A Senior Manager spoke about the administration of the Area Health Service:

“If you think of the Area, it’s a huge organisation…you’ve got quite a number of organisations in the hospitals and communities in the Area, and all of them at different levels, and all of them needed to change, and some needed to be more rapid than others…And it’s probably an enormous challenge, an enormous responsibility for a few people”.

Although Glouberman and Mintzberg (2001) state that managers are intimately connected to the institution, this is somewhat debatable. This is mainly because of the size of the Area Health Services that hospitals operate within. In NSW, there are approximately 10 hospitals within one Area Heath Service. The hierarchical nature of Area Health Services, referred to in Chapter Two, prevents executives in charge of the Area from having close connections with every facet of every hospital. This means that there is inevitably some sort of natural disconnect from the hospitals, and people within them are relatively ‘faceless’. In terms of informal networking this is a serious consideration. A Senior Manager commented on this:
Although managers may not necessarily be ‘intimately connected’ to an organisation as was described by Glouberman and Mintzberg (2001), managers have an extensive role, including responsibility of planning, organising, leading and controlling the organisation. A Senior Manager spoke about the all-encompassing role they undertook:

“in terms of my role, I have overall responsibility for the facilities in terms of both the corporate and the clinical governance of the organisation, and that incorporates day-to-day decision-making around resource allocation, staffing, all of those things”.

Whilst some of the participants spoke about the difficulties of being a manager at the organisational level, participants with clinical experience indicated their clinical experience made working in their current managerial role easier. Connectivity with both clinical world as well as managerial world may be seen as an advantage by some and a disadvantage by others. For example in nursing, it would be highly unusual to have non-nurses manage a nursing unit. Hence connectivity to both the hospital management and clinical nurses is a point of negotiation for nurse managers, and is an example of the Allen’s (1997) negotiated order perspective, where professional roles are negotiated between different stakeholders. These
middle managers manage *up* to the senior managers of the organisation, and manage *down* to first line staff of the hospital.

Managing medical clinicians is somewhat more complicated. A medical clinician has assigned authority and autonomy for his/her clinical practice. Control mechanisms are maintained within their colleges, and many medical practitioners maintain a large clinical role in and outside the hospital. The disconnect from the hospital is therefore even more prevalent and an opportunity to form informal social networks is significantly more difficult. As discussed previously, the doctors are a largely transient population and it is therefore difficult for them to have developed social networks if they are moving from one hospital to another.

Managers, including clinical managers, have different levels of connectivity with the areas they manage, be it at the Area Health Service level, hospital level or in a unit within a hospital. With this diversity it is difficult to make informed decisions because of the different specialities and levels involved. Nevertheless, managers are assigned formal authority for the hospital system in relation to staff, budgets, and other systems issues. This formal authority to manage the hospital system is complicated because as Glouberman and Mintzberg (2001) argue, the hospital is not one overall system, but a set of different worlds.

### 7.13 Resources at the Unit Level

The terms managers and administrators are interchangeably used in hospitals. Mostly administrators are removed from direct involvement in patient operations because they have little to no clinical contribution (Glouberman and Mintzberg,
However, managers or administrators are responsible for wider systems issues such as resource and budget management. Although clinicians have responsibility for their individual patients, managers are responsible for the running of the hospital, networks, and area. The wards report to their hospitals, who report to their networks, who report to the overall area health service. A Senior Manager spoke of the formal levels of authority:

“The way the Area is structured is that operationally, clinically, the wards and staff report operationally to their networks, in terms of accountabilities for budgets and patient outcomes”.

Administrators are assigned and practice formal authority, which is their principle of organising (Glouberman and Mintzberg, 2001). A Nurse Unit Manager spoke about managers as sitting in their “watchtower” and giving instructions to clinical staff (i.e. nurses or technicians):

“we’ve been told from upstairs that we must implement this change but, its just working out how to do that with the resources we have and no extra resources available…when its going to increase the workflow significantly for quite a few people on the floor”.

These directives caused frustration amongst the participants. The frustration arose from the fact that they could clinically make decisions about patients but needed to wait for the managers to make decisions about budgets and resources. The doctor participants felt that medical clinicians could better function if they had the formal
authority to make decisions about budgets and resources. A Senior Doctor Manager spoke of their frustration about having to take directions from the administrators:

“But, decisions regarding staffing, regarding transfer protocols, regarding the various networks that we have to establish to get services that aren’t here, they’re the decisions that I can’t make myself….so that we can function”.

Perhaps the most difficult role to describe is that of the Nurse Unit Manager. The Nurse Unit Manager has the clinical experience but –usually- has no clinical workload. Instead, they deal with the nurse administration assisting patient flow within a distinct unit. A newly instated Nurse Unit Manager spoke how they had been removed from direct involvement with the patient and had effectively become an administrator:

“I don’t have any clinical workload at all in this role, and more managing. So far I’ve done some patient complaints, overseeing staff annual leave, recruitment of staff, the reports, anything that’s more the administrative side of the department”.

Clinical managers and administrators are definitive stakeholders and “matter” regarding decision making about resource allocation. However, whilst they are trying to figure out who has formal authority to make what kind of decisions, it appears that the stakeholders who provide care are progressing patient flow via their informal networks.
7.14 Coordination of Patient Flow

Glouberman and Mintzberg (2001) argued that whilst no one was formally charged with the coordination required for the flow of patients, “nurses come closest to affecting it” (p. 61). However, in 2005 in NSW hospitals, a formal role was devised known as a Patient Flow Manager (PFM). Along with this came the introduction of the Patient Flow Unit (PFU) (see description of PFU in Chapter Two). Since doctors are absent most of the time (with the exception of doctors who are staff specialists and employed by the hospital; many of whom are employed on a part-time basis) and managers are clinically distant from patients, the natural intermediary between clinicians and managers is the nurse stakeholder group. Nurses are able to mediate between clinicians and managers because they speak the ‘medical language’ of doctors, and they understand the ‘systems language’ of managers. There is a necessity for dialogue between stakeholder groups when wanting to get things done.

Many participants spoke about how nurses had been in charge of the flow of patients even before the formal allocation of the role of PFM. A Senior Doctor Manager spoke about the role that nurses have in the flow of patients:

“a lot of it’s done through Nursing, of course. The doctor sees the patient and says, “The patient’s sick, needs to be admitted.” Gets a general idea of what sort of bed, surgical or medical, maternity, needs high-dependency, needs cardiac monitoring. So the type of bed’s decided, medically. But the timing of the transfer, and whether or not the bed’s available is done through patient flow, which is mainly nursing. So the Nursing Unit Manager or the nurse in
charge will contact Patient Flow, and they will say, “Yes, there’s a bed/ No, there’s not a bed”.

Another reason that nurses are able to control the flow of patients better than either doctors or managers could is because of their progressive role as a mediator between the doctor and manager stakeholder groups. A Senior Nurse Manager summarised the mediator role that nurse managers, and nurses to a lesser extent, had undertaken:

“But they’re [doctors] not necessarily good managers, okay, but they are good leaders. There’s a difference between managers and leaders, and I think that probably people like, you know, the DONs and the DCOs need to be a combination of managers and leaders. You need to have both. Doctors are definitely leaders, but they’re not good managers”.

This is because Nurse Managers have a dual identity as managers, but have been trained previously as clinicians. Nurse managers manage clinical units and as such interact much more closely than doctors with clinical nurses. This gives Nurse managers the ability to function in three worlds including the cure world of doctors, the care world of nurses, and the control world of managers. A Nurse Unit Manager summed up this ability:

“I’m the liaison person because I see nursing on the ward, so if there’s a problem, I directly, physically, oversee what’s happening on the wards, check, have a look at the patients, liaise back and forward with Patient Flow. If we get
Whilst doctors have the formal authority to admit or discharge a patient, it is the nurses who actually make the decisions about the coordination of patient flow. The role of coordinating patient flow has fallen to Nurse Managers who have clinical backgrounds, and also formal managerial authority. These Nurse Managers liaise with both clinical stakeholders, and non clinical stakeholders such as senior hospital managers. Through their tightly defined roles, these Nurse Managers in hospitals display distinct characteristics. Their work orientation is that of a systems approach, and their nature of work is collective in that they work closely with other stakeholder groups to get their job done.

The managers’ power relationship is made dominant by their function, yet their relationship dynamics are based on facilitative approaches to working with other stakeholder groups. Managers form both alliances and networks with other managers and stakeholder groups, and their cultural orientation is that of attempting integration between the stakeholder groups. Managers attempt to look at the hospital in its entirety to ensure that patients are flowing, and that resources are being allocated in an efficient manner.

7.15 Inter and Intra Professional Interactions

During the qualitative stage, several key themes emerged. These key themes include a pattern of relationships between occupational cultures, cultural boundary constructs, key stakeholder roles and challenges to the historically anchored and
hierarchical division of labour. The keys themes and concepts are valuable in helping outline the differences of the three worlds according to the theoretical framework of Chapters Three and Four. Table 7.1 summarises the differences in inter-professional roles and dynamics of the three stakeholder worlds as found and illustrated in the discussion above.

From an organisational culture perspective, work, roles, power, and relationships assist in understanding “the way we do things around here” based upon the organisation as whole, as well as the different groups and worlds that may exist.

