Clinician-to-manager transitions in remote health work contexts: Lessons from a pilot study

Dr Leigh-ann Onnis

College of Business, Law & Governance

James Cook University, Cairns, Australia

leighann.onnis@jcu.edu.au

Clinician-to-manager transitions in remote health work contexts: Lessons from a pilot study

Abstract: *Connectivity and contemporary employment practices, together with the changing nature of how, where and when we work will impact the way in which frontline hybrid managers work into the future. Some health service organisations are already experiencing some of the anticipated challenges of contemporary hybrid clinician-manager roles. This exploratory pilot study examines the hybrid role of a clinician-manager in a geographically remote context. The remote clinician-to-manager transition was chosen because it exemplifies the nuances of managing nonconventional, insecure and flexible workforces. The four key areas identified were: preparation, support, clinical/managerial role conflict, and the work environment. The findings suggested that further research examining the benefits of relational management practices in supporting hybrid clinician-managers is warranted.*

Keywords: management development, hybrid, relational, clinician-manager, transition.

We live and work in a connected world. Globalisation, innovation and technology have changed the nature of how and where we work. For the first time in history, less than half of the civilian Australian population have permanent full-time jobs with leave entitlements (Carney & Stanford, 2018). Technology improves workforce mobility across the globe; and innovation continues to drive workforce flexibility. As a result, hybrid frontline manager roles, those roles where managers retain professional duties alongside their managerial responsibilities, are increasing. Little is known about how to support professionals for the competing priorities of the contemporary hybrid manager role, particularly where there is increased workforce flexibility, employment insecurity and reduced resources (Martens, Motz & Stump, 2018).

This study examines the hybrid role of a clinician-manager working in a geographically remote context. The clinician-to-manager transition is an excellent example of role conflict; where clinical duties prevail over managerial activities (Chandrasiri, 2015; Thompson & Henwood, 2016). The clinician-to-manager transition in a geographically remote context was chosen because it exemplifies the nuances of a nonconventional workforce, and the insecurity of flexible workforces. The setting for this study is geographically remote regions where high workforce turnover and less favourable work environments result in a mix of local, fly-in/fly-out, Agency and contract staff. While remote health workforce challenges are generally considered a remote health issue; it is proposed that remote workforce challenges are a window into the future for mainstream business as more flexible and insecure workforce solutions are implemented. It is imperative to understand how people successfully transition into hybrid managerial roles to create sustainable solutions for future remote service industry workforces. Hence, this exploratory study aims to learn more about the barriers and enablers for a successful clinician-to-manager transition when it occurs in a remote region.

Clinician-managers

Career progression for most professionals is from technical expert to manager, and health service career paths are no different. Some clinicians at the peak of their careers seek pathways to management. Others become accidental managers encouraged to take on management roles by their own manager, and/or their colleagues (Fulop & Day, 2010; National Rural Health Alliance (NRHA,

2004). In remote areas, clinicians frequently find themselves as accidental managers, appointed because no-one else is there at that time (NRHA, 2004). As a result, many clinicians commence management roles without any management training and/or relevant management experience. These clinicians quickly discover the stark reality that the skills and experience that made them an excellent clinician, do not give them what they need to be an effective manager (Spehar, Frich, & Kjekshus, 2015). Health service organisations often contribute to the presence of unprepared managers, with an analysis of recruitment advertisements for management positions in remote northern Australia, revealing that many organisations do not advertise for candidates with management qualifications and/or experience (Onnis, 2014, 2016).

Clinician-managers are nurses, doctors, or allied health professionals (e.g. psychologists) whose work activities are divided between a management and a clinical role (NRHA, 2004). The clinician-manager has two distinct roles despite usually being considered one role. They differ from Health Service Managers who spend 100% of their time engaged in management duties (NRHA, 2004). In remote regions, many clinician-managers are isolated 'clinically' as well as 'managerially.' When considered in a context of workforce shortages, high turnover, low retention, demanding workloads and isolation; this is a high risk environment for an inexperienced manager. However, this is a real scenario for many clinicians who are prematurely promoted into clinician-manager roles (NRHA, 2004; Onnis, 2019; Thompson & Henwood, 2016). It is a scenario in which they live and work with minimal management training and often with inadequate support (Onnis, 2014; Thompson & Henwood, 2016). For clinician-managers, training and support is vital because the skills and qualities that make good clinicians are very different to those that make good managers (NRHA, 2004; Spehar et al., 2015). This is not an issue restricted to health services. In general, it is becoming more common across the wider service industry arising from an increase in insecure employment leading to less access to employer-paid training, more frequent turnover and greater responsibility placed on the individual to be suitably qualified and competent.

