Using Evidence to Solve Organizational Problems in Hospitals:

A Case Study of Fast Track

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Acknowledgment: Funding for this project was provided over four years (2009 to 2012) under an Australian Research Council Linkage Project grant, LP0989662.
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ABSTRACT: We explore how physician managers, who have been trained in evidence-based medicine, incorporate evidence into their decision processes when responding to organizational problems. Our empirical case study focuses on a Fast Track Unit in the Emergency Department of an Australian public hospital. Our findings reveal a six-stage process of evidence-based decision making: (1) problem recognition and assigning a mandate; (2) assembling literature and internal evidence; (3) cross-pollinating evidence and reformulating the problem; (4) engaging stakeholders and generating evidence-based alternatives; (5) commitment to an evidence-based solution and implementation; and (6) evaluation of outcomes. Our study offers insight into transferability of evidence-based medicine to organizational decision making, and the interplay of rationality and intuition when applying evidence to organizational problems and solutions.

Keywords: Hospital management; redesigning healthcare organizations; health professions; practice climate, culture and environment; emergency department; decision processes; evidence-based medicine; qualitative methods

Physicians are trained to make clinical decisions about patient care and treatment based on the best available scientific evidence, which they have learned to continuously access, evaluate and contextualise to local situations as part of their professional practice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996a; Walshe & Rundall, 2001). Observing how evidence-based practice has improved patient care in medicine, management scholars have begun advocating for decision making approaches from evidence-based medicine to be applied to solve organizational problems (Graen, 2009; Klimoski & Amos, 2012; Pfeffer & Sutton, 2006; Rousseau & McCarthy, 2007). Health care researchers have similarly called for physician managers to transfer the evidence-based thinking they adopt when confronted with clinical problems to the organizational problems that challenge hospitals and other health care providers (Kovner, Elton, & Billings, 2000; Kovner & Rundall, 2006). In this paper, we contribute to this debate by addressing the following research question: How do physician managers incorporate evidence into their decision processes for organizational problems?

We investigate our research question through a case study of the restructuring of the Fast Track Unit within the emergency department of a large public hospital in Australia. Analysis of interview and archival data shows the physician manager who led the Fast Track restructure followed a decision process in which evidence played a central role in problem identification, evaluation and
selection of alternatives, and in engaging stakeholders to commit to a solution. Our findings make two
important contributions to the literature. First, we develop a model of how evidence can be
incorporated into decision processes to generate more effective solutions to organizational problems
inside hospitals. Second, by illuminating how a physician manager applied training in evidence-based
medicine to solve an organizational problem, our study suggests that medicine’s general approach of
systematically finding and evaluating multiple sources of evidence to inform decisions can be
transferred to, and contextualised for, management problems.

THEORETICAL BACKGROUND

Historically, management and medicine have differed in their approaches to evidence. As a
profession, medicine is distinguished by high level of intellectual and technical expertise in a formal
body of knowledge, barriers to entry through certification and training, autonomy in practice, and
commitment to a service ideal (Friedson, 1970). Through their professional training and socialisation,
physicians are indoctrinated into the primacy of scientific method as a way of knowing and a belief in
the generalizability and objectivity of research evidence (Makari, 2009; Walshe & Rundall, 2001).
Medicine’s knowledge base is continuously updated through research and disseminated through
communities of practice, professional development activities, and an accessible literature amenable to
systematic review (Rousseau & McCarthy, 2007; Walshe & Rundall, 2001). Practitioners value,
understand and systematically seek out the best available research findings and integrate these with
their individual clinical expertise to make decisions about patient diagnosis and treatment (Ellis,
Mulligan, Rowe, & Sackett, 1995; Sackett et al., 1996a)

In contrast, management is not a profession (Trank & Rynes, 2003) and few business schools
incorporate evidence-based management in their teaching (Charlier, Brown, & Rynes, 2011; Klimoski
& Amos, 2012). Management practitioners tend to make decisions based on a body of knowledge that
is less formal, highly pragmatic and often generated through personal experience and social networks
(Pfeffer & Sutton, 2006; Rynes, Giluk, & Brown, 2007). Some management scholars have begun to
argue, however, that decision making within organizations can be improved by applying elements of
medicine’s evidence-based approach (Pfeffer & Sutton, 2006; Rousseau, 2006; Rousseau &
McCarthy, 2007). Such application might entail critical evaluation of best available research evidence
in combination with other sources of information, including practitioner expertise and judgment, evidence from the local context, and perspectives of stakeholders impacted by the decision (Briner, Denyer, & Rousseau, 2009). In a similar vein, some health care researchers have called for physician managers to draw on their training in evidence-based medicine to solve organizational problems in hospitals (Kovner et al., 2000; Kovner & Rundall, 2006).

