

**Clinical Leadership in Jordanian Hospitals: The Clinicians' Perspective**

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### **Abstract**

The main aim of this study is to explore the nature of leadership in Jordanian hospitals. This study consists of four objectives; the first objective is to identify the extent to which clinicians perform their role of managing and leading Jordanian hospitals. The second objective for this study is to explore the source of power and authority being adopted in Jordanian hospitals. Then the third objective is to differentiate between doctors and other clinicians from nurses and AHPS in practicing leadership. While the fourth objective to explore the obstacles in developing CL in Jordanian hospitals.

The methodology of a qualitative approach was adopted through analyzing the contents, thus, semi-structured interview was conducted with 38 participants from managers who have a clinical mission besides managerial and supervising ones. The study has found out that there is a lack of administrative qualifications for clinicians, and seems difficult to apply the transformational style in Jordanian hospitals due the fear of responsibility and bad distribution of power and authority among clinicians and doctors in particular. Furthermore, there is a lack cultural diversity and this weakens the provided medical services in matching globalization and international criteria. Communication channels in Jordanian hospitals are acceptable; because both technical and personal settings among clinicians are emerged. Unfortunately, there was no specific and clear agenda for both quality and ethical considerations. Doctors are dominated by the concept of bureaucracy and centralism. Accordingly, some obstacles have been revealed in Jordanian hospitals; doctors are the biggest obstacle because they are holding the whole power. Also, communication channels with other departments and among colleagues are weak. Furthermore, the clinical culture did not reach the creation of cultural system. This is due to the weak coordination among academic faculties and governmental departments to shape the meaningful concept of health care management and leadership.

The researcher recommends that both quality and ethical considerations should be involved in more practical sense and doctors need to be trained to carry out the administrative responsibilities by involving nurses and AHPS to ensure the distribution of power and diversity. This study has added the academic contribution by presenting a new mass of knowledge, and considering clinical team members in Jordanian hospitals as a uniform by creating the comprehensiveness of work culture. Finally, the study proved that both experience and knowledge are additional authorities beside position, law and work that may enrich performance.

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**List of Abbreviations**

<b>Abbreviation</b>	<b>Terminology</b>
AHPS	Allied Health Professionals
APS	Australian Public Service
CEOS	Chief Executive Officers
CL	Clinical Leadership
CPD	Continuing Professional Development
Dept	Department
DOS	Department of Statistics
EFQM	European Foundation for Quality Management
GNP	Gross National Product
GPS	General Practitioners
HFA	Health for All
HR	Human Resources
HRD	Human Resources Department
HRM	Human Resources Management
IC	Individualized Consideration
II	Idealized Influence
IM	Inspirational Motivation
IMR	Infant Mortality Rate
IS	Intellectual Stimulation
ISO	International Standards Organization
JD	Jordan Dinar
JNC	Jordanian Nursing Council
JOD	Jordan Dinar
JPH	Jordan Private Hospital

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JUH	Jordan University Hospital
KAH	King Abdullah Hospital
LEO	Leading an Empowered Organization
LMX	Leader Member Exchange
MBA	Master of Business Administration
MCH	Maternity Care Home
MD	Medical
MDS	Medical Doctors
MLQ	Multifactor Leadership Questionnaire
MOH	Ministry of Health
N	Number
NHS	National Health Service
NQF	National Quality Framework
Nsg	Nursing
PBH	Princess Basma Hospital
PHC	Primary Health Care
PHCI	Primary Health Care Initiatives
PhD	Doctor of Philosophy
PPLS	Professional Practice Leaders
QA	Quality Assurance
RCN	Royal College of Nursing
RD	Research and Development
RMS	Royal Medical Services
TCM	Total Care Management
TQM	Total Quality Management
UK	United Kingdom
UNDR	United Nations Development Report

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UNRWA	United Nations Relief and Works Agency
USA	United States of America
USAID	United States Aid for International Development
USD	United States Dollar

## **Chapter One**

### **Introduction**

#### **1.1 Backgrounds and the Need for Study**

The main objective of this study is to examine the reality of management and leadership in Jordanian hospitals and to find the appropriate answer to the following issue: Are the technical training, academic rehabilitation, and the powers (the role) granted to clinicians in hospitals considered significant factors in creating a concept of leadership with the formation of work experience and knowledge? Basically, the researcher means by clinicians, the health care providers who assist in health care services in Jordanian hospitals. This is an attempt to differentiate those workers from the ordinary employees working in several departments such as management, finance, IT, engineering, maintenance, guarding, etc.

To emphasise the importance of this study, Muasher (2005) suggested that health service management in Jordan is still need some developments regarding staff, sources and process as there is no obvious planning to promote human resources and management. In addition, co-operation between medical or clinical institutions with health care providers is still limited and needs much greater levels of support. Therefore, this thesis argues that classic, bureaucratic management structures are no longer suitable for huge organisations like hospitals health service providers who are attempting to match public demand and customer requirements.

Many authors, such as Preston and Clarke (2000), Heiberg and Hellijesen (2002), Schultz (2004) and Goodwin (1998), have stated that health service managers have often moved into management from a clinical background. They have very little experience of management and

in such cases it is a big responsibility for clinicians or chief executives to have managerial requirements, effectively balancing the demands of clinical and managerial responsibilities. Health services cannot be provided unless such institutions have successful management or leadership, with highly qualified staff who possess both clinical and administrative skills. By making clinicians primary decision makers in the hospital environment, as much money has been spent on leadership development, learning about leadership ideas and skills and learning about transition from administration to management; there must now be a transition from management to leadership, therefore change must occur in order for clinicians to become effective leaders (Lamb and Cox, 1999). There are common characteristics between leadership and management; for example, the topics of management and leadership are severely complex according to Kokkinen et al (2007). To emphasise this issue, Yukl (1981, p2) defines leadership as *“the behaviour of an individual when he is directing the activities of a group toward a shared goal, it is interpersonal influence, exercised in situation, and directed through the communication process toward the attainment of specific goal or goals”*.

This thesis will explore and analyse the ways in which the current standards of health care can be maintained. It is increasingly important that specialised and ethical leadership must provide a source of enthusiasm for all levels of staff; for example, the UK Department of Health (2000) states that the health service will require first class leaders with both clinical and managerial backgrounds. Those leaders believe in shifting the balance of power in order to create a better health care system that tackles bureaucracy. Such a situation means clinicians will take the sole responsibility of managing one health team. Some managerial and leadership skills are needed to facilitate such a new style of leadership based on power. This type of power means visible supervisory roles embodied in knowledge, experience and position for all clinicians.

Unfortunately, clinicians usually have no managerial background as their university curriculum has been focused purely on clinical procedures regarding hospital administration, such as health planning, epidemiological statistics and some information about health communication skills. Instead, they get to practice their management skills throughout their training period under the supervision their supervisors. Clinical associations, such as medical and nursing, as well as clinical colleges, are now aware of the need to teach their clinical students some compulsory management modules in their curriculum. The knowledge they gain from this process enables them to lead their clinical departments more easily. Also, alleviate conflict with non-clinical managers and human resource officers, finance, quality departments, training and development sections, maintenance, engineering, and other departments.

It can be difficult for non-clinicians trickle their roles to clinicians instead of managerial individuals and administrative officers such as accountants, HR officers and others who are working in management. “This often causes a problem of communication for clinicians when passing their clinical information to administrative officers from a non-clinical team, because non-clinicians do not possess clinical knowledge. The opposite is the case when administrative officers pass managerial information to clinicians who have no management background.

To enable more successful communication it would be necessary for clinicians to share their goals and strategies (including those relating to human resources, budgetary, planning, vision and strategy) with their colleagues from a managerial background to a greater degree. Furthermore, top management groups in hospitals, such as chief medical staff, head nurses and clinical directors from allied health professionals (AHPS) should move to being operative



leaders .They are achieving a diverse team formulating CL, led by clinicians from all divisions, not only medical staff, and ignoring the classic understanding of doctors as 'managers' and 'leaders' of hospitals.