Most of the current research about the hybrid clinician-manager focuses on urban hospital-based clinician-managers (Fulop, 2012; Fulop & Day, 2010; Kippist & Fitzgerald, 2009; Spehar et al.,

2015; Thompson & Henwood, 2016). Therefore, much of the current research is situated in urban hospitals where clinician-managers typically have access to training, peers, resources, and usually leave the hospital at the end of a shift to go home to family and/or friends. This is a very different scenario to the one in which many remote clinician-managers work. The isolation means that they are working in resource poor communities, that they rely on technology or travel vast distances to access training, and have no other managerial peer in close proximity. As a result, the hospital-based research does not adequately address the nuances of remoteness, and in the past what works in an urban hospital has not always worked in the remote context (Onnis, 2019). A few studies investigated the impact of the hybrid manager role at the micro-level focusing on identity, leadership and professional conflict (Currie & Croft, 2015; Fulop, 2012; Kippist & Fitzgerald, 2009). Some studies have investigated the hybrid manager at a meso-level, most notably the hospital-based clinician-manager (Fulop & Day, 2010). However, few studies have investigated the influences of roles and work contexts conducive to developing successful hybrid managers. Thus, the literature reveals that there is a need for further research about the hybrid manager roles and the transition into such roles (Spehar et al., 2015; Thompson & Henwood, 2016). Despite recognition that the clinician-to-manager transition influences retention and workforce sustainability, and the importance of both clinical and managerial competence in remote areas; this remains an under researched area.

METHODS

The pilot study used a qualitative, exploratory research design. A purposive sampling method was used to recruit clinician-managers working in remote areas of Far North Queensland (FNQ). The participants were recruited for the pilot study through an invitation appearing in the CRANAplus newsletters circulated from January to March 2019. Then, a snowball sampling method was used to invite further participants until a small sample of four participants were recruited. The participants worked in a clinical role prior to commencing a clinician-manager role, and were working in a geographically remote area in FNQ during the clinician-to-manager transition. The pilot study comprised four female participants who were fairly representative of the clinician-manager

population. A gender-balanced sample was not achieved due to the high proportion of females in clinician-manager roles in the region and the voluntary nature of participation.

The method for the pilot study comprises an initial interview, a series of reflective discussions supporting the clinician-managers development during the transition period and a final interview reflecting on the clinician-manager's development during the study. This paper reports on the first part of the pilot study where data were collected through the initial interviews with participants. A typical interview included: background (qualifications and experience), how and why they became a clinician-manager, barriers and enablers, and how/where they sought assistance. The interviews were recorded, transcribed and a thematic analysis was conducted using NVivo12. Subsequent analysis of the emerging themes identified four key areas that acted as either barriers or enablers for each participant as they commenced their clinician-to-manager transition in FNQ.

RESULTS AND DISCUSSION

Participants

The clinician-managers who participated in the pilot study transitioned from clinician to clinician-manager in a remote community or town in Far North Queensland. Three of the clinician-managers transitioned into the management role with at least ten years experience as a clinician (two in nursing, one in allied health) and the fourth transitioned into a clinician-manager role with less than five years clinical experience in nursing. The three clinicians who were in a later stage of their career described their transition as something that they were encouraged to do, and commented on the opportunity arising through being there at the time, saying 'I was encouraged to apply for the team leader job' and 'I decided that I could be better than some of the managers that I had seen, so I decided to put my money where my mouth was and have a crack at it.' Another explained,

> *I had that quite broad experience ... that's why I was considered. Also, maybe partially because there was a limited amount of people that were interested in going and working in [a remote Indigenous] community ... so the pool of people they would have been drawing from maybe was quite small. Anyway, I was really pleased to be asked.*

In contrast, the fourth clinician-manager aspired to be a senior health manager, an ambition that developed during her university study. She said, 'being in management is the pinnacle ... I've just always wanted to get into Exec.' This resulted in a more defined career path, including management training in an urban hospital which preceded her transition into remote health services.