Some scholars have suggested that an evidence-based approach fits within a rational-analytic perspective in the broader literature on organizational decision making (Baba & HakemZadeh, 2012). Perspectives on decision making span a continuum between a cognitive process comprising a sequence of discrete steps at the rational-analytic end and anarchy as the limit to rationality at the other end (Langley, Mintzberg, Pitcher, Posada, & Saint-Macary, 1995). Seminal at the rational-analytic end is Simon’s work on bounded rationality, in which decision makers search for alternatives until they find one that satisfies evaluation criteria rather than the optimal solution (Simon, 1976). At the anarchy end lies the garbage can model, in which solutions randomly meet up with participants, choice opportunities, and problems (Cohen, March, & Olsen, 1972; Padgett, 1980). In between the two ends, the rationality of decision processes is impacted by factors such as bureaucracy (Cyert & March, 1963) and politics (Allison, 1971; Pettigrew, 1973; Pfeffer & Salancik, 1974). As the continuum moves away from the rational-analytic end, intuition is argued to play a role in decision making (Dane & Pratt, 2007; Vance, Groves, Paik, & Kindler, 2007). Intuition is based on sensing and feeling grounded in a decision maker’s expertise, experience, and perceptions (Miller & Ireland, 2005; Mintzberg & Westley, 2001; Sadler-Smith & Shefy, 2004).

Nevertheless, much of the literature advocating transfer of an evidence-based approach from medicine to organizational decision making is conceptual (Reay, Berta, & Kohn, 2009). Although scholars speculate that managers can incorporate ‘best available evidence’ into the stages in rational-analytic decision making, prescriptions for how this can be done are ambiguous (Baack, 2007) and there is little empirical research showing how evidence-based decision processes occur in practice (Briner et al., 2009). Our paper seeks to fill this gap by presenting an illustrative case study of how a physician manager engaged in an evidence-based decision process to solve an organizational problem.

**METHODS**
We investigated our research question through an empirical case study of the restructuring of a Fast Track Unit in the Emergency Department (ED) of a large public hospital in an Australian city. Fast Track units deal with patients whose conditions can be treated rapidly and discharged, such as minor cuts and abrasions, sprains, and simple fractures. The type of organizational problem in our case study – how to restructure department work flow to improve efficiency – is consistent with problems studied in prior research on decision processes in management and organization studies (Hickson, Butler, Cray, Mallory, & Wilson, 1986; Nutt, 1984; Nutt, 2008). The initiative to improve the Fast Track Unit was led by an emergency physician, Dr Clancy (a pseudonym), who had completed his specialty training two years previously and had been associated with the hospital for 11 years. Dr Clancy spent 80% of his work time performing a clinical role and the remaining 20% was devoted to managing the ED’s Patient Flow Portfolio, which included the Fast Track Unit. Dr Clancy was trained as an evidence-based medical practitioner but did not have any formal management training.

The hospital saw 70 000 emergency patients annually, with around 90% of these being treated and discharged. Patient assessment and treatment in the ED is overseen by emergency physicians, like Dr Clancy, who have completed their fellowship in emergency medicine. These physicians supervise registrars completing speciality training in emergency medicine and junior doctors in their first and second years of basic training. Before seeing a doctor, patients are classified by a triage nurse into one of five urgency categories on the Australasian Triage Scale. Patients with life-threatening conditions requiring immediate treatment are classified as Category 1; those with the least urgent conditions are Category 5. Category 1 and 2 patients are directed to a Resuscitation (‘Resus’)’ track for assessment and treatment, Category 3 patients to an Acute track, and Category 4 and 5 patients to either Acute or Fast Track depending on the nurse’s assessment of whether or not the patient met the selection criteria for Fast Track. Prior to the restructure of the Fast Track unit, all patients were seen in order of urgency category. Around 100 patients were seen in Fast Track on average each day.

Data collection involved semi-structured interviews with 24 emergency physicians and registrars, four hospital executives, and one nurse who had been heavily involved in the design of Fast Track. Background information was obtained from other nurses through a further 22 interviews, conducted by a research associate. We were given access to organizational documents including
reports of working parties and their meeting updates, drafts of Fast Track patient selection criteria, systematic literature reviews, PowerPoint presentations, and floor plan modifications. We also accessed publicly available documents including government reports and guidelines.