Doctors have no serious problems regarding practicing CL because they are usually awarded a high level of authority in their hospitals, being the most qualified of those with a clinical background. They are also considering themselves to possess decision making and managerial responsibilities within the hospital environment. For this reason they are often involved in health care management as policy makers in the strategic apex of government. My research demonstrates that physicians, as clinical members were involved in decisions during the development of strategy as they are very fast learners. This is one of the important reasons for health services naming doctors as health service management leaders. However, the increasing work-load of many doctors may affect the clinical side of their occupation negatively; the more they are heavily involved in the managerial process the greater the potential for this to impact on their original medical roles and responsibilities.

Therefore, it is frequently common for other clinicians, such as nurses, to hold highly advanced academic certificates of clinical setting and health service management. This is either in the form of completed training courses or separate administrative qualifications such as a diploma, masters or PhD. These qualifications enable lower level of clinicians to practice CL, however, in spite of holding qualifications and possessing a great deal of experience. Basically, lower level clinicians do not usually have the positional power to be decision makers in their hospitals, as doctors do. Furthermore, they are represented on hospital boards by one person while doctors have more than 3 or 4 members such as the chairman, clinical leaders and assistants for strategy, planning etc. The same situation applies to AHPS who, as a

separate group, do not have strong powers and are not strongly represented on hospital boards.

In spite of the country's good level of health care delivery and highly developed infrastructure, health service management in Jordan is still a relatively new concept. Increasing public expectations require wise management and leadership abilities in order to successfully establish a new culture aimed at promoting better health care quality. This research intends to fill some of the aforementioned gaps in knowledge surrounding Jordan's health care system. To this end variables have been formulated to explore the state of Jordanian CL. For example, in 1997 Jordan's Ministry of Health (MOH) drafted a strategy for advancing health care by 2010, which informs much of the fieldwork of my own study. The document suggested special measures to strengthen health management, professional standards and maintain Jordan's role as a centre for excellence in medical treatment in the Middle East. The strategy defined the role of the MOH in planning, training and continuing the education of health professionals. Also it is promoting and institutionalizing health research and technology development according to international standards by linking management performance to health economics principles.

For this reason, many commissions, such as the Primary Health Care Initiative (PHCI) and United States Aids for International Development (USAID), have established significant roles in CL working to promote quality services at the MOH. Furthermore, these commissions were named also to introduce and sustain a quality assurance programme, train staff, strengthen health communication and conduct research (PHCI, 2002). Moreover, they enhance the relationship between lower level employees and those of the upper levels. In this approach, Jordanian clinical faculties are increasingly aiming to introduce their students to management

and leadership concepts, preparing them to manage care, make appropriate decisions related to clients and utilise the knowledge in planning health care (Abu-Mughli and Zu'mut, 2006:a). Also, it is important to remember the vital role that health care organizations in Jordan can play in adjusting the quality of the health service to meet the international standards, including organisational structure, communication systems, administration recruitment, staffing, expertise and qualified personnel, quality assurance, code of ethics, nursing administration and management and leadership (JNC, 2006:a).

Interestingly, Jordan began to establish a good, solid base for CL and hospitals started to prepare their clinical followers, such as doctors, nurses and AHP, to be leaders in their hospital believing they are the most appropriate people to make clinical decisions concerning health strategy and planning. This system is generally regarded as being more appropriate than managers with an MBA with no medical training. However, it would be easy for clinicians to make decisions due to having the benefit of both clinical and managerial background at the same time

Currently, Jordanian hospitals (which constitute the fieldwork of this study) are looking for international accreditation. Yet they are struggling to meet the requirements regarding the standardisation of health care quality and the adoption of highly developed management and leadership. Furthermore, health service delivery is now measured by the demanding standards of ethics, criteria and international standardisation in participation with clinical institutions, such as medical and nursing faculties and professional associations.

My reasons for initiating this study are numerous and include an acknowledgement that health as a concept does not refer only to pathological and physical considerations, but also healthy management and leadership. Indeed, the health service, as a large, multifaceted organization,

should be at the forefront of progressive administrative methods (Goodwin: 2000). For example, clinicians, especially doctors, nurses and HPS are required to be involved in the managerial process by providing them with suitable training to overcome misunderstandings which may arise with non-clinical administrative. In other words, fostering highly cooperative behaviour instead of conflict. Because the medical sector has shown such a high level of development in recent years regarding highly complicated medical surgeries and procedures, clinicians are the best who can assess their own needs and hospitals non-clinical bodies.

In order to conduct this study, qualitative method was applied to gather data from doctors, nurses and AHPS in different medical departments in four Jordanian hospitals from the public and private sector. This was also including the academic ones to achieve diversity. The purposive sample were interviewed to extend the data and to give a comprehensive picture about the study concepts and the most important obstacles faced by clinicians regarding CL and their views to the general philosophy and strategy of the hospital. The open ended interviews have an obvious role in describing the panoramic view; which helps to draw out the findings, recommendations and obstacles that stand in the way of achieving such objectives. In addition, the result of this study will have a strong impact in the academic, managerial, and clinical contributions that could be taken in future when conducting similar studies to identify the managerial reality of the health sector. The use of the contents analysis for qualitative analysis is to support all manner of other ways in order to facilitate generalization.

Accordingly, the objectives described in the next part of the thesis are attempts to detail all of the relevant issues regarding the clinical environment and the important role clinicians have in

improving clinical and managerial approaches to a level in line with those of more successful international and western countries.

## **1.2 Research Objectives**

This first objective of this thesis can be summarised as follows: to identify the extent to which clinicians perform their role of managing and leading Jordanian hospitals according to their clinical background. For this reason, it will be surmised that clinical knowledge is not enough for clinicians to be managers and leaders. The second objective for this study is to explore the source of power and authority that clinicians have in practicing CL, and linked to this point, to consider if it might be possible and indeed beneficial for all clinicians (not only doctors) to perform CL in order to secure the diversity of the clinical system? To highlight this issue, the third objective in this project will be to differentiate between doctors and other allied health professionals, in terms of leadership effectiveness. Finally, in order to evaluate the effectiveness of current CL and potential means of improvement, the fourth objective will be to explore the obstacles in developing CL in Jordanian hospitals.

## **1.3 Organization of the Study**

This thesis comprises eight chapters. Chapter two, entitled leadership as a concept, explores the importance of leadership concepts and multiple styles of leadership; it also details the necessary combination of many factors that are needed in order to be successful in leadership professions. Chapter three contains a discussion of CL in terms of clinical professions, such as the group of leaders, doctors as leaders and nurses as leaders, health quality, clinical and managerial ethics and communication, among health professionals. Chapter four, the Jordanian experience in CL, documents the situation of leadership in Jordanian hospitals and its health service sector in terms of the health status in Jordan, the background of Jordanian

CL, USAID participation in Jordanian CL, CL in Jordanian curriculum, standardisations of Jordanian CL and clinicians' attitudes towards CL in Jordan. Chapter five provides the research methodology. Chapter six is a discussion of the qualitative data analysis. In Chapter seven, the research findings are discussed and, finally, Chapter eight provides the conclusions and implications of this study.

## **Chapter Two**

### **Leadership as a Concept**

#### **2.1 Introduction**

This chapter aims to discuss the nature of leadership, focusing on transformational leadership. This kind of leadership is influenced by many factors, including the leader and his characteristics, the team and their beliefs, the organizational culture and its contribution to shaping the ideal leadership, as well as relationships and types of communications amongst the different hierarchical levels. In order to reflect this multiplicity, this chapter is structured as follows: section 2.1 presents the introduction, section 2.2 details leadership and professionalism while section 2.3 and 2.4 explain the definitions of leadership as a concept and differing theories of leadership. Characteristics of leaders and power are discussed in section 2.5. In section 2.6 leadership style and culture is discussed. Following this discussion, sections 2.7 and 2.8 explore the concepts of the team and communication as important features of leadership.