Barriers and Enablers

The participants identified the barriers and enablers of a successful clinician-to-manager transition. The four key areas identified were: preparation and training for the role; support (from their manager and their team); clinical/managerial role conflict; and the work environment. Each key area was identified as being either a barrier or an enabler for a successful clinician-to-manager transition depending on whether it was absent or whether it was adequately addressed by the remote health service and/or the remote clinician-manager. The key areas identified were consistent with the findings of other studies (Fulop & Day, 2010; Lenthall et al., 2011; Onnis & Dyer, 2017; Spehar et al., 2012; Thompson & Henwood, 2016).

Preparation for the clinician-manager role

The lack of preparation for health professionals commencing management roles has been previously recognised (Fulop & Day, 2010; Spehar et al., 2012). In this study, one participant had a pathway to management that was more planned than the other three; however, all four found that the transition into the clinician-manager role in the remote health services organisation lacked the necessary preparation. One participant said that when she asked for time to have handover so that she would know what she was doing, the supervisor 'just laughed at me and said "Oh, you'll just have to wing it like the rest of us".' Another said 'the pre-training was missing ... as you became more senior as a clinician there wasn't anything that was going with that training that was preparing you to move up into the next role but also once you got into the role there was not anything formal around to help.'

Most of the participants explained that initially, 'you don't know what you don't know'; however, once the clinician-managers became more self-aware they found ways to supplement their knowledge through corporate services (e.g. Human Resources, Finance), management books, formal qualifications (e.g. post graduate study), Google searches, and some later had access to informal

internal training opportunities offered through their health service organisation. These usually involved travel to a regional centre or a larger town. A few participants said that the transition lacked sufficient orientation, suggesting that a better handover and orientation into the role would have improved their transition.

Support

All of the participants mentioned that the support, from both their line manager and their team, was vital for a successful clinician-to-manager transition (Onnis & Dyer, 2017). For three of the participants, their transition was from a member of the team to the clinician-manager of that same team. This scenario typically created challenges as they continued to work with team members as peers for the clinical component of their role. At the same time they were adapting to the managerial role where they now manage their former clinician colleagues. One participant explained this overlap saying that the initial challenges included, 'Doing the clinical [work] plus trying to get the handover from the team leader and then the transition ... I'm in the team leader job but I'm still finishing my clinical [work] to handover.' For two of the participants, one of their first tasks was to recruit someone to replace themselves, so they were under resourced from the start and could not reduce their clinical work until they had recruited a new clinician.

Furthermore, access to support from their line manager was impacted by the high turnover typical of remote areas. Where there is high turnover, typically people are either prematurely promoted and unable to manage the demands of the role, or those showing competence are quickly promoted to more senior roles (Pluchino, Rapisarda & Garofalo, 2010). This further contributes to the challenges of gaining the necessary support needed by clinician-managers, as one explained, she was told 'You'll get all the support you need. That's not a problem ... so, just as soon as I took that job ... the manager got a secondment, and then obviously [someone else] then stepped in and after a month [he] said 'I don't want to do this job anymore ... So then, he stepped out.' All of the participants described the impact of secondments, temporary and short-term appointments, and movement within the remote health service organisation and the region; all of which contributed to workforce instability, and reduced their access to support.

All four participants mentioned the benefits of mentoring. One participant commented on the lack of mentorship saying, 'nobody was prepared to mentor me and my line manager at the time didn't do anything to help with the transition'; and another commented on a conversation at an external training program where the facilitator asked, 'Why don't you have a mentor? And I said because nobody ever offered me one and where would you get one from here? And to be honest that's our problem in FNQ.' In contrast, two participants described the support that they had received as being helpful and mentioned people that they considered to be informal mentors and role models. While no-one had a formal mentoring arrangement in place for their management development, they all commented on the need to have someone when you are working in remote settings because you cannot talk to your team about it, so it can be very isolating. One participant captured the sentiment of all four participants in saying, 'I think that you get worn down if you don't have the support.'