We analysed the data using inductive procedures recommended for case studies (Eisenhardt, 1989b; Eisenhardt & Graebner, 2007; Miles & Huberman, 1994). We began by ordering the empirical material about Fast Track chronologically and developed a timeline of key decisions and events. Drawing upon analytical methods recommended by Corbin and Strauss (2008), the first author reviewed all of the interviews and documents and performed open coding by asking ‘sensitizing questions’ of what is being done, when, by whom, and why. Statements that related to a similar stage of decision making were grouped together into preliminary categories, and descriptive labels were assigned to each stage (Miles & Huberman, 1994). The decision stages that emerged from this analysis were reviewed by other members of the research team and refined through an iterative process of comparing labels against data. Table 1 reports representative data from this coding. We completed our data analysis by using our coding to generate a narrative that represented ‘a relatively complete rendering of the story’ of Fast Track (Eisenhardt & Graebner, 2007: 29).

**FINDINGS FROM THE FAST TRACK CASE STUDY**

The ED began experimenting with protocols for streaming patients whose conditions could be fast tracked in 2000 as ‘the development phase’ (I-5) for the ED’s relocation to larger premises a few years later, when floor space was allocated to a Fast Track unit. A working party of emergency physicians and nurses developed criteria for deciding which presenting patients could be safely and efficiently diverted to the Fast Track unit. The working party also evaluated staffing requirements, recommending one registrar and two advanced practice nurses. Although this Fast Track unit had the potential to reduce waiting and turnaround times for low acuity patients, these benefits remained unrealized. Several working parties attempted to refine the patient selection criteria but documents showed these criteria continued to be applied inappropriately. Staffing of Fast Track was inconsistent and insufficient, with medical and nursing staff distracted by other duties and care priorities in the ED. The result was that Fast Track ‘was not fast. People just sit there and nothing happens to them’ (I-
3). Less than 44% of Category 4 patients were seen within the recommended waiting time of 60 minutes and patients ‘would get so frustrated’ (I-23). For medical staff, Fast Track was ‘a terrible place to work …. the thought of having to spend a whole day at Fast Track was soul destroying’ (I-8).

In 2006, a management consulting firm undertook a patient flow project in the hospital. Their report recommended patient streaming in the ED, including assigning a separate workforce of nurses and senior doctors to Fast Track. Recommendations were ignored. A hospital executive explained, ‘it was done to people. They didn’t have any ownership’ (I-26). In the years that followed, the group of senior emergency physicians who oversaw the ED took ownership of the strategic direction and functioning of their department. They began by identifying core strategic portfolios in clinical care, teaching, and research, and assigned physicians responsibility for each portfolio in addition to their normal clinical duties. In 2008, Dr Clancy acquired the patient flow portfolio.

**Problem Recognition and Assigning a Mandate**

When Dr Clancy took over leadership of the patient flow portfolio, there was shared recognition among staff in the ED that Fast Track was a problem: ‘We all recognised that we needed to do something’ (I-12). Increases in ED overcrowding created pressure to manage resources with ‘optimal efficiency’ and make the Fast Track area ‘more functional’ in caring for patients (Working Party Report). As one physician noted, ‘Everyone knew it was one of those things that should have been done well and hadn’t been, and we were happy to make it a priority’ (I-5). Thus, Dr Clancy was ‘given the mandate by the team’ (I-4) of senior physicians to resolve the problems with Fast Track.

The hospital’s executives were supportive of an internal change agent within the ED taking responsibility for patient flow after the department’s resistance to the consultant review. An executive claimed, ‘I’m not a big fan of management consultants. But (instead) you let doctors think up their own ideas and support them’ (I-28). Medical and nursing staff were also accepting of the need for change in their work practices. An interviewee described how assigning Clancy ownership of the problem triggered a process characteristic of medicine’s evidence-based professional practice:

*We had someone in the trenches preparing and collecting data and being methodical about it and then preparing a good evidence-based response to the problem.* (I-12)

**Assembling Literature and Internal Evidence**
Dr Clancy approached his mandate by collecting both internal and external evidence relevant to the problem. Clancy was both systematic and open-minded in this process of evidence collection. Consistent with the medical profession’s scientific empiricism, he sought to bracket any potential biases that might have arisen from his personal experience of Fast Track by following the evidence:

\textit{In terms of gathering the evidence, it wasn’t just a case of find the evidence to prove or disprove what I wanted to do. ... I went out there and I read it all and the answers started to just come out of the woodwork. (I-Dr Clancy)}

Dr Clancy began with a literature review of patient flow studies in Emergency Departments. Searching peer-reviewed scientific journals, Clancy identified 24 articles most relevant to the problem of streaming ED patients who have short processing times (11 Australian studies, 13 international studies). He systematically reviewed each article in terms of the intervention (what strategy, activity, or structural design is being studied?), methodology (what data are collected using what methods?), and outcomes (what are the outcomes of the intervention?). Articles selected for review applied concepts from operations research in organization and management studies to hospitals, including queuing theory, process mapping, process re-engineering, lean thinking, six sigma, and change management. Clancy subsequently used the language of operations management in his reports and in his interview, he spoke of ‘wearing my operational efficiency hat’ (I-Dr Clancy).

In addition to his systematic review of external evidence about patient streaming strategies in other hospitals, Clancy assembled internal data about patient flow in his local hospital context. The ED in our case study used an electronic patient registration and tracking system, the Emergency Department Information Systems (EDIS). For every service episode, staff entered data into EDIS to record patient registration, basic clinical decision making, patient movements, and laboratory test ordering. Clancy accessed data recorded in this system to develop a baseline understanding of patient flow, including waiting times, length of stay, and variations in demand at different time periods. Other evidence was available to Clancy in the reports of previous working parties and of the hospital review undertaken by the management consulting group. These reports presented stakeholder and management consultant perspectives on the causes of Fast Track’s problems, recommended solutions, and evaluated the outcomes of those solutions which had been implemented.

\textbf{Cross-Pollinating Evidence and Reformulating the Problem}
After assembling the evidence he appraised to be most relevant to the problem, Dr Clancy looked for patterns within and between the different sources of evidence using an approach resembling the highly iterative analysis of qualitative researchers (Eisenhardt, 1989b; Miles & Huberman, 1994). Clancy described how he engaged in a process of ‘cross-pollinating all this information’ to help inform decision making about Fast Track. He tested insights from the literature review against the EDIS data to assess the applicability of different streaming strategies to the local hospital context. At the same time, when patterns emerged in the EDIS data, Clancy integrated insights from the literature to explain the underlying ‘reasons’. As analysis proceeded, the patterns from EDIS and the literature began to converge into a set of tentative ‘ideas’ about possible models for reforming Fast Track which he assimilated with the recommendations of previous working parties:

Some things just keep coming up over and over and over again. You’ve already heard a million ideas and you read a lot of things ... And then in addition to that, when I did some counting here (of our internal capacity data), I noticed that this would go on at these times of day and so on. So now I’ve got these ideas about how we can make the department function more efficiently. ... And then you look at these things that have worked, it’s apparent to you from cross-pollinating all this information why it is and there’s still a little bit of intuitive filling in the blanks.

Immersion in the internal and external evidence provided Clancy with deep insight into the problem ailing Fast Track. The evidence supporting the use of Fast Track units to stream emergency patients was compelling. Moreover, the recommendations for improving Fast Track offered in previous reports were based on ‘good ideas’ that were well supported in the literature: ‘I just kept coming back to the same recipe as had been suggested beforehand’. Thus, Clancy concluded that the problem with Fast Track was failed implementation rather than a fatally flawed organizational design. The evidence suggested implementation had been undermined by resource allocation and patient selection criteria. With the problem reformulated, Clancy moved on to engaging stakeholders.

Engaging Stakeholders and Generating Evidence-Based Alternatives

Dr Clancy formed a small working party and presented a 17 page report of the evidence he had collected and analyzed. Under Clancy’s leadership, the working party evaluated two alternative strategies for streaming patients: (1) two streams of Admit or Discharge, and (2) three streams of Resuscitation, Acute, and Fast Track. The first strategy was rejected because EDIS patient volumes suggested it ‘would not conform to the ideal Fast Track clientele endorsed by the literature’ (Working
The second strategy was currently in use but not working well. Principles on how to better implement this strategy were derived from the literature. First, evidence supporting early input from senior medical staff was ‘so compelling that it is perhaps the single greatest requirement of a successful Fast Track service’ (Working Party Report). Second, the literature indicated ‘the overall gain in efficiency’ of a Fast Track unit was related to the extent to which its resources - both staff and space - were quarantined from the rest of the ED (Working Party Update). Third, the ‘defining characteristic’ of a Fast Track patient was the shortness of expected processing time (Update).