#### **2.2 Leadership and Professionalism**

Creating climates of constructive cooperation and organisational learning mean achieving a certain level of professionalization (Glover and Hughes, 2000). In this context, Ollila (2008) also emphasizes that management is now considered as a system of methodical support. A manager's basic task is to reduce work overload and add to the wellbeing and welfare of the team; providing comprehensive support systems and ensuring competence. However, Englmaier et al (2010) stated that a manager with a free hand means poor decision-making within unproductive projects.

In this sense, Abbot (1988) concentrates on the movement from an individualistic to a systematic view of professions, which is “healing our body and measuring our profit” (Abbot, 1988, p.1). To emphasise this idea, Freidson (1986, p.21) defines professionals by saying that they are “*intelligentsia, intellectuals, technicians and experts*”. *Professions are addressed in management training and business education to create vocational post experience management to teach something useful such as accountancy, marketing and personnel management*”. Abbot has also concentrated on the knowledge involved in professions, stating that the organizational formalities of professions are meaningless unless we understand their context. The term "professional employee" here refers to any employee engaged in work which should be varied in character as opposed to routine mental, manual, mechanical or physical work, over which they should have some judgement and specialised knowledge (Freidson, 1986).

Cooper and Palmer (2000) emphasized that work needs a type of supervision exploring the practitioners’ mission where the supervisor is expected to have some responsibility for work and identify problems . This also means that team members have a mutual responsibility to succeed in their leaders’ or supervisor's mission sharing their organisation’s aims and vision. For example, Freidson (1986) stated that, in bureaucracy, subordinates are expected to obey their officials by virtue of their formal position as officials.

It can be concluded that being a professional means possessing a distinct set of characteristics, often believing in the importance of knowledge, experience and education, combined with strong trust with followers and open channels communication. Dynamic organisations believe in such professionalism and try to encourage it where possible. That means professionalism setting is a complete concept consisting of individuals, experience and process by matching the organisation goals and employees interests Arguably, current management and bureaucratically systems are no



longer suitable in achieving organisational goals, instead a leadership style based on professionalism; applying a distinct style of supervision depending on consultation, training and delegation, may be a more successful solution in creating potential leaders from team members. In other words professionalism according to above discussion means that as sense of life could be given to organisations while considering the source of power for both leaders and followers embodies in experience , knowledge and some ethical considerations as well as the situation need .

### **2.3 Definitions of Leadership**

The topics of management and leadership are profoundly complex; as a result management and leadership overlap in the field of personnel management (Kokkinen et al, 2007). We should not ignore the fact that leadership is an important concept, with many linked definitions. In this Yukl (1981, p2) defines leadership as *“the behaviour of an individual when he is directing the activities of a group toward a shared goal, it is interpersonal influence, exercised in situation, and directed through the communication process toward the attainment of specific goal or goals”*. Decades of academic study of leadership have reported more than 850 definitions (Bennis and Nanus, 1985). Many authors, such as Fiedler (1967), Riseborough and Walter (1988), Drucker (1947), Shackleton (1995) and Yudelowitz et al. (2002), have argued that it would be useful to have a clear logic behind why this concept is important in any organization in spite of the lack of leadership practiced in these organizations. Both Dexter and Prince (2007) have introduced leadership in the public sector as an accountability and performance management .In this approach, Seniore et al (2011) argued that the psychological of leadership is a huge topic understanding the psychological factors driving leadership behaviours within socio-biology which can may facilitate and enhance leadership effectiveness.

By using these studies as a basis of leadership, we can say that “leadership is the power and characteristic of a person to influence groups to achieve goals after a systematic process starting with selecting the team, sharing ideas, inspiration, communication, decision making, motivations empowerment and delegation ending with power for subordinates”. Furthermore, Cole et al (2011) say that leaders or managers transmit their belief to team members through role modelling by providing guidance and reinforcing behaviour that supports a leader's favoured achievement orientation. In other words, leadership means sometimes a charisma which the followers can detect the behaviour of their leaders according to their perceptions (Levay, 2010).

Accordingly, leadership means that there are some factors and a suitable atmosphere for work environment such as an appropriate behaviour for both subordinates and leaders. These factors are embodied in open communication and transmitting information smoothly thorough the different managerial levels. So, sense of power for leaders is a need to direct their followers in order to achieve goals. In other words, the charismatic setting is not enough for leaders to have their power and strength on team members, but sharing their interest seems important for success. It seems also that the definition of leadership does not mean only managerial approach but also social and psychological as well as biological. Furthermore, leading personnel needs qualified leaders and followers to build such concrete concept; this could be valid for leadership approach which means that management concept becomes narrow besides leadership indications.

It can be detected that leadership is a comprehensive term of organisational care concentrating on the behaviour of both leaders and followers. It can also achieve the vision and mission by using the talents and abilities of individuals to be involved in decision-making and goals. Theories given next might explain and answer this questionable issue.

## 2.4 Theories of Leadership

There are several fields of leadership theories, these theories spread throughout the twentieth and twenty first centuries. It was based on the characteristics of leaders, individuals, organizations and elements that constituted the concept of leadership. For example, Trait theory, at the highest of its fame till 1940, focused on individuals' characteristics. After that theory, style theory spread throughout 1940s and 1960s, concerned with behavioural aspects and respecting the followers' needs. Then the contingency theory came into existence during the late sixties and continued till the early eighties, it focuses its attention on the general atmosphere that governs organizations and companies. Later on, contemporary theories emerged throughout the 1980s and beyond, these include the transformational, charismatic, visionary and transactional theories. (Sullivan and Williams: 2007).

Trait theory has been discussed by many authors such as Armandi et al. (2003), Sullivan, (1990), Yukl (1981), Mc Arevery et al. (2001) and Metclafe and Metcalfe (2007). Such authors believe that Trait theory can be used to differentiate leaders from non-leaders, with the theory focusing on characteristics such as the desire to lead honestly and with integrity, self-confidence and intelligence and job relevant knowledge as signifiers of leadership potential. This is also called the Great Man Theory. The style approach, according to Ohio State University and the University of Michigan refers to the belief that there are two general types of leader behaviours. The first concerns interpersonal relationships between leaders and subordinates, whilst the second relates to the initiating of structures or achieving of goals (Armandi et al., 2003). The third theory, contingency suggests that the degree to which the situation allows the leader to control and influence is important (Armandi et al , 2003). In this vein, Schneider and Littrel (2003), Grint (1997) and Sullivan (1990) explain that contingency theory opens the door for the possibility that successful leadership could differ given the situation and as such is dependent on two factors: the personality of the leader (leadership style) and the situation itself in terms of size, structure and the

purpose of the setting as well as the climate (the atmosphere of the organization, supportive or non-supportive).

Hernandez et al (2011) added that contingency theories consider the situational factors such as leader-member relations, task structure and position power for leader which is high. This means that leaders cannot manage the situation without considering the additional sources of power coming from the leader himself, the follower's experience and the consistency of task. Under these circumstances, a leader is supported by the situation because he has some influence and potential power on followers. He also emphasised that the path-goal theory is a situational theory will lead to a valued outcome. For example, the effective leader, according to path-goal theory, classifies employee's paths to work goals and the link between work goals and valued personal outcomes.

Interestingly, Bedeian (1986) notes that these theories overlook or ignore the possibility that the followers have an active role to play in the success of the leader in achieving ideal decisions and desired goals. However, both Armandi et al (2003) and Bedeian (1986) have discussed the importance of suitable forms of communication, ethical frameworks, follower's motivational levels and work place quality as crucial factors in achieving good leadership. Bryman (1986) agrees with Hernandez et al (2011) that path goal theory is to shape leadership style according to leaders' characteristics. He mentions five styles being embodied in.

- 1- Directive leader: telling subordinates what to do.
- 2- Negotiating leader: developing bargaining to achieve goals.
- 3- Consultative leader: discussing with subordinates before making a decision.
- 4- Participative leader: subordinates take a part in decision - making process.
- 5- Delegating leader: subordinates are left free to make their own decision.