**Table 7.1: Comparison of the Three Worlds in Hospitals**

<table>
<thead>
<tr>
<th></th>
<th>Cure World</th>
<th>Care World</th>
<th>Control World</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Occupant</strong></td>
<td>Doctors</td>
<td>Nurses</td>
<td>Managers</td>
</tr>
<tr>
<td><strong>Nature of Work</strong></td>
<td>Individualised</td>
<td>Collective</td>
<td>Collective</td>
</tr>
<tr>
<td><strong>Work Orientation</strong></td>
<td>Project</td>
<td>Process</td>
<td>System</td>
</tr>
<tr>
<td><strong>Role Delineation</strong></td>
<td>Defined</td>
<td>Loosely defined</td>
<td>Defined</td>
</tr>
<tr>
<td><strong>Perceived Power Relationship</strong></td>
<td>Dominant by level of education</td>
<td>Dominant by numbers</td>
<td>Dominant by function</td>
</tr>
<tr>
<td><strong>Relational Dynamics</strong></td>
<td>Protective</td>
<td>Intermediary</td>
<td>Facilitative</td>
</tr>
<tr>
<td><strong>Inter-professional Relations</strong></td>
<td>Alliances</td>
<td>Networks</td>
<td>Alliances and Networks</td>
</tr>
<tr>
<td><strong>Cultural Orientation</strong></td>
<td>Differentiation</td>
<td>Ambiguity</td>
<td>Integration</td>
</tr>
</tbody>
</table>

within the organisation. Whilst each of the three stakeholder groups operates within its own paradigm, the worlds of the doctors, nurses, and managers cross over because they all work in the same organisation. However, different work orientations, role delineations, and cultural orientations make it difficult for these worlds to work together. This is where inter-professional relationships become important. As
discussed earlier in this chapter, the nurse stakeholder group has become a conduit, or an intermediary for the different stakeholder groups in the hospital.

7.16 The Intermediaries

In addition to the effects of a changing role of nurses, interactions between actors in the three worlds of cure, care and control about patient flow in the hospitals are influenced by temporal factors. For example, whilst doctors spend time with the patient intermittently, nurses administer continuous care to the patients. In addition to physical care, a lot of the nurses’ time is spent organising and gathering data to facilitate diagnosis, which is eventually confirmed by a doctor. Nurses provide patient information to doctors and managers. The flow of patients depends on the information provided by nurses, who then relay the information to the managers with formal authority for patient flow. In this sense, nurses have a multidisciplinary role.

Nurses care for patients, provide patient information to other nurses as well as doctors and managers, and operate in an open system where they affect and are affected by the environment. This multidisciplinary role provides the basis for nurses to be intermediaries between the various stakeholders in the decision making process of patient flow. Nurses are able to affect decisions made about bed allocation because of the multidisciplinary role and their ability to interact with various stakeholders and subcultural groupings in the hospital.

Nurses are less inclined to directly oppose directives given by senior management. Instead, the intermediary nature of a nurse is particularly evident through the role of a nurse unit manager. The nurse unit manager was mentioned as being a “link” by
several participants. This may be because the nurse unit manager is responsible for so many parts of the patient journey. A Senior Nurse Manager commented:

“I think the Nursing Unit Manager is one of the most important roles in the hospital, because it links to so many different things. It links to the nursing staff, it links to the medical staff, it links to Allied Health. It links to the patient, it links to management. And they’ve probably got to have a sort of dual repertoire of language.”

Because of the diverse interpretations of different professionals about formal organisational rules, the role of nurse managers has become one of facilitation and negotiation between authority and autonomy expressed by other professionals. The role therefore has developed into one of “support” and “facilitation”, rather than a dictatorship. Allen (2004) notes the “role that nurses perform in managing and mediating the multiple agenda and discourses which shape contemporary healthcare systems” (p. 273). Allen acknowledges the importance of the multipurpose role of nurses in the process of patient flow. Equally, Chambliss (1997) states that nurses juggle the demands of competing parties such as occupational groups, patients and families, and hospital bureaucracy.

However, the literature seems to be devoid of studies that discuss the function of nurses as intermediaries in the decision making of patient flow from the emergency department to a ward. This gap in the literature makes it difficult to fully understand the decision making dynamics of professional groups when managing patient flow,
particularly in the complex NSW health care system. In particular, it is difficult to
gauge who the most influential stakeholders are in the patient flow process.

Glouberman and Mintzberg (2001) argue that doctors are the most influential
stakeholders in the hospital. However, this may be a simplistic view given the finding
of this thesis that different stakeholders affect different parts of the decision making
process in relation to patient flow. That is, whilst doctors may be the most influential
stakeholder during the diagnostic part of the patient flow process, other stakeholders
may be more important in other parts of the patient flow process.

Contrary to assertions that doctors are the most influential members of the hospital
community (Glouberman and Mintzberg, 2001; p. 62), this thesis argues that actual
power may lie with nurses when facilitating the flow of patients from the emergency
department to a bed in a ward. It is important to consider that there are different
stakeholder groups involved in some or all parts of the decision making process.
However, whilst the researcher recognises that in this particular process doctors,
nurses and managers are all definitive stakeholders, the question is, who is the most
definitive.

Current literature suggests that the most important stakeholder in an organisation is
the person/group that matters the most, or is the most salient (Scholl, 2004; Mitchell
et al, 1997). A stakeholder is considered salient when they display the three factors
of power, legitimacy and urgency (Mitchell et al, 1997). The first factor, stakeholder
power, is the ability to influence decisions. The second factor, authority, is legitimacy
or verification to use their ability to influence decisions. The third factor, urgency,
includes time sensitivity and criticality of the decisions. In hospitals, doctors have
definitive decision making power when it comes to clinical decisions. Managers have
definitive decision making powers when it comes to organisational or logistical
decision making.

However, the thick boundaries between these two formal and influential groups when
making decisions are reinforced by their perceptions of status, as well as
incongruent approaches to work. In terms of status, both doctors and managers
have formal definitive power in decision making. Glouberman and Mintzberg (2001)
argue that their perceptions of their power can clash in formal decision making
situations. In addition, managers and clinicians appear to have an incongruent
approach to work, where managers are concerned with the process of patient care,
and doctors use a more project oriented approach in treating individual patients
clinically. This paradigmatic incongruence between a project approach or a process
approach is bound to cause tensions, resulting in an ontological divide that can act
as a barrier to getting the tasks done. The intermediary role of nurses gives them the
power in the decision making process, making them definitive stakeholders.

7.17 Size Matters

In facilitating patient flow throughout the hospital, the boundaries between different
functional groups (managerial and clinical) and professional groups (doctors, nurses,
managers) shift according to the size (and associated culture) of the hospital. This
was demonstrated by the researcher’s observations of the small hospital culture that
was more like a family unit and largely integrated. In contrast, the larger hospital
displayed more factions between subcultures and the culture was observed to be
more ambiguous. For example, in the smaller hospital the staff in the emergency
department met regularly for social activities, such as a monthly dinner. However,
the emergency department staff in the larger hospital found that social activities were
too difficult to organise. The perception was that within such a large department
there were too many people on the roster, each with their own agenda, thus causing
difficulties in negotiating social engagements.

The differing thickness of these boundaries in small to large hospitals defines how
easy or difficult it is for outsiders to penetrate groups. An outsider may be from
another organisation or from a different professional or functional group in the same
organisation. Smaller hospital cultures are more collegiate (integrated) than larger
hospital cultures, which are more disconnected (differentiated and ambiguous). In
smaller hospitals, where the culture is more integrated, boundaries become more
permeable between the various stakeholder groups. The researcher observed that in
the smaller hospitals the staff knew each other’s names and clearly identified when
an outsider entered the hospital by stating they did not even know the outsiders
name.

Thus far this chapter has outlined the roles that doctors, managers, and nurses
undertake in the patient flow process. The following section will further discuss these
roles in an attempt to gain a clearer understanding of the influence of different
stakeholders on the decision making process.
7.18 Discussion of Findings

Doctors and managers have the highest formal status as demonstrated by recognition from the community and a higher level of pay. As a result, these two groups struggle for power, status, and recognition. The outcome of this struggle is tension within the hospital and a thickening of the boundary between cure and control. During the meetings the researcher attended, she noted that the managers and doctors sat at either end of the table and there was very little dialogue between the groups, unless necessary. This observation of tension between doctors and managers adds to the existing literature.

The role of nurses is different. Their boundary with doctors and managers is well defined, but thin. This is evidence by the fact that nurses deal with the doctors at a clinical level and managers at managerial level, and allows nurses the ease of boundary crossing. For example, the researcher observed a discussion between a manager and a nurse, where the nurse was sent discuss a clinical issue with the doctor and report back to the manager. Nurses have a lower formal status than either doctors or managers. However, nurses seem to ‘matter’ significantly more compared to doctors and managers when it comes to facilitating the flow of patients. This is because, as the divide between the two high status groups (doctors and managers) seems to grow, nurses act more as an intermediary. Nurses understand the ‘medical’ language that doctors speak, as well as the ‘systems’ language that managers speak.

The concept of homophily is evident in these hospitals as doctors stick with other doctors and managers stick with other managers. However, nurses are much more
fluid and able to mix with both groups. The concept of homophily explains how doctors interact with one another, and managers interact with one another. That is, birds of a feather flock together, and consequently, doctors flock to other doctors, whilst managers flock to other managers. Accordingly, whilst the boundary between the doctor group and the manager group is thickening, the boundaries between doctors and nurses, and managers and nurses remain more fluid.

The formal allocation of duties for patient flow through PFU’s has been given to specialised nurses. These nurses have certain characteristics, deep smarts, that allow them to juggle various responsibilities. This is because these nurses have developed capabilities to invest in relationships as a resource, also known as social capital, which can help them ‘get things done’. As a result, nurses have been conducting the flow of traffic (doctors, allied health staff, corporate services) necessary to assist patient flow.

The above would suggest that whilst most managers and medical clinicians are struggling to communicate across thick boundaries defined by status, nurses’ boundaries between these two groups are much more fluid and permeable. Therefore this research suggests that nurses are used as an intermediary to facilitate relations between managers and clinicians. This has resulted in latent, less transparent role definitions; the doctors treat, the managers’ support and the nurses enable the processes. As a result, the real definitive stakeholder in decision making is the nurse, not the manager nor the doctor. From a cultural perspective, the ambiguity perspective best describes the nurses’ role. The nurses role is therefore one of acceptance of uncertainty in the internal and external environment as a
necessity to get things done. This acceptance of uncertainty allows nurses to be more fluid and therefore gives them the understanding and tools needed to undertake the liaison role.

The above discussion indicates that the currently accepted claims of Glouberman and Mintzberg (2001) can be contested on the following points:

- Glouberman and Mintzberg (2001; p. 66) argue that “considerable power has passed to the managers, especially with regard to the allocation of resources”. However, Glouberman and Mintzberg have not considered that the information that managers need to allocate resources is obtained from nurses. These nurses regulate the information that they give to the managers by the fact that they control the process part of patient flow.