Clinician/managerial role conflict

The impact of high turnover and poor retention in poorly resourced remote areas contributes to the complexity of the hybrid clinician-manager role (Humphreys, McGrail, Joyce, Scott & Kalb, 2012; Onnis, 2019; Onnis & Pryce, 2016). Participants highlighted the absence of role clarity, saying it is not clear 'what percentage should be clinical and what percentage is non-clinical so this is really tricky' and, another said that 'the Director would get frustrated if I wasn't accessible for other things but mindful that clinical stuff always comes first realistically because that's why we do our jobs.' This tension between clinical and managerial duties is influenced by professional identity, with one explaining that 'getting pulled back into that clinical, can take you away from the role as the manager. I would still like to do some clinical work ... I went to university ... I don't suddenly stop wanting to talk to clients.' There was no clear understanding from participants about the expectations of their senior managers about how they were to spend their time between managerial and clinical duties. This was further complicated when their line manager was not familiar with their work environment, and did not grasp the challenges of living and working 24/7 in a remote community with your team, and clients. However, it was quite clear that all of the participants put the clinical needs of their clients first (Thompson & Henwood, 2016).

Several studies have described the challenges of balancing the clinical and managerial responsibilities for the hybrid clinician-manager role (Fulop, 2012; Spehar et al., 2015). Building on published findings, other studies have also examined leadership and the hybrid role (Fulop & Day, 2010). As contemporary employment practices continue to move towards more flexible and insecure employment arrangement, the importance of role clarity and accessible contextualised resources prior to the onset of managerial difficulties increases (Di Fabio & Kenny, 2019).

Work environment

As highlighted previously, high turnover and workforce instability increased the number of people who were new and were learning their own jobs, which adds further pressure for new clinician-managers, especially in navigating systems, processes, networks and relationships. As one participant explained, 'It was like I was managing all of them, let alone the system. I couldn't get it done.' The participants thought that the transition would have been smoother if they could have chosen their own administrative support people, and had HR people more familiar with the remote context and the organisation's policies and systems at their disposal. However, the participants suggested that these challenges were a broader health service issue and not necessarily just about their understanding of the remote context. As a result, the isolation made clinician-managers feel that they were, as one participant explained, 'dragged in this stuff that wasn't even mine' when seeking assistance. Similarly, another said that 'if there's a policy or procedure I will follow that and then I will always go back to, well this is what the policy says and this is what we should be doing' but where policy was absent they depended on their own communication skills in trying to seek clarification about processes and systems from other areas of the organisation.

The remote context necessitates effective communication because often there is no in-person contact with other team members and line managers. The participants emphasised the benefits of regular ongoing meetings with line managers and the team, and the importance of trust where there was an absence of daily contact due to the vast distances over which the health service operates. Also, orientation and an adequate handover were highlighted as areas that could be improved if the clinician-to-manager transition is to be smoother. However, the participants emphasised the

challenges with handover, saying that often the previous clinician-manager left abruptly, because they were unwell, took personal leave before going, or the position had been filled by a series of short-term incumbents – all of which result in the new clinician-manager not having an opportunity to meet the previous incumbent for handover. As a result, they often walked into a work environment where everyone was working above or beyond their capacity to maintain safe practice for their clients but did not have the capacity to do anything more. One participant, having previously worked short-term in a clinician-manager role in a remote community described how much easier it was to transition into a clinician-manager role in FNQ. She said,' It is different ... there were two factors, one is [previous team leader] had been there ... adding a lot of processes and it was running [well] ... the key other factor was that there was an amazing Administrator ... 80% of the role was just administration and she had all of that running smoothly.' So, they were completely different experiences. The first time, an exhausted clinician-manager took sick leave and then did not return so she found herself walking into the office with paperwork 'flowing out of the drawers.' Whereas the second time, the previous clinician-manager had been there to handover, and everything was running effectively making for a smoother transition.

What can we learn from the pilot study?