Furthermore, Hernandez et al (2011) has pointed out that situational leadership theory depends on the followers' level of maturity and the leaders should match their behaviours with the followers' maturity level by moving through the phases of telling, selling, participating, and delegating to correspond and increase follower readiness.

So, these styles of leadership can be summarised as a mutual contract between the leader and his/her team members made because there is much more support of the leader in technicalities and consultation. The authors, Kelloway and Barling (2000) and Yukl (1989) stated that transformational theory elevates the interests of followers in an attempt to generate awareness and acceptance of the purpose and the mission. In contrast, Bass (1985) explains that transactional leadership as the clarification of goals, work standards and task assignments which focuses on task completion and engendering compliance based on incentives and rewards to appeal to the self-interest of followers.

Most of the researchers on transformational leadership have used the multifactor leadership questionnaire (MLQ) developed by Bass Avolio (1994), which emphasised that transformational leadership is composed of four dimensions. First, *idealized influence (II)*, which refers to extraordinary leaders who usually emerge in the context of crises or major change. Secondly, *individualized consideration (IC)* means the extent to which the leader cares about the individual followers' concerns and development needs. Third, *intellectual stimulation (IS)* means the degree to which the leader provides followers with interesting and challenging tasks and encourages them to solve problems in their own way. The fourth dimension is *inspirational motivation (IM)* based on the communication of expectation and followers' confidence in their leaders' vision and values as well as challenging the old ways of thinking in addition to personal attention, mentoring, listening and empowering (Gillespie and Mann ,2004 and Stone et al, 2004).

In fact, the authors Gaughan (2001), McAreavey et al (2001), Horner (1997), Monica (1990), and Jabnoun and Al-Rasasi (2005) have added that, being either positive or negative transformational can be seen as an expansion of transactional leadership. In their further discussion of leadership styles, the authors Godiwalla et al. (1997), Cooney et al. (2002), Manning and Robertson (2002) and Brazier (2005) have proposed that transformational leadership definitely creates the culture and climate of the organization and enables its workers to participate in a shared vision and strategy, where the vision is a vital factor in providing leadership with a real strategy to improve employee satisfaction through efficient management. Consequently Hancock (2005) argues that the transformational leader will provide the skills for the profession to stretch its boundaries and be innovative in the way in which its problems are viewed and solved.

To summarise transformational leadership, Utley et al (2011) discussed transformational leadership by revealing the meanings of its components. For example individualized consideration means knowing employees and showing concern for employee's needs. While intellectual stimulation is encouraging employee creativity and problem solving as well as learning., in addition to providing opportunities for creativity. Inspirational motivation means doing best and recognizing quality work performance. Finally, idealized influence is acting as a role model and demonstrating desirable behaviours

Again, Hernandez et al (2011) has also added that there are some theories are emerging with leadership such as value driven concentrating on ethics and values. These theories called ethical, spiritual and authentic leadership. For example, ethical leadership is demonstration of appropriate conduct through personal actions and interpersonal relationships by focusing on two-way communication, reinforcement, and decision-making. While Spiritual leadership theory is focusing on the leader's spirituality and the followers' spiritual needs. Authentic leadership theory interacts

with social identification by increasing the followers' levels of hope, trust, positive emotions, and optimism because it is cross-cultural leadership. Moreover, Zhu et al (2011) identify how authentic transformational leadership develops group ethical climate and follower moral identity to enable individuals to create ethical complexity and behave fairly. Also, Simola et al (2010) stated that equality and fairness assume moral decision making and sharing of societal norms and respect for laws. In this approach, Wright and Quick (2011) clarified that values-based or ethical leadership also focuses on moral qualities leading to better society embodied in being courageous, forgiving and self-controlled. Generally speaking, DeChurch et al (2010) have emphasised that a phenomenon is emergent that leadership affects four types of emergent constructs: cognitive, behavioural, affective and motivational and there are some interaction and similarities amongst leadership theories.

Many authors such as Fitzsimons et al (2011) revealed further theories called distributed leadership by acknowledging that multiple individuals are involved in the leadership mission not only leaders by exploring the interactions between individuals and situation in which leadership is enacted. Interestingly, Edwards, G, (2011), emphasised that this kind of leadership also appears to have other labels such as dispersed leadership, institutional leadership, co-leadership, shared leadership, multidirectional leadership and rotated leadership, all these names are similar. Therefore, Thorpe et al (2011) have seen distributed leadership within a social phenomenon with constitutive of the practice of leadership, concerned with thinking and actions in situation focusing on actions rather than role or position. Thus, co-leadership, shared leadership; and self-managed teams are considered to shape this type of leadership. In this vein, Boldon, R, (2011), consider that distributed leadership is a notion that has seen a rapid growth since the year 2000 which is a group activity that works within relationships rather than individual action. Accordingly, Currie and Lockett (2011) argued that this style of leadership is appropriate to be practiced in health sector for

many reasons. First, health and social care are a pattern of how contextual influences linked to professional hierarchy and policy impact. Second, health and social care is a fast mover in policy reform. Third, it is an ethical practice associated with lack of power by those positioned as followers. Therefore this kind of leadership is a super leadership is the emphasis placed on leading others to lead themselves.

In conclusion, we can say that the transformational style of leadership involves a belief in the culture and vision of the organisation; in breaking down the bureaucracy as well as expanding the definition of environmental factors to serve communities. Transformational leadership is an attempt to change the organizational culture and stretch its boundaries to move from management to leadership and to create leaders believing in consultation, direction, negotiation, direction and participation. To emphasize this Wang et al (2011) pointed out that the favourable effects of transformational leadership behaviour on followers include strengthening followers' confidence in the leader, making followers feel good in the leader's presence by obtaining respect from employees. So, both transformational and transactional leadership involve two types of behaviour, one the firm, such as planning, vision or goals and the second on the followers by proving support technical assistance. In this approach Menges et al (2011) have added that transformational leadership is a positive and affective climate with high trust providing high levels of performance in followers due to strong interaction between leaders and followers. Furthermore, the transformational leadership framework assumes transformational leader behaviours to create a meaning for organizational change and creating followers to be leaders by working together to meet organizational requirements and enhance its performance ( Wallis et al, 2011).In other words, there is a positive relationship between transformational leadership and effectiveness according to Cho and Dansereau (2010).



## 2.5 Leader and power

One of the most important facts of studies into leaders and leadership is the attempt to identify the characteristics that enable an individual to successfully lead others with sense and vision. Consequently, Kelloway and Barling (2000) ask the question: Who stands out as the best leader you have had? As if to answer this theoretical question, both Bennis and Nanus (1985) replied that the leadership of Winston Churchill, Mahatma Gandhi, Golda Meir, Franklin D, Roosevelt, Tom Watson, Edwin Land and Alfred P. Solan stood out for them as suggesting they would be able to build great organizations.

It is important to note here, the difference between being a manager and being a successful leader. It may be possible to surmise that anyone can be a manager but very few people embody leadership qualities. When you talk about a successful leader you are often in reality talking about someone who is both heroic and charismatic. Dexter and Prince (2007) address this issue, stating that leadership can be only learned, not taught. They go on to suggest that the leader often tends to use a narrow view of teaching which fails to recognize the roles of a range of pedagogic methods that can develop certain skills and attributes. The leader is often a unique person who is normally bigger than others, not in age but in what he is doing (Damiani, 1998). In a similar vein, the authors Bass (1960), Tapeen (2001), Oni (1995) and Guo (2003) argue that a leader becomes a father and that the most important attribute for leadership is the desire to lead. All of this discussion points to the belief that the extraordinary leader will be someone who claims authority, knows the weaknesses and strengths of his subordinates, and is able to develop the deficient areas and promote the competencies of his workforce. Role conflicts arise from intangible differences in values, about the content or importance of required job tasks, between workers and various supervisors, (Michael, 2009).