- Glouberman and Mintzberg (2001; p. 62) argue that doctors “are the most influential members of the hospital community”. This point is questionable because nurses have developed an intermediary role, which allows nurses to facilitate the flow of patients through the hospital.

- Glouberman and Mintzberg (2001) propose an additional “world” in a health care system known as community. This addition is weak in relation to decision making about patient flow because the stakeholder groups do not view the community as a definitive stakeholder group. Community should not be seen as a separate group because all members of a hospital are part of the community – the difference is their perception which varies according to size.
of the hospital. That is, the smaller the hospital, the more the members see themselves as belonging to the community. While the views of the community external to the hospital may affect the decisions made by hospital staff (e.g. community views on euthanasia) they have no direct role in the decision making process within hospitals, and as such cannot be counted as definitive stakeholders in the process observed for this research.

Whilst there is formal authority given to managers to make decisions about patient flow, the above analysis has shown that formal authority is no guarantee that decisions will be made according to hierarchical divisions of labour. Even though doctors have clinical authority to make decisions about admissions, and managers have hierarchical authority to makes decisions about resource allocation, it is mainly the nurse stakeholders who facilitate decisions about patient flow from the ED to the ward. In addition, to facilitate flow, they use their individual informal networks to get things done.

According to Mitchell et al (1997) the person or group that is most salient is considered a definitive stakeholder. The analysis above has proven that there is tension between doctors and managers in relation to who matters most, or who is most salient. To overcome this tension, nurse leaders, be they Patient Flow Managers, Nurse Unit Managers, or other “deep smart” individuals, who have varied formal functions in decision-making, use their informal social networks. Although these nurse leaders have varied formal power, they function in a role that has made them facilitators and intermediaries between doctors and managers. The informal networks allow them to either hasten or slow the flow of patients from the emergency
department to the ward. The informal networks, as a collective, are the real definitive stakeholders in the process of patient flow from the emergency department to the wards in a hospital.

In conclusion, this research maintains that informal networking is necessary for quick and decisive actions, and that such decisiveness is dependent on intimate connections that form informal social networks to assist with decision making about patient flow in hospital emergency department wards. The purpose of this chapter was to answer the research questions about network and alliance creation/crossing between diverse stakeholder groups in relation to decision making about patient flow.

The following chapter looks at the way that stakeholders in hospitals use both formal and informal avenues with health services to progress the flow of patients through the hospital. Furthermore, the following chapter answers the overarching question, “how does informal social networking interact with decision making about resources, and how can this be explained from an organisational culture perspective?”
8 Discussion
8.1 Introduction

The purpose of this PhD study has been to investigate how informal social networking interacts with decision making about resources, and how this can be explained from an organisational culture perspective. The research found specific emerging themes, such as the nature of stakeholder groups’ work, work orientation, role delineation, perceived power relationships, relational dynamics, and inter-professional relations. These themes were related to three different occupational groups, making up three of the four worlds in a hospital, as described by Glouberman and Mintzberg (2001). In this chapter, the findings of this research will be reported reflecting on the cultural snapshots discovered and discussed in Chapters Six and Seven, from which conclusions will be drawn. In addition, within the scope of this research, implications for hospital managers will be outlined and some suggestions will be made for further research.

8.2 Integration Perspective of all Four Worlds

As outlined in Chapter Seven, Glouberman and Mintzberg (2001) suggest that there are four worlds that operate within a hospital. These worlds are occupied by different occupational groups. This research largely confirms that different functional groups occupy these diverse worlds, viewing patient flow from alternative perspectives. These diverse groups are stakeholders within the organisation, with diverse requirements and mindsets. The different worldviews may be a result of strongly defined divisions in labour, geographical location of work, or working a day or evening shift. For example doctors and nurses share clinical responsibilities and managers and nurses share operational responsibilities.
Doctors and nurses are responsible for patient treatment and care, whilst managers and nurses are responsible for the transportation of patients and operating budgets. Hence, whilst division of labour is well defined by professional delineations, functional boundaries between doctors’ and nurses’ clinical work, and between nurses’ and managers’ managerial work are blurred. The biggest distance is between doctors’ clinical work and managers’ managerial work. As discussed in Chapter Seven, this research found that nurses tend to be intermediaries facilitating boundary crossing between doctors and managers. Figure 8.1 depicts the boundaries between hospital professions.

Figure 8.1: Distance between health professions

Notwithstanding the many differences, there are also similarities between the various stakeholder groups. These similarities can be based upon cultural forms, manifestations, and formal and informal practices (Martin, 2002). For example, all of the stakeholder groups are involved in the same hospital in some capacity or another. The stakeholder groups work within the same organisation; that is, they share the same space. Because multiple groups share the same space, some
researchers have argued that there is a single organisational culture, i.e. ‘the way we do things around here’. However, this view is simplistic because although organisational members have shared values and beliefs, there are perceptions of uniqueness in terms of feelings of affiliation. Viewing one overall organisational culture is known as the integration perspective, which Martin argues as “those manifestations of a culture that have mutually consistent interpretations… ambiguity is excluded” (2002; p. 94).

As discussed in Chapter 3, an integration perspective, or a positivist view of culture, can lead people to think that cultures can easily be changed, or that culture is a variable that can be manipulated to achieve certain outcomes (Schein, 1996, 1991, 1985; Martin and Frost, 1995; Phesey, 1993; Trice and Beyer, 1993; Dunford, 1992; O’Reilly, Chatman, and Caldwell, 1991; Dunphy and Stace, 1990; Morgan, 1989; O’Reilly and Chatman, 1986; Louis, 1985; Nord, 1985, Barley, 1983). The researcher observed in the smaller hospitals that there was an identifiable overall culture with pockets of smaller subcultures. In the larger hospital, the overall culture was less identifiable because it was less integrated, with larger pockets of strong subcultures identifiable.

Whilst it is important to understand the overall culture of an organisation, it is also important to acknowledge and understand subcultural influences in an organisation. Acknowledging the existence of subcultures in an organisation is in line with the argument that differentiation also occurs in an organisation’s culture.
The differentiation can be relatively minor, or can dictate the way an organisation actually functions. For example, a smaller hospital may be nurse driven, whilst a larger hospital may be driven by a more bureaucratic culture, with several levels of hierarchy. Therefore, it is important to understand the overall organisation’s culture taking into account both a differentiation perspective as well as an integration perspective. The differentiation perspective is related to the hospitals discussed in the following section.

8.3 Differentiation Perspective: Hospital Worlds

According to Glouberman and Mintzberg, the health care system is complicated because there are several decision makers with differing aims and objectives (Cater, 2002; Glouberman and Mintzberg, 2001). Therefore, the healthcare system should be viewed as four separate ‘worlds’ which are care, cure, control, and community. Figure 8.2 gives a graphical representation of the four worlds.

The cure world represents the way doctors view their contributions to overall organisational goals, characterised by an emphasis on healing and cure of the individual case. In NSW, there are typically two types of doctors who work in hospitals. There is a small group of residents (and interns) who work for the hospital, while the majority are Visiting Medical Officers (VMOs) who have admission privileges (Carter, 2001; p. 6). These doctors intervene in the patient process to cure the patient, and are then able to move back to their private practice, thereby increasing their income. As addressed in Chapter Seven, a doctor’s world is characterised by project or case management in a rather autonomous manner, notwithstanding some organisational constraints.
The *care* world represents the way nurses operate within the organisation, characterised by attending to the provision of holistic care to patients and their family. Nurses represent the care world and typically spend the most time with the patient. This reinforces the overall view that a nurse’s world is characterised by process management, working within a rules based cooperative hierarchy.

The *control* world represents the way administrators and managers operate, characterised by an emphasis on operational effectiveness and efficiency. Managers and administrators represent the control world, and are employed directly by the hospital to control resources. They are mostly removed from direct involvement in clinical operations, and typically do not interact with patients, except when there is a problem that is escalated by patients or staff. This reinforces the overall view that a manager’s world is characterised by leading systems control for efficient use of resources.

The *community* world represents governmental control, characterised by strategic management at the level of Area Health Services, and at the funding level by State and Federal Government bodies. As mentioned in Chapter Six, the community world is not a part of the analysis conducted to determine the influence of stakeholder groups in relation to patient flow and resource allocation.

In New South Wales, Australia, paradigmatic differentiation in terms of occupational role characteristics is further complicated by the way in which hospital workers are formally associated with the hospital; some are on salary, others are conducting their
business in the hospital and charge a fee for service. Nevertheless, whilst there seems to be a focus on the divides between the paradigms, there are also some similarities between the worlds. The similarities can be typified according to clinical similarities, or hierarchical similarities. For example, doctors and nurses share some similarities based upon the fact that they are involved with the patient at a clinical level. Their focus is solely on providing best individualised patient care. On the other hand, managers are further removed from direct clinical contact with patient. Their focus is on providing the best possible patient care within a collective system and within budget. Such paradigmatic differences can cause a manager – clinician divide.

The next section examines the findings of this research in terms of the divides and similarities between the four worlds. The four worlds are depicted in figure 8.2.

Figure 8.2: Four Worlds View of a Hospital according to Glouberman and Mintzberg (2001)
Because “community” is not a professional or functional group, the fourth world is not part of this investigation. Thus, community was excluded from the analysis as it was beyond the focus of the study.

### 8.4 Horizontal Divide

The horizontal divide of the model presented by Glouberman and Mintzberg is representative of the divide between those that manage (managers and Area Health Services) and those that focus on patient care (doctors and nurses). Carter (2002) argues that the groups form coalitions based upon their management focus into clinical operations. That is, doctors and nurses form a “clinical coalition”, and managers and government form a “containment coalition”.