The participants suggested that relationships and personal/professional networks were central to how well they navigated the challenges typical of the key areas that emerged in the study: preparation, support, clinical/managerial role conflict, work environment. The emphasis on relationships, communication and networks was consistent with the findings from other research conducted with remote health professionals (Lenthall et al., 2011; Onnis & Dyer, 2017). This is typical of a changing work environment where the focus shifts from transactional management to relational management. According to Di Fabio and Kenny (2019), relational competencies and emotional regulation are central to improved resilience and individual wellbeing, 'and are increasingly sought by employers for their contribution to organizational effectiveness in a rapidly changing global workplace.' With the work of Seligman's Positive Psychology at its core, Di Fabio and Kenny's (2004) study emphasised the role of relational psychological contracts in an environment where transactional psychological

contracts are impeded by short-term employment contracts, casualisation, labour hire and flatter organisational structures (Carney & Stanford, 2018; Di Fabio & Kenny, 2019). Within some traditional professions there may be opportunities for professional training guiding traditional career paths; however, this may no longer be at the forefront of organisational priorities as service industry labour is purchased to meet specific demands from a global pool of potential workers, rather than cultivated and nurtured by one organisation.

In the pilot study, the participants all had a high level of self-awareness, and described support seeking activities. Two of the clinician-managers proposed that they found it difficult when they first transitioned due to the lack of support, and being unfamiliar with the processes and systems. They all used policy when they were unsure to ease their anxiety with a given situation; and emphasised the value of existing relationships and professional networks including support from their immediate manager during their clinician-to-manager transition. Psychological Contract Theory (PCT) and Social Exchange Theory (SET) have previously been used to examine remote health workforce sustainability (Onnis, 2016; 2019) and appear to also be relevant theories to explore the clinician-to-manager transition. PCT describes an individual's beliefs about their employment relationship and 'what they think they are entitled to receive because of real or perceived promises' from their employer' (Bartlett, 2001, p.337). While the sample size is too small to draw conclusions, the disappointment and frustration shared by some participants may be partly explained by unfulfilled promises and the clinician-managers perceived obligations.

Similarly, SET which proposes two types of social exchange, Perceived Organisational Support (POS) and Leader-Member Exchange (LMX) appears relevant to the experiences described by the clinician-managers. POS focuses on the exchange relationship between the employee and the organisation and LMX emphasises 'the quality of the exchange between the employee and the supervisor and is based on the degree of emotional support and exchange of valued resources' (Ko & Hur, 2014, p.177). Some of the clinician-managers described an absence of orientation to their new role, and they all commented on the impact of the level of support they received from their immediate manager and the organisation more generally on their clinician-to-manager transition. Regardless of

whether they highlighted a supportive manager, or commented on the absence of support from their manager once they commenced the clinician-manager role, they all described their expectations and their perceived level of support.

The impact of high turnover and less secure employment practices, such as short term contracts, secondments and Agency staff was evident in the experiences described by the four participants in this study. The impact of these employment practices was beyond the scope of this pilot study; however, it is anticipated that they will be associated with transactional psychological contracts. Yet, the emphasis on the benefits of relationships and networking by the clinician-managers appear more aligned to relational psychological contracts where reciprocity may be rewarded by loyalty and organisational commitment. Hence, it is proposed that further research will not only contribute to the evidence-base for remote contexts, it will improve the depth of our understanding about clinician-to-manager transitions in contemporary health service organisations.

LIMITATIONS

This pilot study is limited by the small sample size. Also three of the four participants were from one field within the broader health service which occurred due to the snowball sampling method and the voluntary nature of the research. The field has not been disclosed to protect their identity given the study was limited to one region in Australia. For these reasons, the pilot study is being used to refine the exploratory research methods and to further our understanding of the barriers and enablers for the small group of clinician-managers based in Far North Queensland.

CONCLUSION

Given that their professional careers involve human services, and that in remote contexts health professionals live and work together within the remote community; relationship are deemed to be important for overall success and good health. With isolation comes an increased need to develop relationships and effective ways of communicating with others to seek the resources and information required to be an effective manager. For health service organisations, there is an opportunity to develop support networks and to create more supportive relationship-based work practices for remote and isolated health professionals, support staff and managers. As employment practices become less

secure and workforce flexibility increases; there is a need for further understanding about the impact of relational management practices when working with contemporary workforces.

With an increase in community health services being provided by non-government organisations (NGOs) who are often paid on a ‘per occasion of service’ system, and implementation of the National Disability Insurance Scheme, more and more health professionals will provide not only geographically remote health services (e.g. outback towns and islands) but also more community-based remote health services. As a result, health services will be provided remotely from a head office within regional and urban settings (e.g. at home or in community care). Hence, there is a need for further research into effective ways for those hybrid clinician-manager roles to manage remote health service workforces in light of contemporary employment practices, changing government funding models, and increased competition for limited resources.