In a slightly different take on the notion of the leader, Townsend and Gebhardt (1997, p.136) mention that the representative of the US House, Sam Rayburn, has said “*You cannot be a leader and ask other people to follow you, unless you know how to follow, too. He added that it is his responsibility to create new leaders*”. Furthermore, both Dierendonck (2002) and Thacker (1997) illustrate that LMX, (Leader Member Exchange Theory) describes how leaders use their positional power to develop and exchange relationships with different subordinates.

Sydow et al (2011) pointed out that leaders are influencing the social activities and relationships towards the production, reproduction or transformation of a social order due to their (powerful) situation known as knowledgeable agents enabling them to monitor organisation . The leader should be productive and valuable in their handling of both production and people, developing cooperation more than competition with a low level of productivity that may discourage employees, making them feel un-rewarded and poorly coordinated as well as frustrated (Liu et al., 2002). In this approach, Subasic et al (2011) pointed out that there is shared psychological sense between leaders and followers called power tools strengthening the leader's influence and authorities by rewarding certain behaviours and sanctioning other. Additionally, Fisher et al (2011) indicate that the absence of power has negative effect on social behaviours because when people are powerless they feel uncertain increasing interpersonal conflict and reducing procedural justice. In the same vein, Murali and Nagpal (2011) stated that power is not only material resources such as money, food, and jobs, but also social resources like knowledge, respect and psychological state. For example the cumulative evidence according to Rucker et al (2011), suggested that power is an omnipresent force shaping and guiding human behaviour. Moreover, Fast et al (2011) said that over-confident power makes people to feel subjectively and powerful in decision making. The same thing, People in high power are more likely to see themselves as autonomous rather than connected to others (Cazaet al,

2011). To emphasise the importance of powerful leaders Ruset al (2011) suggest that holding powerful leaders means powerful tool to prevent potential self-serving actions on their part.

Definitions of what it means to be a leader are numerous and most focus on the leader's personality more than their physical state. For example, Durbin (1988) pays attention to the leader's ability to inspire others and their intelligence, particularly in terms of self-confidence and managing crises. Another slightly different definition sees a leader as "*a person who has ability to get the other people to do what they don't want to do and like it*" (Manske: 1990, p1). Perhaps the most important characteristic for a leader is a defined set of morals as in Krishnan's perspective (2003). Krishnan believes that the moral leader should work towards the enduring benefit and growth of their followers. As a result, Yang et al (2011) emphasised that leaders have a complexity in their characteristics and emotional intelligence such as self-awareness, self-regulation, motivation, empathy, and social skill. They added that there are six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal.

It is evident that a leader is an important element of the teamwork concept as he is often considered the father and boss of any organisation due to his high levels of experience and training and strong work ethic. He must also listen to his subordinates when it is necessary, a process which enables him to lead others more easily, taking care of their respective ethical considerations.

## **2.6 Leadership and Culture**

Different situations of employees are needed in organisations. In this sense, Park and Tim (2009) have given a particular attention to the idea that organizational culture should embrace belief

ideology, custom, norm, tradition, knowledge, and technology; it influences the behaviour of an organization and its members. In this sense, Bonoet al (2011) emphasised that cultural characteristics is the extent to which leaders and others agree in ratings of leadership behaviour.

Both Millward (2005) and Brooks (1997) have argued that a suitable culture is needed to provide a framework for behaviour. They added that structure and culture might be experienced as one state. Following this approach, Block and Manning (2007) indicated that the long term success of a leadership development initiative requires an organizational culture that considers developing future leaders as a long term strategic priority. Similarly, a positive organizational culture is co-created by leaders and their followers as they mutually engage in the process of sense making.

As discussed earlier, Loo (1997) has pointed out that many organizations went from the 1980s to the 1990s concentrating on culture, leadership and vision because an emphasis on structure and systems did not produce the expected organizational results. Lok and Crawford (2001) highlight the functional relationship between leadership and organizational culture by saying that the leader has an improvement role in managing shared values, which are considered the core of organizational culture. Accordingly, Schein (1985, p595) defines culture as *“a pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problem of external adaptation and internal integration, and have worked enough to be considered valid”*. Additionally, Mackenzie (1995) has added to this discussion that *“it is common held beliefs, attitudes and values which give meaning to the organization for its members and provide them with roles for behaviours”*.

The authors Wright (1986), Bettenger (1989), Allen (1995) and Gordon (1985) discuss several of the aspects that a successful organizational culture must be aware of, these include human resource orientation, conflict resolution, attitudes and beliefs, innovation, employee commitment, clarifying of organization direction, management styles, attitudes ,mistakes, leadership, communication style and customer orientation. In this sense Senior et al (2011) pointed out that the transformational leader motivates followers and encourages them to transcend self need for the favour of organisation by supporting the concept of culture for change.

Culture should be linked strongly with the vision of the organisation because an emphasis on structure alone will produce results. Similarly, regarding the clinical sense, Park and et al. (2009) has declared that education of clinical and administrative staff is an important precursor prior to the implementation of any new information system.

## **2.7 Leadership and Team**

Being part of a team, according to Landsberg (2000) , Bezzina et al. (2001) and Storey and Buchanan( 2008) means giving individuals and teams some power might take management support out of the system, and acting as a partnership in order to achieve a mutual goal together under the direction of a leader. In this sense, leadership requires team members to understand and respect the role of each other when implementing and evaluating decisions. One of significant reasons to organize work in group's teams because group performance means different and several knowledge and perspectives of group members in which distributed knowledge is exchanged, discussed, and integrated to establish decision making with distributed information (Van et al, 2011).

Stones and Granthan, (2009) suggested that corporate social responsibility has favourably translated equity, employee satisfaction, reputation, team building, and community relations into a

solid reputation. In this vein, Ayoko and Callan (2010) emphasised that the team task has a social by improving the quality of working life of members. In the same vein, Carmeli et al (2011) emphasised that the team behavioural integration believes in the process of quality of information exchange among team members and collaborative behaviour among the team members. Furthermore, according to Yang et al (2011) that teamwork is statically significant by influencing the project performance and there is a visible relationship between teamwork and overall project success. Additionally, Monica (1990) indicates that the team can create a positive group dynamic by achieving the following things: greater sensitivity to follower needs and desires.

In this sense, Schippers et al. (2008) pointed out that transformational leadership attempts to transform followers by stimulating them to go beyond self –interest. It does this by changing their morals, values and ideals, and motivating them to perform above expectations. Furthermore, Schippers et al. (2008) added that leadership for the team means having a shared, overarching goal or vision of the future. In the same vein, individual’s identification – internalization of the organization’s goals and values in addition to involvement measure the individual’s sense of belonging towards the employing organization, (Michael, 2009).

The importance of teamwork factors such as those outlined above can be seen in the study of the UK NHS by Bamford and Griffin (2008), who note that the NHS regarded the following factors as essential in teamwork development: purpose; organization; leadership; climate; interpersonal relations; communications and composition. The authors Millward (2005), Greenberg and Barcon (2003), Gillespie and Mann (2004) and Akhlaghi and Mahony, (1997) all argue that it is critically important for those in frontline leadership to make the team process visible and actively manageable in order to successfully develop the idea of integrated teamwork. They added when people are multi

skilled they tend to be more interested in their jobs, similarly when they feel happy and satisfied their performance in terms of quality and problem solving is likely to improve.

A recent study by Gillespie and Mann (2004), entitled *Transformational Leadership and Shared Values: the Building Blocks of Trust*, investigated the relationship between a set of leadership practices (transformational, transactional and consultative) and members' trust in their leader in a research and development (RD) team. In conclusion, the study found that the behaviour of team leaders who have the task of managing teams are highly educated, committed and often individualistic scientists and technologists who work together. Schippers, (2009) declares that transformational leadership enhances team collectiveness; it develops team reflexivity by focusing on the role of leader behaviour, enhances a common goal and mutual vision in the team that will enhance its abilities, the thing that shall have a strong impact upon the team objectives, strategies and collectiveness.