![Figure 8.3: Horizontal Divide of Managers, Doctors, and Nurses](image)

Figure 8.3: Horizontal Divide of Managers, Doctors, and Nurses
The clinical and containment coalitions provide a basis for the researcher to explain the findings in relation to the creation of alliances between stakeholder groups. For example, doctors form alliances with other doctors for specific purposes, such as expediting the flow of patients from the emergency department into a ward bed. Nurses form networks with both doctors and managers, by nurturing relationships and friendships with both stakeholder groups. Furthermore, the networks also provide a basis for an explanation about the boundary crossing between stakeholder groups. Specifically, the researcher found that nurses have become conduits or intermediaries between other stakeholder groups, such as doctors and managers. This intermediary role is investigated further in the latter part of this chapter.

In addition to the horizontal divide based upon functionality, a vertical divide also exists. This divide is based on coalitions (Glouberman and Mintzberg, 2001).

### 8.5 Vertical Divide

The vertical divide is represented by those who are status dominant (doctors and Area Health Services), and those who are concerned about the daily functioning of the hospital (nurses and managers). Doctors and trustees manage “out” because they do not work for the hospital (generally), and are therefore independent of the organisation. However, doctors and government are considered powerful stakeholders because of their high status in the hospital. Across the vertical divide, managers and nurses administer “in” as they work for the hospital and are responsible for the functioning of the hospital on a daily basis. Managers and nurses are similar in that they share a strong hierarchical structure and are tightly coupled. Therefore, it can be said that doctors and Area Health Services executives form a
“status coalition”, and unit managers and nurses form an “insider coalition”. In this way we can modify Figure 8.3 to reflect the different types of coalitions that various stakeholder groups form (see Figure 8.4).

Figure 8.4: Vertical Divide of Managers, Doctors, and Nurses

These coalitions range from formal professional alliances, to informal networks. Chapter Five discussed the subcultural differences between doctors, managers and nurses. Doctors relied on more extrinsic factors such as status and recognition, whilst nurses relied on more intrinsic factors, such as friendly cooperative co-workers and a good working environment. In Chapter Six of the thesis, these findings were reinforced and further developed. For example, doctors were found to form alliances with doctors and other stakeholders to further develop their status and ‘get things done’. Nurses tended to form networks with other stakeholders by developing
connections through social events and conversations. Contrary to doctors who formed alliances for specific purposes, nurses formed networks for future unspecified purposes. Doctors tend to flock together with other doctors, as they are more homophilic.

Stakeholder groups in hospitals form coalitions with other stakeholder groups based upon similarities. The similarities may be based upon comparisons of clinical responsibilities, or similarities based upon status. Consequently, there is some differentiation between groups. However, these groups share similar concerns. All three stakeholder groups investigated are concerned with the patient in some form or another. Managers are concerned with moving the patient through the system using as few resources as possible, doctors are concerned with the right diagnosis, and nurses are involved with the patient throughout the entire patient flow process. Although the groups are all concerned with the patient, the concerns differ depending on the stakeholder group.

Therefore, the differentiation between groups is evident. The differences between the groups confirm previous research that concluded that a cultural perspective of differentiation is really integration perspective at a lower level (Fitzgerald, 2002). However, the integration in each quadrant is of a different intensity. That is, the new groups that are formed between different stakeholder groups seem to be of a different nature. The researcher argues that doctors and managers form alliances, whereas nurses form networks. The difference is that alliances are formed for specific purposes and networks are formed for future unspecified purposes.
8.5.1 Networks and Alliances

During the semi-structured interview and observation phase of the research, it was clear from the discussion with all participants that staff in hospitals relied on formal as well as informal channels to get things done. Participants spoke about the need to use the informal channels to bypass cumbersome hierarchical rules and procedures. For example, having a good relationship with the clerical staff meant that ordering stationery took less time than by using formal channels. However, the type of informal network formed by stakeholder groups differed.

Doctors spoke about using their networks to achieve specific outcomes, such as progressing patient imaging results or patient referrals. Whilst doctors used the term “networks”, it was evident from the examples given that doctors were not forming networks as much as they were forming alliances. This argument is as a result of the evidence that doctors would enter into informal agreements with other stakeholders for a specific purpose or a specific outcome. This argument became more crystallised when compared with the types of coalitions that other stakeholder groups form.

Similarly, managers also form alliances with other stakeholders to get things done. The researcher observed this alliance building on several occasions. For example managers actively sought other stakeholders with management responsibilities to ensure that operational staff would accept initiatives more readily. The researcher was further alerted to management alliances by the type of language used. Managers argued that they needed to ensure that certain organisational members
were “on side” so that they could allow for a smoother transition of operations management throughout the hospital.

In summary, doctors form alliances with each other; managers form alliances with each other as well as with other stakeholder groups; and, nurses were observed to rely on informal coalitions. Moreover, nurses did not seem to be as involved in building alliances as doctors and managers were. Instead, nurses tended to form networks. The key difference seemed to be the intent of the stakeholder group. That is, whilst doctors and managers formed alliances for a specific purpose, nurses formed networks for future undetermined purposes. Nurses tended to talk about coalitions in terms of relationships and an ongoing commitment to those relationships. They understood the importance of nurturing and maintaining those relationships for their future working in the hospital. Furthermore, nurses who left the hospital, and had undertaken nurse management positions in other hospitals of the same Area Health Service, spoke about taking the time to maintain those relationships by visiting their old hospital site whenever possible. The reason for the visit was not for a specific purpose, such as progressing a specific patient, but to maintain the relationship just in case the network could be used for a future event.

As a result, the researcher observed that in the hospitals studied, nurses were often an intermediary between the two highly influential stakeholder groups of doctors and managers. Whilst managers control the costs and budgets of a hospital, doctors determine how the costs will be spent (Cater, 2001). The tension between doctors and managers seems to be expanding. This tension is often resolved by the stakeholder group that is in the middle of the two groups, that is, nurses.
Thus far, the chapter has dealt with understanding hospital decision making about patient flow from an integration perspective as well as a differentiation perspective. The next section of this chapter considers the ambiguity perspective of studying an organisation’s culture. Specifically, the researcher discusses what makes a nurse’s role ambiguous.

8.6 Ambiguity Perspective

Whereas doctors work in their highly focused silos according to their clinical specialties (e.g. surgery, paediatrics) nurses are more flexible. This flexibility may be attributed to the variability of the nursing role. Nurses have both clinical responsibility and administrative responsibility. Nurses also operate within a loosely coupled hierarchy. They belong to many subcultures within the hospital including the hospital itself, the ward they work in, the ward they used to work in, morning, day, or night shift and so forth. The point is that nurses seem to belong to many groups both clinically and administratively. Belonging to several different groups and not belonging coincides with the ambiguity perspective of culture where “lack of consistency and consensus, and above all ambiguity” (Fitzgerald, 2002; p. 32) defines the constant flux and multiplicity of cultural manifestations. Some of these cultural manifestations were evident through the conversations with nurses. For example, during conversations the researcher observed and took part in, nurses were able to present opinions about a variety of topics expressing their values and beliefs. Nurses talked about their attitudes as mothers, friends, daughters, being part of a netball team, specialty nursing group, and being a member of a specific team, i.e. night duty.
Since nurses belong to many groups, the researcher found that nurses can rely on their informal social networks to “get things done”. Nurses in all three hospitals were involved in various social events. Nurses meet with other nurses for coffee and weekend functions. These social networks were used as a foundation for progressing patients throughout the hospital. Having a wider social network allowed for nurses in positions of power, such as Patient Flow Managers (PFM), to further processes in the hospital. For example, knowing when the birthdays of the children of nurses occurred, allowed the PFM an opportunity to offer extra shifts, and thus extra income, during winter when fewer nurses would generally accept night shifts.

Hence, nurses hold a pivotal role in the hospital. Apart from their clinical expertise and responsibilities, and sharing clinical understanding with doctors, nurses have operational responsibility. In NSW hospitals, mostly nursing staff are charged with progressing the patient through the system and organising for other staff to be involved, such as transport and cleaning services. The operational role of nurses allows them to share control understanding with managers. This understanding of both the clinical and control worlds puts nurses in a perfect position to be a conduit between doctors and managers. This research confirms the fact that information between doctors and managers is more efficiently communicated when nurses are involved. In this sense, whilst there may be tension between clinicians and managers, nurses are able to dissipate some of this tension by allowing boundaries to be circumvented. This increases nurses’ saliency when making decision about resource utilisation or non utilisation. Therefore, the ambiguous nature of nurses’
culture in hospitals is a good platform for wider understanding and facilitates communication across boundaries between professional and functional groups.

8.7 Relationship Dynamics

However, not all nurses can function as a conduit. This requires special skills and characteristics known as "Deep Smart" characteristics. Chapter Two gave an outline of the characteristics that could be used to identify a deep smart person. To recap, these characteristics include (1) skills and know-how; (2) systems thinking; (3) separation of signal from noise; (4) swift, wise decision-making; (5) ability to take context into account; (6) networks; (7) pattern recognition; (8) ability to deal with novelty; and (9) enthusiasm/passion for the knowledge domain (Leonard, 2007).

It is argued that keeping Deep Smart people in organisations adds to an organisation’s social capital. The researcher found that there were several stakeholders within the organisation who possessed some of the characteristics. However, very few stakeholders possessed all of the characteristics. It became evident upon consideration of the anecdotal evidence and observation, that the nurse stakeholder group clearly had some Deep Smart persons. These nurse stakeholders possessed skills and attributes that allowed them to use their expertise in making decisions. As discussed in Chapter Two, Deep Smarts is more than just individuals who have expertise in an organisation. It is about the way in which those individuals use their knowledge, networks and other characteristics of deep smarts that classifies them as experts. It became clear on consideration of the data collected, that some of the nurse managers in the hospitals studied were able to affect the decision making about patient flow due to their attributes. These nurse managers were pivotal to their hospitals because of their knowledge and skills. The
knowledge and skills of these pivotal people are essential when considering the inter-occupational negotiations between different stakeholder groups.