These evidence-based principles helped Dr Clancy and the working party generate ideas for how to resource and select patients for Fast Track. At a combined forum for medical and nursing staff, Clancy presented alternative ideas for reforming Fast Track. To facilitate evidence-based discussion of these ideas, he provided executive summaries of the literature in pamphlet form:

Clancy of course presented various ideas to us and there was discussion about what would and wouldn’t work. It wasn’t like a dictatorship where we were presented with a plan and that was it. We all had the opportunity to have input. (I-5)

The working party used this stakeholder feedback to refine their ideas. They also incorporated the results of a Staff Satisfaction Survey administered by the hospital. As they worked to evaluate and refine alternatives for resourcing Fast Track, Clancy continued to test out the practical feasibility of these alternatives using current and predicted activity levels based on EDIS data. Through this process of fitting general principles derived from external evidence to internal evidence capturing the local context, the working party consolidated their ideas into what they labelled a ‘detailed evidence-based model’ for Fast Track (Working Party Report).

**Committing to an Evidence-Based Solution and Implementation**

The model recommended by Dr Clancy and the Working Party comprised the following elements: (1) three streams, with patients in Resuscitation treated in order of urgency and patients in Fast Track and Acute treated in order of arrival; (2) patient selection criteria adapted from previous working parties; (3) hours of operation estimated from EDIS data on patient volumes and peak arrivals; (4) autonomous staffing, with registrar and nursing needs calculated by extrapolating medical and nursing productivity rates reported in the literature; and (5) structural
redesign involving both new construction and reconfiguration of existing ED spaces to quarantine physical space for Fast Track. Each recommendation in the Working Party’s report was justified by internal and/or external evidence, which helped to persuade ED staff and hospital executives to make a commitment to implementing the Working Party’s recommendations. After the Working Party’s recommendations were accepted, hospital management funded the restructuring of the physical layout of the ED and staff were trained in the appropriate application of the revised patient selection criteria. Underpinning the hospital’s commitment to implementation was trust in Dr Clancy as an evidence-based practitioner:

Most people felt there wasn’t too much about patient flow that he hadn’t read or thought about before. So you kind of go, ‘Well, you might as well just leave it to him. If he can’t sort it out, then no one else can’. (I-20)

**Evaluation of Outcomes**

Substantive improvements in efficiency were gained from the implementation of Fast Track. Waiting times for Category 4 and Category 5 patients decreased by 51 minutes and 10 minutes respectively. Patients leaving without being seen, a measure of patient dissatisfaction, decreased from 9.1% to 4.6% of ED patients. Staff satisfaction with Fast Track also increased: ‘As it progressed, Fast Track is actually one of the best places to work. It’s quite satisfying. You have a high turnover, you might see 20 patients a shift’ (I-8). Overall, positive organizational outcomes were produced by implementing the solution that emerged from the evidence-based decision making process, as illustrated in this quote from a registrar who had experience of working in Fast Track before and after its redesign:

*It works better for the whole department. It flows more efficiently. The patients are happier. I like working down there, I like doing hands-on stuff. I like suturing and plastering. I like seeing lots of people and getting them in and out and doing all those things. And most people who work down there love their Fast Track shifts. The way it’s designed, set up and run is very, very good for everyone. You get a lot of positive patient feedback about Fast Track now.* (I-23)

**DISCUSSION AND CONCLUSIONS**

In this paper, we addressed the research question of *How do physician managers incorporate evidence into their decision processes for organizational problems?* Our case study of Fast Track revealed an evidence-based process involving six stages: (1) problem recognition and assigning a mandate; (2) assembling literature and internal evidence; (3) cross-pollinating evidence and reformulating the
problem; (4) engaging stakeholders and generating evidence-based alternatives; (5) commitment to an evidence-based solution and implementation; and (6) evaluation of outcomes. Progression through these stages was led by a physician manager who systematically sought out and evaluated the best available internal and external evidence to generate alternative solutions. He drew upon this evidence to engage, and persuade, his colleagues and hospital executives to commit to implementing the solution that fit both the scientific literature and the local context. Once implemented, this solution increased operational efficiency, as measured by patient turnover and reduced waiting times, and increased both staff and patient satisfaction levels.