Moreover, setting and sharing common values with team members using a set of inter-related leadership techniques based on consultative decision and modelling a collective and value -driven vision. Both Townsend and Gebhardt (1997) have established guidelines for the followers such as seeking self-improvement and getting more practice.

In their study on a similar subject, Konu and Viitanen (2008) point out that the philosophy of shared leadership involves decentralization and creating an empowering environment. Accordingly, transformational leaders can influence a team environment by influencing the followers' values in an attempt to achieve the organisation goals (Hur et al 2011),

In many ways team members can be seen as the leaders of the future as they have the same interests as their leaders concerning achieving the organisation's goals and strategies. They are often technically proficient which enables them to emphasise that knowledge and experience are considered powerful characteristics, and qualifies them to be decision-makers. The successful team member should believe in coordinating, evaluating, directly educating and sharing knowledge with others. They should be able to take the initiative and not need to be spoon-fed by leaders or directors. In this manner, transformational leadership is dependant not only on the characteristics of leaders but also team members, who will be qualified to be leaders one day.

## **2.8 Leadership and Communication**

The word communication comes from the Latin, *communico* meaning to share (Damiani: 1998. p117). While Greenberg and Barcon (2003, p.318) define it as a “*process by which a person, a group organization (the sender) transmit some type of information (the message) to another person, group or organization (the receiver)*”. Though traditional communication is a formal and rigid process (Seifre, 2001) it can be a useful means through which to increase teamwork productivity. Communication is also an important component of providing a work atmosphere in which employees can feel appropriately motivated and creative, as Thacker (1997) argues. In his study (Bell, 2007) explores how the ability to communicate successfully requires specific training among managers and team members. The supportive communication style is more likely to foster creativity than control while the controlling style may decrease individual motivation and does not allow for creativity. Therefore, the team with a directive/assertive leader reported that the leader’s communication style had a negative impact on the creative processes of the group, while the team with a consultative team oriented leader reported that the team leader’s communication style had a positive impact on the creative process. In the same vein, both Tourish and Hargie (1996) clearly illustrate that in a major survey of over 300 organizations during the late 1980s, most employees



still felt that senior managers did not understand the pressures of their job and did not invest enough effort in improving communication, particularly on a face-to-face basis.

The authors Daft (1999), Miles and Mangold (2002), Wilson et al. (1996), Tourish and Hargie (1996) state that an open communication climate involves sharing types of information across functional and hierarchal levels in order for individuals to work more easily. They emphasize that the use of open questions enables subordinates to generate solutions for problems. The same thing is important when using open communication, which can enable respondents to feel free to express their own opinions and thoughts. In this sense, Yang et al (2011) has added that team communication is the uniform of team members and make the team more effective making critical team performance.

Kelloway and Barling (2000), Sullivan, (1990) and Smith (2004) also focus on the message ('I know you can do it') as a powerful way of raising the employee's sense of efficiency and inspiring the individual to try harder. They added that communication could be upward from subordinates to supervisors or downward from supervisors to subordinates and lateral between colleagues or departments on the same level in order to build better relationships and develop more awareness of problems.

It can be suggested that communication and leadership are twinned, that is to say that successful leadership cannot be achieved as a concept with closed and formal channels of communication. Instead it involves the gaining and sharing of knowledge and experience among employees. Open and descending communication enables employees to reflect on the organisation's goals more easily, because they are the main power as an operational core and every change has to be started from them, not a strategic apex. The purpose of communication has been studied by Cranwell and Maakie (2002) and Gent et al. (1998) who explain the purposes of communication such as

informing, gaining support and trust, sharing others to improve continually and generate creativity. Furthermore, communication can create openness, resolve conflict, optimise resources and improve relations in order to resolve problems and gain approval or authorization to perform tasks. Generally speaking, Leurer et al (2007) emphasize that dissatisfaction regarding a perceived lack of communication usually means lower levels of effectiveness in terms of HR and organisational activities.

To summarise, organisations will find it difficult to develop successfully without open forms of communication (such as bilateral and upward communication) and a strong relationship between all levels and departments. Open communication can enhance the quality of care, culture and structure of the teamwork concept. In many ways professionals are the people most in need of open communication, which serve to break down negative ideas of bureaucracy, creating positive concepts such as friendship, support, consultation and problem solving through the use of mutual decision making. Therefore, organisations have to set special courses on communication skills for their members to enable them to become effective mediators with top management in reflecting public and customers' needs.

It can be concluded from the mentioned literature according to Table 2.1 (page 31-33) coming next that professionalism means ensuring competency and intellectual technicians within open communication. This could be emphasised by theories of leadership. For example, trait theory means characteristics of leaders, while the style approach believes in leaders' behaviours and interpersonal relationships between leaders and subordinates. Then contingency is dependent on two factors: the personality of the leader and atmosphere of the organization. Path-goal theory, classifies employee's paths to work goals and the link between work goals and valued personal outcomes. The most popular theory which can absorb the demands of professional setting as a comprehensive approach is transformational theory which elevates the interests of followers in an attempt to generate awareness and acceptance of purpose leading to achieve goals and development.

This type of theory is focusing on open channels and challenging tasks by encouraging problem solving with high expectations of confidence and values. There are some different names of theories give unique meanings of interpersonal relationships between leaders and followers such as ethical leadership, spiritual, dispersed leadership and institutional leadership as well as co-leadership. Additionally, shared leadership and multidirectional leadership as well as rotated leadership, all these names are similar.

The authors emphasised that the extraordinary leader who holds authority and knows the weaknesses and strengths of his subordinates, but they have no particular demands regarding the most required leaders valid for leadership. They only added six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal as a general approach. Basically, the ideology culture is focusing on beliefs, customs, norms, traditions and knowledge as well as technology. It seems that it is a mutually engaged in the process of development in addition to achieve external adaptation and internal integration. In other words it means leadership and customer orientation.

Team is also playing as partnership in order to achieve a mutual goal which requires team members holding different and several knowledge and perspectives. But this type of knowledge should be exchanged, discussed, and integrated in order to get highly rational decision. Also positive and dynamic group is required to achieve greater sensitivity on organisation needs through multi skilled members. Transformational leadership enhances team collectiveness which can develops team reflexivity by focusing on the role of leader behaviour, enhances a common goal and mutual vision. The same importance is for communication which increase teamwork productivity and facilitate a work atmosphere in which employees can feel appropriately motivated and creative. This issue could not be specific without training and sharing types of information across functional and hierarchal levels. The authors point to the type of communication which also gains support and trust

Table 2.1: The Indications of Leadership Literature and its Concepts.

Factors	Sub factors	Categories and Indications	
Professionalism		Comprehensive support and competence	
		Intellectual and experimental setting	
		Knowledge, experience and education	
		Open channels communication	
Theories of Leadership	Trait theory	Individuals' characteristics	
	The style approach theory	Two general types of leader behaviours: interpersonal relationships between leaders and subordinates and achieving of goals	
	Contingency theory	Personality of leaders and situation or climate	
	Path-goal theory	Link between work goals and valued personal outcomes to produce directive leader, negotiating leader, consultative leader, participative leader and delegating leader	
	Transformational theory		Idealized influence context of crises or major change
			Individualized consideration: individual followers' concerns
			Intellectual stimulation means providing followers with interesting and challenging tasks
			Inspirational motivation means expectation and followers' confidence
			Team reflexivity and strategic

		collectiveness.
Theories of Leadership	Ethical leadership theory	Appropriate conduct of personal actions and interpersonal relationships by focusing on two-way communication, reinforcement, and decision-making
	Spiritual leadership theory	Spiritual needs
	Dispersed leadership, Institutional leadership, Co-leadership, Shared leadership, Multidirectional leadership and Rotated leadership theories	Cooperating and sharing
Leader and Power		Knowing the weaknesses and strengths as well as knowing how to follow. Developing cooperation more than competition. Focusing on personality more than physical. Having six categories embodies in physiological characteristics, social background, intelligence, personality and social interpersonal.
Culture		Ideology of custom, norm, tradition, knowledge, and technology
		External adaptation and internal integration
		Common beliefs, attitudes, values and employee commitment.
		Management and leadership styles; attitudes mistakes, communication style and customer orientation.