In Chapter Two the researcher discussed the role of doctors, nurses, and managers using professional identity literature. The professional identity literature resonates with the notion of the Negotiated Order Perspective (NOP) by Allen (1997). The NOP relates to the inter-occupational negotiations between doctors and nurses. However, in these writings the Negotiated Order Perspective is mostly related to clinical work, in particular pointing out the changing division of labour. The recommendation by Allen (1997) included an “increased need for inter-occupational negotiations and associated tensions at the boundary between nursing and medical work” (p. 516). Allen also argues that “the strategies staff developed in order to manage the tensions associated with the social organisation of hospital work, meant that non-negotiated informal boundary-blurring was a taken-for-granted feature of normal nursing practice” (p. 516). Doing the job needs to take place in an environment created by the people in it: that is, the organisation’s cultures. Therefore, NOP lacks contextual elements that would suggest that jobs get done contextually. But in fact, in this thesis, the researcher has demonstrated the “way we do things around here” is largely dependent on informal inter/intra professional relationships.

Therefore, the researcher argues that the proponents of these informal professional relationships are predominantly nurses who act as the conduits between the other stakeholder groups in the hospital. Whereas Glouberman and Mintzberg suggest that there are four worlds in a hospital, the researcher proposes that there are three worlds, including care, cure, and control. Each of the worlds has their own distinct
identity and subcultures, which enforces boundaries between the groups. However, whilst the boundaries between two of the worlds is thick (i.e. cure and control), the cure world acts as buffer between the conflicting worlds. These propositions are modelled in Figure 8.5 below.

![Figure 8.5: A Model of for Stakeholder Interactions in Hospitals](image)

### 8.8 Stakeholder Interactions

Figure 8.5 depicts the various stakeholders involved in decisions about patient flow and bed allocation. The decision making process about bed allocation is complex because of the involvement of such diverse stakeholder groups. Different paradigms shape the way that groups approach the issue of bed allocation, and the diverse
expectations further complicate the process. Moreover, the environment and
government pressures also impact bed decisions due constraints of funding and
community expectations. The researcher found that the complicated process of
resource allocation is made somewhat clearer by studying the role of nurses in the
patient flow process. Although there are other stakeholders who may have more
formal power, such as managers, nurses have an intermediary role which allows
them to facilitate the resource allocation process between diverse stakeholder
groups.

The Mitchell et al. (1997) stakeholder model was employed in part of the survey
questionnaire analysis to classify the stakeholder groups according to power,
legitimacy and urgency. Power is the ability to influence decisions, legitimacy is the
authority to influence decisions, and urgency is about how essential it is for a
decision to be made. According to Mitchell et al. (1997) researchers can use the
model to identify and classify stakeholders with the most saliency, or the priority
given to stakeholders by management. From the analysis conducted in Chapters
Five and Six, managers and doctors would usually be given the highest priority in
relation to decisions made about bed allocation, based upon formal authority.

However, the Mitchell et al. (1997) stakeholder model does not take into account
personal and informal relationships or the magnitude (thickness) of relationships
when making decisions about saliency. The researcher found that the relationships
and networks developed by stakeholder groups influenced the decision making
process about bed allocation. Therefore, it can be concluded that the Mitchell et al.
(1997) model is lacking a fourth dimension, relationships, that could be considered
the glue that holds together the other three factors for determining stakeholder saliency. Decisions about bed allocation, and subsequently steady patient flow, are not made simply according to formal rules and procedures, or formal roles that stakeholders hold. Instead, patient flow is affected (either positively or negatively) by the relationships that diverse stakeholder groups have within the groups and with other groups.

By taking into account the informal intermediary role of nurses, it is evident that a group with little or no authority or formal power can influence the way that decisions are made. Due to the nature of the nurses’ role, they are involved in patient flow from the point of triage until the point of patient departure from the hospital. Therefore, the presence of nurses during the patient flow process enables them to interact with diverse stakeholder groups. Moreover, the finding that nurses form networks and friendships for unspecified future purposes, makes their role significant compared to doctors and managers who tend to form alliances for specific purposes.

There are several implications for researchers and managers from the findings detailed in this chapter. Theses implications are detailed below.

8.9 Contributions and Implications

This research has added to stakeholder theory by its demonstration of the gap in current theory, and has addressed this by adding the concept of magnitude to the application of Mitchell et al.’s (1997) stakeholder theory in organisation studies.
In order to gain a better understanding of who really matters in relation to patient flow in Mitchell et al. (1997) stakeholder theory, it is useful to understand how decisions are made within a health organisation. The three factors proposed by Mitchell et al.: power, legitimacy and urgency help researchers to identify who are the definitive, or the most salient, decision makers in a hospital. However, this research has found that there is an important element missing from the stakeholder model. That element is the magnitude or strength of relationship between people within the organisation. The researcher discussed the alliances and networks that various stakeholders form to promote the flow of patients from the emergency department to wards. These alliances and networks are based upon relationships between various professional and functional groups. However, these relationships are not taken into account in the Mitchell et al. Stakeholder model.

Further, this research has added to social capital theory by acknowledging that social capital can be used as a way of facilitating patient flow through hospitals. Using the concept of homophily, the researcher argues that these similarities can assist in common understandings between like minded groups to improve the flow of patients through the hospital. Conversely, the inherent differences between individuals and groups can be bridged by using ambiguous points of similarities through conduit groups, such as nurses who have the ability to bridge gaps.

This research has added to organisational culture theory by identifying that there are environments that are more integrated, such as smaller hospitals, and environments that are more differentiated and ambiguous, such as larger hospitals. Given these differences in organisational culture, it is clear that who and what really matters when
making decisions about resource allocation varies depending on the size of the organisation in question.

There are two distinct implications arising from this research. The first is the importance of the management of key individuals for the organisation’s culture. A proposition of the research is that the decision makers who really matter appear to display similar characteristics, or “deep smarts” as proposed by Leonard and Swap (2005). People with deep smart attributes have highly developed characteristics including the ability to network, systems think, and heuristics based on experience to come to a judgement. The skills that these deep smart people have allow them to build networks and alliances with the right people to promote the flow of patients. Therefore, managers should identify these deep smart people and take care to nurture them.

The second implication is the management of the climate in organisations. The organisation’s culture in these hospitals heavily influences who and what really matters when making health services management decisions. In smaller hospitals, the organisation’s culture is more integrated, whereas in larger hospitals, the culture is more fragmented with less discernible patterns of similarity between and within stakeholder groups. In smaller hospitals, there is less of a need for alliance building, as the environment does not allow for obvious factions. However, in a larger hospital, alliances and networks are increasingly important for patient flow, particularly when the formal rules and procedures are cumbersome and time consuming. Having a good relationship with different stakeholder groups allows for boundary crossing
between factions within the hospital and the Area Health Service to which the hospital belongs.

### 8.10 Future Research

Having good relationships with different groups, particularly in a larger hospital, means there are points of commonality that facilitate the flow of patients from the emergency department to ward beds. However, it would be beneficial for more hospitals to be included in the study to determine if the assertion is correct that good relations help expedite patient flow.

Further, there is limited research about stakeholder theory in hospitals. Much of the research about stakeholder theory and hospitals is in relation to marketing and consumerism. Therefore, an area for future research could be about stakeholder theory and other hospital related issues such as patient flow, human relations, or funding. Additionally, the implications of role theory and social capital for patient flow may be further examined as areas for future research.

A further area of research would be to investigate what it is that attracts workers to the care world that suits them to facilitate in the intermediary role.

### 8.11 Conclusions

The aim of the research was to understand occupational and professional dynamics when managing patient flow from an organisational culture perspective. In particular, the researcher attempted to distinguish who really matters when making decisions
about bed allocation. The researcher argued for the need to look at informal attributes to distinguish how powerful a stakeholder claim can be considered, particularly when stakeholders are affiliated with diverse subcultures and professional groups. Using a multi perspective methodology, the researcher was able to speak to various stakeholders and gain an understanding of the overall culture as well as subcultures of the hospitals examined.

Construction of the theoretical framework revealed some gaps. One of these gaps was the use of informal practices, including networks, to influence the way that decisions are made about resource allocation. Another gap was the use of social capital to influence the flow of patients through hospitals. A further gap was identified as being the way that different stakeholder groups used different tactics to influence decision making.

The question posed at the beginning of the research was “how does informal social networking interact with decision making about resources and how can this be explained from an organisational culture perspective?” The following sub questions were devised to answer the question.

1) How can the organisational culture be described in a:
   a. small hospital
   b. medium hospital
   c. large hospital

There was little variation in the way that respondents from the small hospital answered. This may indicate that in this small hospital, there is a high level of
integration between professional groups. The same can be said for the medium hospital. However, in the larger hospital, more differences emerged between respondents. These differences would indicate that there is greater fragmentation in the larger hospital.

2) Do subcultures exist within these hospitals, and if so, how can they be differentiated?

Table 8.1 summaries the subcultural differences between doctors, nurses, and managers, according to the analysis from the survey questionnaire, supported by the qualitative interviews.

Table 8.1: Subcultural Differences Between Doctors, Managers, and Nurses

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Nurses</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmentally Consciousness</td>
<td>Environmental Consciousness</td>
<td>Environmental Consciousness</td>
</tr>
<tr>
<td>• work is generally of an autonomous nature with minimal cooperation</td>
<td>• prefer friendly, co-operative co-workers</td>
<td>• prefer friendly, co-operative co-workers</td>
</tr>
<tr>
<td>Extrinsically Motivated</td>
<td>Intrinsically Motivated</td>
<td>Extrinsically Motivated</td>
</tr>
<tr>
<td>• income conscious</td>
<td>• not income conscious</td>
<td>• job security conscious</td>
</tr>
<tr>
<td>Independent</td>
<td>Interdependent</td>
<td>Both Interdependent and Interdependent</td>
</tr>
<tr>
<td>• prefer the freedom to use their own approach</td>
<td>• work together to deliver patient care</td>
<td>• work together to deliver patient care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• lead groups of people</td>
</tr>
</tbody>
</table>

3) (i) How are alliances created and boundaries crossed between stakeholders from different organisational cultural backgrounds?