This six-stage process is consistent with Briner, Denyer and Rousseau’s (2009) description of evidence-based decisions being grounded in practitioner expertise, the local context, scientific evidence, and stakeholder perspectives. Our case study provides one example of how an evidence-based decision process can play out in practice to solve organizational problems in hospitals. We do not suggest that the process we uncovered is the only way to use evidence to inform decision making. A more complete understanding of the different decision processes through which EBM can be implemented requires further comparative case studies in a variety of organizational contexts.

This limitation notwithstanding, our study contributes to the decision making literature by building on studies of intuition (Dane & Pratt, 2007; Sadler-Smith & Shefy, 2004) to illuminate how rationality and intuition play off each other in evidence-based approaches to solving organizational problems. Extending Eisenhardt’s work (1989, 1999), we find that collecting and analyzing empirical findings from the research literature in addition to internal information deepens the development of a decision maker’s intuition about organizational problems and possible solutions. Cross-pollinating between empirical literature and local operational data, as Clancy did, adds more layers of holistic understanding about the problem confronting the organization and increases pattern recognition of how contextual factors might impact the feasibility and likely success of alternative solutions. Our finding that intuition has a role in evidence-based decision processes is an important insight because it challenges prior literature suggesting these processes fit narrowly within the rational-analytic perspective (Baba & HakemZadeh, 2012; Reay et al., 2009) and counters criticism that evidence-based decision processes privilege science and rationality (Learmonth, 2006).
Finally, our case study opens up new research directions by highlighting the influence of individual factors on how a physician manager translates training in evidence-based medicine to solve organizational problems. While medicine was one of the first fields to pioneer an evidence-based approach to decision making (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996b), in reality not all clinical practice in medicine is evidence-based because the evidence may be poorly disseminated, unclear or conflicting (Casaubon et al., 2008; Feinstein & Horwitz, 1997) and some physicians are reluctant to change their practice (Grol & Grimshaw, 2004; Naylor, 1995; Sackett et al., 1996b). Although clinical practice may not always match the ideal of evidence-based medicine, medical training, as one interviewee explained, tends to create experts who “have appropriate discipline and scepticism and really wanting to be rational in their logic about making decisions” (I-21). Thus, when Dr Clancy was tasked with improving the efficiency of the hospital’s Fast Track unit, his expertise and experience in medicine informed his use of an EBM decision process. Prior research in the decision making literature similarly found that an individual’s expertise and experience influences their choice of decision making strategy (Langley et al., 1995; Useem, Cook, & Sutton, 2005).