Team	Partnership and a mutual goal
	Understanding and respecting the role of each other and evaluating decisions with common goal and mutual vision
	Exchanging decision with distributed information. Positive dynamic and multi-skills group as well as sensitive to members' interests
Communication	It is an important component of providing a work atmosphere means sharing types of information across functional and hierarchal levels in order for individuals to work more easily. In order to gain support and trust

## **Chapter Three:**

### **Clinical Leadership**

#### **3.1 Introduction**

The technology demand and international norms of management mean that leadership in different organisations is becoming specific and more specialised. In clinical terms, doctors, nurses and AHPS have vast experience in clinical settings and patient care. It is impossible to discuss effective CL without taking into account factors such as government legislation, individual power and authority combined with clinicians' professional experiences and knowledge. In many ways doctors already hold these responsibilities, due to classical norms and their professional demands, in spite of the presence of others from clinical bodies that are able to carry out such procedures, such as: nurses, pharmacists, radiographers, laboratory technicians and clinical researchers. It is crucial to create a fair balance of power distribution in the health care system so that all employees can be decision makers,

Buchanan et al (2007) stated that leadership appears to be a novel concept; better leadership means better patient care by putting that process at a premium. However the potential causal linkages between leadership practice and patient outcomes depend upon what the term leadership transmission means in operation. The aim of this chapter is to discuss CL within health service management (hospitals in particular), and to identify the

experience of clinical managers or clinicians such as doctors, nurses and AHPS, how clinical quality is achieved and such individual's engagement with clinical ethics.

This chapter consists of eleven sections. Section 3.1 contains the introduction; section 3.2 gives the background to CL and associated professions. Section 3.3 discusses the background of CL, while the issue of clinicians and power is discussed in section 3.4. Sections 3.5 and 3.6 explain the importance of clinicians, doctors and nurses as leaders. Health quality is explored in section 3.7. Section 3.8 contains a discussion of the impact of clinical ethics on CL. The combination between transformational and CL, and the interaction of CL factors are discussed in 3.9 and 3.10. Finally, the summary is presented in section 3.11.

### **3.2 Clinical Leadership and Professions**

The World Health Organisation (WHO) has a comprehensive definition of health which covers multiple aspects: "health is not merely the absence of disease, but the complete physical function, social function, role function, mental health and general health perceptions". This definition was evaluated and a move to the development of patient centred measures (O'Connor, 2004, p.2). It is no longer enough to discuss health as an abstract concept away from health care individuals and the social, mental, cultural and administrative issues surrounding them. That means according to (WHO) that the health concept means clinical and managerial approaches as well as individual considerations for both patients and staff at the same time.



Professionals in all sectors (Glover and Hughes, 2000) are increasingly expected to follow the norms of commercial and managerial professionalization. For example, in the National Health Service (NHS), doctors are increasingly expected to be competent managers. In addition to this, it would be helpful for all employees, professionals and managers to have social, educational, occupational, professional and sectoral backgrounds in order to enhance their skills and training. Clark and Armit(2008) indicate that historically, the medical profession has not particularly encouraged doctors to attain competency in management and leadership, but some attempts to get individual doctors involved with voluntary management training and development have been made. They added that the royal college of physicians now defines the medical profession as a set of values, behaviours and relationships. Regarding nursing, Leigh et al (2012) argued that health care policy clearly identifies the need for a healthcare workforce demonstrating creative approaches to work through complex leadership and management in an attempt to develop the sense of flexibility and confidence in health care industry .This needs nurses to join postgraduate programmes to investigate the gap between theory and practice

In terms of clinical supervision, Cultiffe et al, (2001) have argued that clinicians are focussing on organisational and management issues, clinical work, professional development, educational support and interpersonal problems. As a result of this complex situation, the management of health care sectors such as hospitals has become a difficult job, as candidates need both clinical awareness and some experience of environmental and cultural dimensions. Cultiffe et al, (2000) showed that, in multi- professional teams,

self-respect, mutual appreciation of colleagues, and the level of support provided by fellow employees makes management a very challenging job. Furthermore, Kunzle et al (2010) explain ensuring patient safety is critical need to be introduced by care teams, and leadership skills are increasingly recognized the concept of patient's safety. Thus, effective leaders play an essential role in promoting team performance to be adaptable to situational demands and shared between team members

That is why there are strict criteria for hospitals to obtain accreditation not only in terms of health or disease protection but also with regards to developing management and creating successful leadership. This does not just refer to those professionals who do the everyday work of teaching and doctoring, but also members of the profession with supervisory and managerial positions such as physicians, dentists, chiropractors, optometrists, pharmacists, podiatrists, veterinaries, registered nurses, dieticians, health technologists, dental hygienists, health record technologists, radiological technicians and therapy assistants. Health care institutions have become interested in training their professionals in management as well as different subjects besides the health care service in order to meet public demands and customer needs. Therefore, their followers are requested to enhance their professional abilities, improving their skills at solving problems and making rational decisions.

There is a need to construct a language of understanding in the health care service. For example, Jones and Hughes (1995) and Seedhouse ( 1988) emphasised that the expert is expected to communicate effectively with clients, colleagues and families, to listen as

well as to explain, educate and negotiate, and to use language that is appropriate to the people and situation. Involved professionals are expected to communicate effectively across language, cultural and situational barriers. Basically, there is lack of communication among clinical departments and poor practice of the two-way communication style. Andersson et al (2002), Kruijver et al (2000) and Smith and Preston (1996) recommended that communication be informal in order to minimize the stressfulness of the situation and minimise conflict between doctors and nurses.

Abbot (1988) pointed out that professionals should be trusted and guaranteed by various institutional forms, associations, and licensure and ethics codes. Since the 1960s an unparalleled amount of growth has occurred in the number of professional codes of practice, conducts and ethics. This has been due to a range of factors, including growth in the number of professions, a growing interest in the field of business, professional and administrative ethics and increasing public and political criticism of some professions (Glover and Hughes, 2000). For example, it could be argued that physicians are becoming more marginalized, with less power and control over their own work, at the same time external factors are exerting a growing influence on the working conditions of physicians and other professions are heading for management positions (Vultee et al, 2007).

Glover and Hughes, (2000) note that doctors, who have traditionally been very highly qualified super health technicians rather than true medical technocrats capable of managing all aspects of the health care profession, have begun to fight back against the

threats of commercialism and encroaching management by taking a much more active interest in the non-medical aspects of health care. Glover and Hughes added that the power of doctors influenced their professional associations, health authorities and general practice.

In the same hospital environment, nurses are struggling to gain a role in managing the health sector. Johnson (1997) has emphasized that nurses are insufficiently assertive and experience substantial stress in achieving their goals of care in the context of emotional labour. However, Jones and Higgs (1995) argued that clinical reasoning is important for nursing practice because the nursing health profession is becoming increasingly more complex and difficult. In this sense, Senn, B, (2010), stated that the oncology nurses provide clinical management and leadership at all levels of clinical practice by discussing the context of social, cultural context.

Based on these arguments, quality of clinical services is necessary to enable individual practitioners to develop knowledge and competence in complex clinical situations (Cutcliffe et al, 2001). For this reason, Freidson (1986) states that statutory certifications is a need for professions, creating an exclusive right to use a particular title not establishing an exclusive right to practice in order to work in a particular occupation. To summarise the purpose of organisational quality, Manjunath et al (2007) addressed the different criteria of quality in the health service industry, including leadership, strategic planning, customer and market focus, measurement, analysis and knowledge management, human resource focus, process management and business results.