The clinical and containment coalitions suggested by Glouberman and Mintzberg (2001) provide a basis for the researcher to explain the findings in relation to the
creation of alliances between stakeholder groups. For example, doctors form alliances with other doctors for specific purposes, such as expediting the flow of patients from the emergency department into a ward bed. Nurses form networks with both doctors and managers, by nurturing relationships and friendships with both stakeholder groups. Furthermore, the networks also provide a basis for an explanation about the boundary crossing between stakeholder groups. Specifically, the researcher found that nurses have become conduits or intermediaries between other stakeholder groups, such as doctors and managers.

(ii) How do stakeholders with diverse subcultures make decisions about resource allocation?

Whilst there is formal authority given to managers to make decisions about patient flow, the above analysis has shown that formal authority is no guarantee that decisions will be made according to hierarchical divisions of labour. Even though doctors have clinical authority to make decisions about admission, and managers have hierarchical authority to makes decisions about resources, it is often the nurse stakeholders providing care who actually determine patient flow through their use of informal networks.

4) Does the magnitude/thickness of the stakeholder-managerial relationship influence whatever decision is going to be made, and if so how?

The Mitchell et al. stakeholder model does not take into account personal and informal relationships or magnitude (thickness) of relationships when making decisions about saliency. The researcher found that the relationships and networks developed by stakeholder groups influenced the decision making process about bed
allocation. Therefore, it can be concluded that the Mitchell et al. model is lacking a fourth dimension, relationships, that could be considered the glue that holds together the other three factors for determining stakeholder saliency. Decisions about bed allocation, and subsequently steady patient flow, are not made simply according to formal rules and procedures, or formal roles that stakeholders hold. Instead, patient flow is affected (either positively or negatively) by the relationships that diverse stakeholder groups have within the groups and with other groups.

The researcher found that there were practical implications for these findings. She found that magnitude or strength of relationship is a fourth attribute that should be considered when using Mitchell et al’s (1997) stakeholder theory to determine who matters when making decisions about resource allocation. In addition, it was found that managers should identify and nurture those people with “deep smarts” characteristics in hospitals. Further, building and maintaining good relationships with various stakeholders assists managers with boundary crossing within hospitals and Area Health Services.

In an effort to ensure employee performance, those charged with ensuring patient flow in the emergency department, draw on their individual informal networking capabilities and usually display deep smart characteristics. Hospital managers and administrators would do well to recognise, support and encourage mutli-cultures that welcome opportunities for social interactions. Improved interprofessional and cross functional dynamics will build organisational social capital through formal and informal social networking. Improved performance has positive effects on hospital patient flow and assists with combating access block.
The prologue of this dissertation is one example that illustrates the main finding of this thesis: When making decisions, the most salient stakeholder is not who has the formal authority to order an activity. Rather, the organisational actors who are employed to carry out the action, matter most.
References


Buchan, J. (2002). Global nursing shortages are often a symptom of wider health system or societal ailments. British Medical Journal, 324(7340), 751-752.


Thomas (Eds.), *Managing Ambiguity and Change* (pp. 93-125). New York: John Wiley & Sons.


### Appendix 1 - Peer Group Definitions

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 Principal Referral</td>
<td>Acute hospitals, treating 25,000 or more acute casemix weighted separations* per annum.</td>
</tr>
<tr>
<td>A2 Paediatric Specialist</td>
<td>Establishments where the primary role is to provide specialist acute care services for children.</td>
</tr>
<tr>
<td>A3 Ungrouped Acute</td>
<td>Establishments whose primary role is the provision of acute services of a specialised nature for which there is insufficient peers to form additional peer groups. Limited comparisons can be made with other hospitals in either A1 or A2.</td>
</tr>
<tr>
<td>B1 Major Metropolitan</td>
<td>Acute hospitals, treating 10,000 or more, but less than 25,000 acute casemix weighted separations* per annum.</td>
</tr>
<tr>
<td>B2 Major Non-Metropolitan</td>
<td>Establishments located in rural areas providing acute specialist and referral services for a catchment population from a large geographical area.</td>
</tr>
<tr>
<td>C1 District Group 1</td>
<td>Acute hospitals, treating 5,000 or more, but less than 10,000 acute casemix weighted separations* per annum.</td>
</tr>
<tr>
<td>C2 District Group 2</td>
<td>Acute hospitals, treating 2,000 or more, but less than 5,000 acute casemix weighted separations* per annum, plus acute hospitals treating less than 2,000 acute casemix weighted separations per annum but with more than 2,000 separations* per annum.</td>
</tr>
<tr>
<td>D1 Community Acute</td>
<td>Acute hospitals, treating less than 2,000 acute casemix weighted separations* per annum, and less than 2,000 acute separations* per annum, and with less than 40% non-acute and outlier bed days* of total bed days.</td>
</tr>
<tr>
<td>D2 Community Non-Acute</td>
<td>Hospitals, treating less than 2,000 acute casemix weighted separations* per annum, and less than 2,000 acute separations* per annum, and with more than 40% (or more) non-acute and outlier bed days* of total bed days.</td>
</tr>
<tr>
<td>F1 Psychiatric</td>
<td>Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental or behavioural disorders. Centres of non-acute treatment of drug dependence, developmental and intellectual disability are not included here. This group also excludes institutions mainly providing living quarters or day care.</td>
</tr>
<tr>
<td>F2 Nursing Homes</td>
<td>Establishments which provide long-term care involving regular base nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and / or licensed by the State, or controlled by government departments.</td>
</tr>
<tr>
<td>Multi-Purpose Services</td>
<td>Multi-Purpose Services (MPSs) which provide integrated acute health, nursing home, hostel, community health and aged care services under one organisational structure, as agreed between the Commonwealth and State Governments. MPSs provide a range of services which are negotiated with the community, the service providers and the relevant Departments. This group is further split into current and future MPSs.</td>
</tr>
<tr>
<td>F3 Current Future</td>
<td></td>
</tr>
<tr>
<td>F4 Future</td>
<td></td>
</tr>
<tr>
<td>F5 Hospices</td>
<td>Establishments with a specific function of providing palliative care to terminally ill patients</td>
</tr>
<tr>
<td>F6 Rehabilitation</td>
<td>Establishments with a primary role in providing services to persons with an impairment, disability or handicap where the primary goal is improvement in functional status.</td>
</tr>
<tr>
<td>F7 Mothercraft</td>
<td>Establishments where the primary role is to help mothers acquire mothercraft skills in an inpatient setting.</td>
</tr>
<tr>
<td>F8 Ungrouped Non-Acute</td>
<td>Establishments whose primary role is the provision of non-acute services, but for which there are insufficient peers to form an addition peer group. Limited comparisons can be made within this peer group and with other non-acute facilities.</td>
</tr>
</tbody>
</table>

* - Please refer to Figure 1 for inclusions and exclusions in calculating the figures used to determine the peer groups.

## Appendix 2 - Survey Questionnaire

**Section A: Organisational Assessment**

I am interested in the feelings and beliefs you hold about this organisation

Please **write** the number that best describes your feelings and beliefs about this organisation

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Disagree</strong></td>
<td><strong>Disagree</strong></td>
<td><strong>Slightly Disagree</strong></td>
<td><strong>Neutral</strong></td>
<td><strong>Slightly Agree</strong></td>
<td><strong>Agree</strong></td>
<td><strong>Strongly Agree</strong></td>
</tr>
</tbody>
</table>

I tell my friends this organisation is a great organisation to work for

If the values of this organisation were any different than what they are, I would not want to be attached to this organisation

Since working for this organisation, my personal values and those of the organisation have become more similar

My private views about this organisation are different to those I express publicly

The reason I prefer this organisation to other organisations' because of what it stands for, its values

I feel a sense of “ownership” for this organisation

Staying with this organisation is a matter of necessity

What the organisation stands for is important to me

Leaving the organisation at this time would disrupt my life too much

**Comments:**

I am interested in the organisational /managerial characteristics that **you** believe this organisation exhibits.

Please **write** the number that best describes your beliefs about organisational and managerial characteristics at this organisation

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Disagree</strong></td>
<td><strong>Disagree</strong></td>
<td><strong>Slightly Disagree</strong></td>
<td><strong>Neutral</strong></td>
<td><strong>Slightly Agree</strong></td>
<td><strong>Agree</strong></td>
<td><strong>Strongly Agree</strong></td>
</tr>
</tbody>
</table>

At this organisation, managers treat staff as their equals

At this organisation, managers include staff in decision-making processes

At this organisation, individual staff are given little freedom about determining their own activities

At this organisation, being part of an organisation that values and encourages personal achievement, brings people together

At this organisation, people are expected to support their managers and the members of their immediate work group when disputes arise

**Comments:**
<table>
<thead>
<tr>
<th>1</th>
<th>Strongly Disagree</th>
<th>2</th>
<th>Disagree</th>
<th>3</th>
<th>Slightly Disagree</th>
<th>4</th>
<th>Neutral</th>
<th>5</th>
<th>Slightly Agree</th>
<th>6</th>
<th>Agree</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please write</strong> the number that best describes your feelings and beliefs about this organisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Managers focus on ensuring that staff comply with the organisation’s requirements

At this organisation, most staff, including the managers, have little choice over how they do their jobs

At this organisation, managers are expected to develop their staff into strong work teams

At this organisation, managers control their work teams in a decentralised way

Managers focus on encouraging staff to meet organisational goals and objectives and helping them be productive

At this organisation, staff support the organisation’s overall mission (purpose)

At this organisation, people value getting on with one another

Competition between people is encouraged in order to increase performance

At this organisation, people tend to rely on rules and policies for resolving dispute

At this organisation, people share the view that rules have to be followed whether they personally like them or not

At this organisation, people put a strong emphasis on getting on with one another

At this organisation, people put a strong emphasis on resolving disputes in ways that preserve their relationships

Managers focus on developing a sense of loyalty and group spirit amongst staff

At this organisation, people feel a sense of belonging and loyalty to their particular work group

At this organisation, people are allowed a fair degree of freedom in deciding how they can meet goals and objectives

Comments:
I am interested in your opinion of this organisation’s goals

Please rank the statements below from 1 to 8. Place number “1” next to the most important, number “2” next to the next most important and so on through to number “8” for the statement least important

Do not use the rank more than once.