References

Bartlett, K. R. (2001). The Relationship between Training and Organizational Commitment: A Study in the Health Care Field. *Human Resource Development Quarterly*, 12(4), 335-352.

Carney, T. & Stanford, J. (2018). The Dimensions of Insecure Work: A Factbook: The Australia Institute, Centre for Future Work.

Chandrasiri, S. (2015). Transitioning to the dark side: Evidence-based strategies for managing the critical challenges confronting new Clinician Managers. *The Quarterly,* 508.

Currie, G. & Croft, C. (2015). Examining hybrid nurse managers as a case of identity transition in health-care: developing a balanced research agenda. *Work, Employment & Society,* 29(5), 855-865.

Di Fabio, A. & Kenny, M. E. (2019). Resources for enhancing employee and organizational well-being beyond personality traits: The promise of Emotional Intelligence and Positive Relational Management. *Personality and Individual Differences*. (online)

Fulop, L. (2012). Leadership, clinician managers and a thing called "hybridity". *Journal of Health Organization and Management,* 26(5), 578-604.

Fulop, L. & Day, G. E. (2010). From Leader to Leadership: Clinician Managers and Where to Next? *Australian Health Review,* 34(3), 344-351.

Humphreys, J. S., McGrail, M. R., Joyce, C. M., Scott, A. & Kalb, G. (2012). Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data. *Australian Journal of Rural Health,* 20(1), 3-10.

Kippist, L. & Fitzgerald, A. (2009). Organisational professional conflict and hybrid clinician managers: the effects of dual roles in Australian health care organizations. *Journal of Health Organization and Management,* 23(6), 642-655.

Ko, J. & Hur, S. (2014). The Impacts of Employee Benefits, Procedural Justice, and Managerial Trustworthiness on Work Attitudes: Integrated Understanding Based on Social Exchange Theory. *Public Administration Review,* 74(2), 176-187.

Lenthall, S., Wakerman, J., Opie, T., Dunn, S., MacLeod, M., Dollard, M., Rickard, G. & Knight, S. (2011). Nursing workforce in very remote Australia, characteristics and key issues. *Australian Journal of Rural Health,* 19(1), 32-37.

Martens, J., Motz, J. & Stump, L. (2018). A Certified Registered Nurse Anesthetist's Transition to Manager. *AANA Journal,* 86(6), 447-454.

National Rural Health Alliance (NRHA). (2004). Supporting Health Service Managers in Rural and Remote Australia.

Onnis, L. (2014). *Managers are the key to workforce stability: an HRM approach towards improving retention of health professionals in remote northern Australia*. 28th ANZAM Conference, 3-5 December, UTS Sydney.

Onnis, L. (2016). *A Sustainable Remote Health Workforce: Translating HRM Policy into Practice.* (PhD Thesis), James Cook University, Cairns, Australia.

Onnis, L. (2019). HRM Policy choices, management practices and health workforce sustainability: Remote Australian perspectives. *Asia Pacific Journal of Human Resources.* 53, 3-27.

Onnis, L. & Dyer, G. (2017). Maintaining hope: the intrinsic role of professional support. *The Journal of Mental Health Training, Education, and Practice,* 12(1), 13-23.

Onnis, L. & Pryce, J. (2016). Health professionals working in remote Australia: a review of the literature. *Asia Pacific Journal of Human Resources,* 54, 32-56.

Pluchino, A., Rapisarda, A. & Garofalo, C. (2010). The Peter principle revisited: A computational study. *Physica A: Statistical Mechanics and its Applications,* 389(3), 467-472.

Spehar, I., Frich, J. C. & Kjekshus, L. E. (2012). Clinicians' experiences of becoming a clinical manager: a qualitative study. *BMC Health Services Research,* 12(1), 421-421.

Spehar, I., Frich, J. C. & Kjekshus, L. E. (2015). Professional identity and role transitions in clinical managers. *Journal of Health Organization and Management,* 29(3), 353-366.

Thompson, A. M. N. & Henwood, S. M. (2016). From the clinical to the managerial domain: the lived experience of role transition from radiographer to radiology manager in South-East Queensland. *Journal of Medical Radiation Sciences,* 63(2), 89-95.