We do not contend, however, that everyone who has expertise and experience in medicine will follow the same decision process as Dr Clancy. On the contrary, several of our interview respondents speculated that Clancy’s approach was unlikely to be typical of physicians. Two personality factors seemed especially pertinent to Clancy’s choice of decision process: conscientiousness and internal locus of control. Dr Clancy is task-oriented and extremely detail focused, which are characteristic behaviour manifestations of the ‘Big Five’ personality dimension of conscientiousness (Goldberg, 1981; McCrae & Costa, 1987). In addition, Clancy believes people control their own destiny and can solve problems through effort, stating in his interview, “There aren’t too many problems that can withstand sustained consideration from someone as long as someone’s prepared to take it on.” Clancy’s belief is consistent with a high internal locus of control (Rotter, 1966). Thus, our study suggests the need for future research examining the impact of personality factors, such as conscientiousness and internal locus of control, on whether and how a physician manager incorporates evidence into their decision processes in response to organizational problems.
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<th>Category</th>
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| **Problem Recognition and Assigning a Mandate** | Flow is an important thing to try and maintain functionality. … We’ve just got to keep looking at different things and improve specific patient’s care. (I-16)  
Despite good intentions, this clinical area has consistently failed to meet expectations, and efforts to identify the underlying reasons for this poor performance have not translated into sustainable solutions (Working Party Update).  
When I was a resident here, Fast Track was the least well supported area. If we were short staffed, Fast Track was the first place we took staff away from. There would be shifts where we had no doctors there treating patients and we would commonly have 20 or 30 Category 4s and 5s waiting to be seen and we just kept seeing the 2s and 3s because they were higher priority patients, which meant our waiting times were terrible, our did-not-wait times were terrible, patient complaints I’m sure were very high and it was a very unsatisfying shift working. (I-8)  
I think to some extent we wanted to try something because it wasn’t working what we were doing and we needed to get better. (I-19)  
We knew we needed to look at those processes. Clancy was the one who put his hand up and I guess as a group, we all said, ‘Well, we trust that you are going to go off and do a good job.’ (I-5)  
Any way of actually providing us with some direction is a good thing. So I think there was a lot of backing for Clancy to do that. … Senior backing. (I-12) |
| **Assembling Literature and Internal Evidence** | Clancy can give you his little summary of all the literature that he’s made that literally is that thick of journal articles and his own summary. There’s lots of things that are tried. There’s no magic bullet. (I-16)  
The rest of the country and internationally people talk about what we can do to improve patient flow in terms of Fast Track, different ways of streaming patients. So I guess Clancy has probably thought about this a bit more. (I-3)  
Clancy did a lot of research, presented a lot of statistics as to what he thought … Claney loves doing all those figures and numbers. (I-5)  
If you’re trying to work out a problem, gather the data about it. (I-14) |
| **Cross-pollinating Evidence and Reformulating the Problem** | I was also quick to acknowledge the fact that I had adapted a lot of other people’s ideas just to develop an understanding of why it hadn’t worked the first time. (I-Dr Clancy)  
Through good careful analysis, there’s a better way of doing patient flow. (I-21)  
Clancy put in a lot of intellectual time and initiative to try and make something work. (I-20)  
He’s also one to be a little bit more rational in his thinking … They’re usually good ideas. They’re well thought out. (I-29 – Executive).  
When Clancy went and did all the research and all the papers that have been published about this stuff, he came up with a set of recommendations which were almost exactly the same as a set of recommendations made by one of the nurses who had a lot of experience in that area. (I-17) |
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<tr>
<td><strong>Engaging Stakeholders and Generating Evidence-Based Alternatives</strong></td>
<td>There’s a huge amount of thought and time and effort. Clancy didn’t just come to us with an idea. He came to us with an idea and all the data that supported it. Like he just threw it out there and it just made sense. (I-9)</td>
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<td>Clancy had the input of nursing staff and had to engage them because it made a difference to how they practised. (I-8)</td>
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<td>I tried to have a couple of meetings where I’d involve people who I thought were key stakeholders locally. It wasn’t the kind of thing I thought required involvement of anyone outside the department for fast tracking – it’s discharged patients, it doesn’t really involve other members of the hospital. (I-Dr Clancy)</td>
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<td><strong>Commitment to an Evidence-based Solution and Implementation</strong></td>
<td>He had enough evidence to support the fact that Fast Tracks do help, other people are doing it, that it wasn’t hard to be convinced to give it a go. (I-19)</td>
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<td>I have no interest to go and do all of the same research that Clancy has so I am kind of relying on the fact that he has gone and done all of that work. He has presented me with a model. It seems like a good model to me. I am happy to go along with it. (I-5)</td>
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<td>I looked at what caseload I thought should be managed by Fast Track then working out how many people that actually translated to and what are their cumulative lengths of stays now, what would I hope they would be, how many hours of bum on seat is that going to be, how many cubicles will I need. So I sort of did those things. (I-Dr Clancy)</td>
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<td>Clancy diagnosed some problems, said this is how I think it should happen. We trusted him enough to try and that had good results. (I-17)</td>
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<td>The way the new Fast Track is modelled it is a lot easier to get patients in and out quickly because you have got three dedicated beds, they are almost always free, you have got a dedicated nurse and it is more about the patient selection and the patients that are going there. … (I-24)</td>
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<td><strong>Evaluation of Outcomes</strong></td>
<td>Fast Track is great. It is a simple efficiency manoeuvre that is also better for patients. (I-21)</td>
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<td>Great positive feedback for the organization and then great positive feedback from outside the ED because our numbers have started getting better. We perform well on our times and part of that is a result of Fast Track. (I-17)</td>
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<td>It makes for a very satisfying morning when you can just see quick simple things, treat them and dispose of them appropriately. I find that is a lot more satisfying, in terms of being able to provide quick and appropriate care, so that is good. (I-24)</td>
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<td>Patient satisfaction-wise … you actually get the automatic feedback from them, especially since a lot of them have unfortunately been on the flip side of it a few years before or have heard stories or know of people. And so to now come up, have your wound sutured and be home within half an hour, they’re always amazed and grateful. So it’s really nice to actually see people satisfied with the service – which is the way it should be. (I-23)</td>
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References