In rank order, I believe the goals that are currently pursued in this organisation are:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal access for all patients</td>
<td></td>
</tr>
<tr>
<td>Financial viability</td>
<td></td>
</tr>
<tr>
<td>Improved productivity</td>
<td></td>
</tr>
<tr>
<td>Organisational stability</td>
<td></td>
</tr>
<tr>
<td>Reputation for service innovation and industry leadership</td>
<td></td>
</tr>
<tr>
<td>Service quality</td>
<td></td>
</tr>
<tr>
<td>Staff welfare</td>
<td></td>
</tr>
<tr>
<td>Teaching and Research reputation</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Section B: Material Resource Allocation

I am interested in your views about material resource allocation.

Please indicate the extent to which you agree or disagree with the statement listed below, by writing the response on the scale provided which most closely corresponds with your view.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Resource allocation to individual patients should be based solely on their needs, as determined by managers immediately involved

Resources should not be allocated to a new clinical procedure until its efficacy has been demonstrated through clinical trials

In today’s economic climate, cost and efficiency concerns have to take precedence over concerns about equity and access

Medical and surgical interventions should be open to economic assessment

Resource issues have no place in clinical decision making

Continually increasing the financial accountability of clinicians will cause them to compromise their responsibilities to patients

Comments:
Section C: Interactions with Various Occupational Groups

I am interested in your opinions about interactions with members of different occupational groups.

*Using the following descriptions, please circle the number in the boxes following each statement, that corresponds most closely to your observations:*

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Slightly Disagree</th>
<th>4 Neutral</th>
<th>5 Slightly Agree</th>
<th>6 Agree</th>
<th>7 Strongly Agree</th>
</tr>
</thead>
</table>

For each of the occupational groups, answer the following questions based on your interactions with members of the occupational groups

<table>
<thead>
<tr>
<th>Administrators/ Organisational Managers</th>
<th>Doctors</th>
<th>Nurses</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When making decisions about material resources, generally this occupational group exhibits <strong>urgency</strong> (definition: are active in pursuing claims—demands or desires—which it feels are important; where a delay on our part in addressing concerns are deemed unacceptable)</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Employees of this occupational have more influence on their superiors than they think they do</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>When making decisions about allocating material resources, generally the claims of this particular occupational group are viewed by managers as <strong>legitimate</strong> (definition: proper or appropriate)</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Generally, this occupational group has the ability to apply a high level of direct economic reward or punishment [money, goods, services, etc.]</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Generally, this occupational group has the ability to apply coercive force when making decisions</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>In this organisation, employees of this occupational group can influence decisions about material resources</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

Comments:
<table>
<thead>
<tr>
<th></th>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Slightly Disagree</th>
<th>4 Neutral</th>
<th>5 Slightly Agree</th>
<th>6 Agree</th>
<th>7 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally, this occupational group uses its social influence [on reputation, prestige, etc., through media, etc.] to obtain its will</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>This occupational group has input when making decisions about material resources</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>When making decisions about material resources, generally this occupational group receives high priority from our management team</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>When making decisions about material resources, employees of this occupational group actively influence their superiors</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Generally, this occupational group uses access to formal processes to obtain its will [legal, professional association etc.]</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Generally, I interact with members of this occupational group on a professional level only</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Generally, I interact with members of this occupational group socially [outside of work hours]</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Generally, I choose to share my work breaks with members of this occupational group</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Section D: Work Values

There are two parts to this question. Please answer both parts.

I am interested in what is important to you in choosing a job.

Part 1: In the spaces provided, rank the factors listed below from 1 – 10 in terms of the importance to you in choosing a job.

In completing the question, try to think of those factors, which would be important to you in an ideal job; disregard the extent to which they are contained in your present job.

Place the numeral “1” next to the factor which is most important to you. Then place the numeral “2” next to the factor that is next most important to you and so on, through to numeral “10”, for the factor that is least important to you.

Do not use the same rank more than once.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>A career structure</td>
<td></td>
</tr>
<tr>
<td>A good income level</td>
<td></td>
</tr>
<tr>
<td>A good working relationship with a supportive superior</td>
<td></td>
</tr>
<tr>
<td>Challenge</td>
<td></td>
</tr>
<tr>
<td>Freedom to use my own approach (autonomy)</td>
<td></td>
</tr>
<tr>
<td>Friendly, co-operative co-workers</td>
<td></td>
</tr>
<tr>
<td>Job security</td>
<td></td>
</tr>
<tr>
<td>Opportunities for further professional development</td>
<td></td>
</tr>
<tr>
<td>Status and recognition</td>
<td></td>
</tr>
<tr>
<td>Work that gives me a sense of personal achievement</td>
<td></td>
</tr>
</tbody>
</table>

Part 2: The following statements are concerned with general beliefs that people hold about work and social relationships.

For each of the items listed below, indicate the extent to which you ‘agree’ or ‘disagree’ by writing the most appropriate response of the scale provided.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Slightly Disagree</th>
<th>4 Neutral</th>
<th>5 Slightly Agree</th>
<th>6 Agree</th>
<th>7 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>To get ahead at work you should never disagree with your superiors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In one’s work, actions involving risk or chance should be avoided</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is best not to break organisational rules even when you think it may be in the organisation’s best interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The most effective manager is one who makes it clear who is the boss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is right for people in positions of power to have some privileges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important that everyone strives to be independent in their personal and social lives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be it at work or in the family, everyone should show respect to their authority figures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ones work and private life should never mix</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisions made by individuals are better than decisions made by groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Section E: Personal Details

I would like to know a few of your personal details. I will use this information when I analyse your responses.

Title of current position: ________________________________

Please indicate the response which most clearly describes you and your work situation by ticking the appropriate box

Gender:  □ Male  □ Female

Age: ____________________

Principal area of practice:  □ Patient care  □ Administration/Management  □ Education  □ Other __________________________

(you may tick more than one)

Percentage of time spent on:

Patient care __________%  Administration/Management __________%  Education __________%  Other __________%

Terms of employment:  □ Full-time salaried staff  □ Part-time salaried staff  □ Visiting medical officer  □ Joint appointment with university  □ Other (please specify) __________________________

Length of employment with current organisation __________________________

Highest educational qualification in management  □ None  □ Short Course  □ Certificate  □ Diploma  □ Undergraduate Degree  □ Postgraduate Diploma  □ Postgraduate Degree
Are there any other comments you would like to make about decision making about material resource allocation at this organisation?

Are there any other comments you would like to make about the social interactions between employees at this organisation?
Are there any other comments you would like to make about the group interactions between employees at this organisation?

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Appendix 3 - Semi structured interview questions

1) How long have you worked here

2) Tell me about your role at this hospital

3) How long have you worked in this role

4) Can you tell about the formal procedures/policies you are supposed to go through when trying to allocate space to patients that require admission to a hospital bed into the wards?
   4.1) Are there ever any occasions when these formal procedures can’t be followed?
   4.2) Why?
   4.3) What happens?
   4.4) Example?

5) How do YOU actually go about getting bed space for patients that require bed allocation?

6) How do OTHERS go about getting bed space for patient’s that require bed space?
   6.1) Do they generally follow the formal procedures? Or do they follow informal procedures?

7) Do different groups go about getting bed space differently? If yes which groups and how?
   7.1) Does this create any issues for working together between the groups?
   7.2) Or does it facilitate the allocation of resources?

8) Do you think there are other ways of getting bed space allocated than the formal avenues? Do you think others use these? Can you give me an example?

9) In many organisations alongside the formal rules/procedures, a lot of decision making gets done by rules of thumb or Heuristics – does this happen here in decision making about who gets bed space? Could you give me some examples?

10) If you could draw a picture, or give me a word or a metaphor to describe this hospital, what would it be?

11) I just wanted to first start off by asking you if you could tell me a bit about your role and how long you’ve been working here?

12) What are the processes that you have to go through, in order to get a patient admitted to a Ward in the ED?

13) So on average, how long would it take to get a patient from the ED into one of the wards

14) Just in terms of what your role was with patient flow, and how long it takes.

15) And you mention that there’s a lot of negotiating when you’re trying to get these patients out. What’s your role?

16) And do you ever have to – as a Nurse Manager – ever have to kind of step in and… Let’s say if there’s an issue with the patient flow or bed allocation?
17) So have you seen other people, when they’re trying to get beds allocated to the patients, have you seen them perhaps go about it in a different way, other than the formal policy, or try to?

18) And that relationship that you’ve got to have, because obviously, you try to get them out of the ED, make room… How do you facilitate that?

19) And how do you develop them then? RELATIONSHIPS

20) So given that it’s much harder to make these networks in the larger hospitals, do you think that there is more of a need for them in the larger ones than the smaller ones?

21) And do you think that these networks that are harder to establish, but you need to establish them more, do you think they’re stronger in the larger hospitals?

22) So you would turn around in your role and kind of say to the director—?

23) So I’m hearing that there’s a lot of kind of informal chat, even though there are the formal rules.

24) If you had to say, about the informal stuff that you had to rely on, compared to the formalities, what percentage would you give for the kind of informal chat that goes on?

25) And do you think it’s important, as a Nurse Manager, to then have that strong relationship with the doctors as well?

26) So would you ever go out, as a group of nurses, with the doctors, or with the administration staff?

27) So, do you think it’s then harder or easier, having people from different professions? Or was it easier before, when you had the nurses who knew the pressures?

28) And as a Nurse Manager, do you find that you have to have a good relationship with the other Nurse Managers of the Departments?

29) Okay. And they’re really, from what I gathered with other CNC roles that I’ve seen, they’re kind of in-between the doctor and nurse role?

30) So how do you then kind of keep those relationships going with those Nurse Managers and not get them offside?

31) If you had to paint a picture, or use a word or a metaphor to describe the organisational culture of this hospital?

32) So then, what would be the vibe in the Emergency Department? Or the feeling? Like, if you had to walk in the Emergency Department as an observer, and you were looking around and saying, “This is the best way to describe the place…”
Appendix 4 Participant Information Letter

RELEVANT AREA
HEALTH SERVICE
LETTERHEAD

Project No:

PARTICIPANT INFORMATION STATEMENT

Title of project: An Exploratory Study of Decision Making Dynamics in the Health System

Subject selection and purpose of study
This organisational cultural study investigates patterns of interactions between individuals and occupational groups when making decisions about material resources. I am particularly interested in manager-stakeholder relationships and influence on decision-making.

You have been invited to enter the study because you are staff member of RELEVANT HOSPITAL.

This study is conducted to meet the requirements for the Doctor of Philosophy degree under the supervision of Dr Anneke Fitzgerald of the School of Management at the University of Western Sydney, Australia.

Description of study
This is a mixed methods study, collecting data via survey questionnaire, as well as field observations and interview. I am seeking your participation by completing the questionnaire and returning it within one week by placing it in the prepaid addressed A5 sized envelope.

The questionnaire will take approximately 20-30 minutes to complete.

We cannot and do not guarantee or promise that you will receive any benefits from this study, however, understanding interactions between managers and stakeholders when making decisions may have managerial and strategic implications. In addition, this study will further our knowledge on the effects of inter-occupational and social networks.

Confidentiality and disclosure of information
Any information that is obtained will be de-identified so your personal details are removed from any raw data and you cannot be identified in any results. No identifying information will be given to any third party.

Financial Costs
Apart from your time, there are no costs associated with participation in this research. You will not receive any payment for participation in this study.
PARTICIPANT INFORMATION STATEMENT (continued)

Title of project: An Exploratory Study of Decision Making Dynamics in the Health System

Your consent
Your decision whether or not to participate will not affect your relationship with THE RELEVANT AREA HEALTH SERVICE or any other institution cooperating in this study. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without prejudice. The data collected as a result of your participation can be returned to you or destroyed at your request.

At any time during the research, you may contact Kathy Eljiz for further information as per below details. If you have any concerns regarding the conduct of research, please contact either Kathy Eljiz or your department manager.

Alternatively, complaints may be directed to the RELEVANT AREA HEALTH SERVICE CONTACT DETAILS

In the unlikely event you experience any undue stress as a result of participating in this research, the usual counselling services are available to you. We suggest you either contact the staff counsellor on phone (), or turn to any community helpline, such as Lifeline on 13 11 14.

You are making a decision whether or not to participate. Having read the information provided above, the return of the completed survey questionnaire implies your consent for participation with that part of the research.

Yours sincerely,

Kathy Eljiz
PhD Candidate
0414 885 793
(02) 4620 3281
ka.eljiz@uws.edu.au

This study has been approved by the University of Western Sydney (UWS) Human Ethics Committee (HREC No: 07/056) and the RELEVANT AREA HEALTH SERVICE COMMITTEE (Project No: ). If you have any complaints or reservations about the ethical conduct of this research, you may contact the UWS Ethics Committee through the Human Ethics Officer (tel: 02 4570 1136) or the RELEVANT AREA HEALTH SERVICE COMMITTEE (tel:). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Page 2 of 2
Version 1 June/July 2007
Appendix 5 - Consent Form

Locked Bag 1797
Penrith South DC NSW 1797 Australia

CONSENT FORM

Title of project: An Exploratory Study of Decision Making Dynamics in the Health System.

1. I, ..............................................................of .........................................................., aged ......................................years, agree to participate as a subject in the study described in the subject information statement attached to this form.

2. I acknowledge that I have read the Subject Information Statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

4. My decision whether or not to participate will not prejudice my present or future employment or my relationship with Sydney South West Area Health Service or any other institution cooperating in this study. If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact the investigator, Kathy Eljiz on 0414 885 793, who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics Secretariat RELEVANT AREA HEALTH SERVICE DETAILS

Signature of subject ......................................... Signature of witness .................................
Please PRINT name ........................................ Please PRINT name ...................................
Date ................................................... Date ...................................................

Signature(s) of investigator(s) ..............................................................
Please PRINT Name ..........................................................................
Date: ..............................................................................................

This study has been approved by the University of Western Sydney (UWS) Human Ethics Committee (HREC No: 07/056) and the RELEVANT AREA HEALTH SERVICE COMMITTEE (Project No:). If you have any complaints or reservations about the ethical conduct of this research, you may contact the UWS Ethics Committee through the Human Ethics Officer (tel: 02 4570 1136) or the RELEVANT AREA HEALTH SERVICE COMMITTEE (tel:). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 6 - Themes and Concepts for the Data Categorisation

Nodes

People
- patient (1)
- staff (person) (2)
- the nurse (3)
- the doctor (4)
- the manager (5)
- the clinicians (6)

Work
- Job (7)

Role
- clinical (8)
- management (9)

Place
- ED (10)
- Ward (11)
- Other Hospital (12)

Care (13)

Culture (14)

Stakeholder Theory
- Power (15)
- Urgency (16)
- Legitimacy (17)

Influence
- Level (18)

Resource (decision making)
- Material (19)
- HR (20)

Alliance (21)

Characteristics of Deep Smarts
- skills and know-how (22)
- systems thinking (23)
- separation of signal from noise (24)
- swift, wise decision-making (25)
- ability to take context into account (26)
- networks (27)
- pattern recognition (28)
- ability to deal with novelty (29)
- enthusiasm/passion for the knowledge domain (30)

**Dominance** (31)

**Other** (32)
# Appendix 7 - Small Hospital Tests

## Professional Groups Analysis – Small Hospital

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Questions from Survey questionnaire</th>
<th>Reliability (Cronbach’s alpha)</th>
<th>Homogeneity</th>
<th>ANOVA</th>
<th>All Respondents Variances</th>
<th>Professional Group Differences</th>
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## Appendix 8 - Medium Hospital Tests

### Professional Groups Analysis – Medium Hospital

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*Doctors rank hospital as (M, E, L, C least to most) Nurses and Others rank hospital as (C, M, L, E least to most) Financial Viability difference between nurses (3.03) and doctors (5.83) Reputation for Service Innovation and Industry Leadership difference between nurses (3.97) and others (5.55)*
## Appendix 9 - Large Hospital Tests

### Professional Groups Analysis – Large Hospital Tests

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<td></td>
<td>development</td>
<td>7. Freedom to use my own</td>
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<td></td>
<td>8. Challenge</td>
<td>approach (autonomy)</td>
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<td></td>
<td>10. Status and recognition</td>
<td>9. A career structure</td>
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<td></td>
<td>10. Status and recognition</td>
</tr>
</tbody>
</table>
## Appendix 10 - Overall Hospital Tests

<table>
<thead>
<tr>
<th>Professional Group (Doctors, Nurses, Others) Differences (All Hospitals)</th>
<th>Functional Group (Clinicians, and Managers) Differences (All Hospitals)</th>
<th>Small Hospital</th>
<th>Professional Group Differences (Doctors, Nurses, Others) Medium Hospital</th>
<th>Large Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of Organisational Commitment</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td>No significant differences</td>
</tr>
<tr>
<td>Perceptions of Work Characteristics</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td><strong>Doctors</strong> rank hospital as (M, L, E, C least to most) <strong>Nurses</strong> rank hospital as (C, M, L, E least to most) <strong>Others</strong> rank hospital as (L, C, M, E least to most)</td>
<td>No significant differences</td>
</tr>
<tr>
<td>Perceptions of Currently Pursued Organisational Goals</td>
<td>No significant differences</td>
<td>No significant differences</td>
<td><strong>Nurses</strong> ranked “Financial Viability” more highly than <strong>Doctors</strong> <strong>Nurses</strong> ranked “Reputation for Service Innovation and Industry Leadership” more highly than <strong>Others</strong></td>
<td>No significant differences</td>
</tr>
<tr>
<td>Perceptions of Orientations to Work Values when Choosing a Job</td>
<td><strong>Doctors</strong> ranked “a good income level” as highest and “freedom to use my own approach” as third highest <strong>Nurses</strong> ranked “friendly co-operative co-workers” as second highest. Also ranked “A good working relationship with a supportive supervisor” as important <strong>Others</strong> ranked “job security” as second highest</td>
<td><strong>Managers</strong> ranked “Freedom to use my own approach” more highly than <strong>Clinicians</strong></td>
<td><strong>Doctors</strong> ranked “Freedom to use my own approach” more highly than <strong>Nurses</strong> and <strong>Others</strong></td>
<td><strong>Doctors</strong> ranked “A good income level” more highly than <strong>Nurses</strong> <strong>Others</strong> ranked “A good working relationship with a supportive superior” more highly than <strong>Doctors</strong></td>
</tr>
<tr>
<td>Interactions with Various Professional Constituencies</td>
<td><strong>Admin/Managers Stakeholder Group</strong> Nurses believe this stakeholder group exhibits <strong>urgency</strong> more strongly than doctors</td>
<td><strong>Admin/Managers Stakeholder Group</strong></td>
<td><strong>Admin/Managers Stakeholder Group</strong></td>
<td><strong>Admin/Managers Stakeholder Group</strong> Nurses believe this stakeholder group exhibits <strong>legitimacy</strong> more strongly than <strong>doctors</strong></td>
</tr>
<tr>
<td>Doctor Stakeholder Group</td>
<td>No significant differences</td>
<td><strong>Doctor Stakeholder Group Managers</strong> believe this stakeholder group exhibits <strong>urgency</strong> more strongly than <strong>clinicians</strong> <strong>Managers</strong> believe this stakeholder group exhibits <strong>legitimacy</strong> more strongly than <strong>clinicians</strong></td>
<td><strong>Doctor Stakeholder Group</strong></td>
<td><strong>Doctor Stakeholder Group</strong></td>
</tr>
<tr>
<td>Nurses Stakeholder Group</td>
<td>No significant differences</td>
<td><strong>Nurses Stakeholder Group</strong></td>
<td><strong>Nurses Stakeholder Group</strong></td>
<td><strong>Nurses Stakeholder Group</strong> Doctors and Others believe this stakeholder group exhibits <strong>power</strong> more strongly than nurses</td>
</tr>
</tbody>
</table>

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