Accordingly, clinical and academic institutions, as well as professional associations, began to include health service management in university modules for clinical professionals, such as doctors, nurses and AHPS. These modules teach the principles and theories of clinical supervision, communication styles, guidelines, and specifications of health care quality, and ethical considerations. Furthermore, clinical procedures, staff, patients as well as managing the health industry are also needed. Doctors with much more power and knowledge have had some conflicts with management. However, nurses practice their management role but do not have enough power to make decisions affecting health care futures, while other health professionals from AHPS such as pharmacies, radiographers, medical lab technologists, clinical technicians have little power and little impact on health care strategy and health management.

Bamford and Griffin (2008) have done some work into operational objectives in promoting team work as a means of raising productivity and encouraging innovation through engaging the talents and experience of all. To put this issue in a functional manner, Buchanan et al (2007) pointed out that it is important to conceptualize the impact of leadership in health care, as one set of processes influencing organizational change and service improvement. This complexity gives rise to a great deal of diversity which is of growing interest to health organizations. Social interaction between doctors, nurses and managers is increasingly being encouraged to ensure shared understanding of issues. In this sense, Bergman (2009) argues that a successful leader must have a high degree of emotional maturity and stability. However, Sullivan and Williams (2007) emphasized

that transformational leadership is becoming more and more sort of moral as it raises the level of human conduct and ethical aspiration of both leader and follower. The transformational leader has to be charismatic, offering guidance and encouragement.

To summarize, it would be difficult for clinicians to manage health organizations alone, instead a level of coordination with administrative managers from non-clinical bodies is required. For example, training on decision making and strategies such as those related to financial and HR settings are useful. In addition to this, clinicians themselves, especially doctors, cannot ignore the significant role of managers or businessmen in constructing the general philosophy of hospital environments. In this manner, the health team is not the only members who serve the patient, as others from the non-clinical staff can aide with processes such as finance, maintenance and records. Furthermore, even though power in hospitals tends to be concentrated around doctors, they should appreciate the experience and knowledge of other clinical and non clinical experts in order to make for better CL.

### **3.3 Background to Clinical Leadership.**

Increasingly hospitals can only be effective if they combine good health service management with successful health care, consequently there is a growing need for health professionals or clinicians such as doctors, nurses and AHPS to serve their sector managerially and clinically, as those professionals have more awareness of their hospitals in terms of the hospital's needs, goals, strategy and patient requirements. They are the

individuals who are best able to diagnose health problems and concerns more so than ordinary managers or businessmen who only hold management and administrative certificates. In contrast, clinicians can perform clinical services and be involved in management, sharing in its strategy and vision.

Similarly, Goodwin (1998) suggested that changes to the UK National Health Service (NHS) from the 1980s onwards should be practiced regarding developing good interpersonal and inter-organization as well as leadership. In order to examine health service culture, Merali (2003) indicates that clinicians should share their knowledge and experiences in order to contribute positively towards the successful development of the hospital.

The effectiveness of CL styles among clinicians have been discussed by many authors, such as Jackson (1998), Gaughan (2001), Hewison and Griffiths (2004), Preston and Clarke (2000), Salauroo and Burnes (1998), Thorne (1997), Walker and Morgan (1996), Gent et al. (1998), and Jackson (1998). Some of these studies concentrate on the organizational effectiveness of hospitals in comparison with clinical effectiveness in order to determine whether levels of overall effectiveness were a result of the management process, the people involved, or a combination of both.

Jackson (1998) has noted that in order to be effective organizations needs visible leadership. In addition to this, Gaughan (2001) determined that the development of

leadership skills in the health care industry is derived from the interaction between the leader and his followers within transformational leadership theories, as developed by Bass and Avolio, and as discussed earlier in chapter two (Leadership as a Concept).

In this sense, Both Hewison and Griffiths (2004) argued that leadership is only one element in the changes that need to be applied in health care. In the same vein, Preston and Clarke (2000) investigated more about health care managers and their experiences. The two found that managers have a high level of awareness of the largely negative perceptions surrounding them and accepted this as an integral part of their role. Thorne (1997) reviewed the role of clinical directors, concluding that they perceived their roles in terms of leadership rather than management.

It can be concluded that at present the clinical sector has a number of and clinical managers practicing in managerial responsibilities who really need training in how to achieve leadership properly. Gent et al. (1998) have explained how hospital administrators often create cross-functional teams, including clinical and non-clinical staff drawn from different functional areas, to face the increasing competition and raise hospital revenues.

Quality of health can be linked to the quality of management and human resources working in hospitals. Health teamwork was reviewed by Wilson (1987) and Smith and Preston (1996), whose work showed the necessity for effective multidisciplinary teamwork within increasingly complex health and social care environments. They



emphasized that good teamwork makes a critical contribution towards the effectiveness of health care delivery. Furthermore, they suggested that the agenda of quality improvement through clinical governance can be delivered illustrating how team coaches have used their clinical experiences to facilitate effective change in health care organizations. From the results of these studies we can see that CL needs serious cooperation between all responsible governmental and private departments and institutions. These organizations need to introduce useful managerial training and support for clinical staff to enable them to deliver a high standard of health care.

It can be concluded from the previous discussion that the preparation of clinicians to be leaders should be a cooperative mission between health service organisations and other business, academic and training agencies, involving not only top managers but also frontline, group leaders, supervisors and ordinary employees. In order for these processes to work health care professionals must build strong relationships with those in the external environment in order to gain more experience regarding management and leadership.

### **3.4 Clinicians and Power**

This section will examine which type of people should operate health management and what type of qualifications and power such managers should have, in order to enhance health care delivery.

Preston and Clarke (2000) have noted that many NHS managers have moved into management from clinical backgrounds. Thus, successful hospital chief executive

officers (CEOs), as Papadimos and Machiavells (2000: p.17) argue, have fostered links between management and clinicians: "*clinical leaders have enhanced relationship with physicians, developed operational focuses, understood finance and debt management, known their board, bosses leadership presence, being team leaders and builders. They do not surround themselves with Yes Men but should conduct themselves with their advisors*". Health care managers need to balance their responsibility to the public with their accountability to political policy makers effectively dealing with any conflicts which might emerge in health care management (Palfrey et al, 2006).

It is a big responsibility for clinical managers or hospital chief executives to have these managerial requirements; they may believe that a clinical background is not enough to lead their staff. Forbes et al (2004) have noted that the clinical managerial combination still poses some difficulties. They have argued that there has been very little attempt to examine this development from the perspective of the individual clinicians entering management and their attitudes towards management. In the same vein, Markens and Spencer (1998) have supported this analysis and tried to solve this dilemma, arguing that, in health services leadership, executive leaders have to facilitate their teams, support their decisions, coordinate their efforts and become coordinators instead of only being supervisors. Heiberg and Helljesen (2002), (Hancock 2005): Buchanan et al (1997) appear to share Markens's opinion that the top management in hospitals such as the head nurse, chief medical staff, and directors of the organization, should move to become leaders.

Now, the question is: Can clinicians and doctors perform CL with their current qualifications in clinical settings? And how will managerial effectiveness in health care be achieved using their current abilities? To answer this question Schultz (2004) diagnosed the qualifications which clinicians need to be effective leaders: to lead health care organization as MDs (medical doctors) or MBAs (business administration). The study revealed that no significant differences exist between medically educated and managerially educated people so far as making strategic decisions or improve the quality of health care organisation are concerned. The characteristics of the individual, rather than their educational degree, appear to have a stronger influence on the CEOs' ability to make successful strategic decisions. Therefore, an educational background should not necessarily be a requirement. Both clinical and chief executives can combine to focus on the improvement of patient care as a first priority (Roland et al, 2001).

Any discussion about the management within the health service would not be complete without some mention of doctors' power. According to Goodwin (1998) stated that doctors have powerful pressure group as national associations and also powerful individually in hospitals as members of health authorities. That means doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power.

A study by Forbes et al (2004) suggested that clinicians are trained within narrow professional limits. Also, they do not have enough managerial experience to fulfil this role in the health service. For example, there are no wider inter-professional and

organisational factors within their employing organisations. Therefore, there is a tension between professional values encapsulated within clinical autonomy and managerial demands.

Power can be defined as *“the ability to influence behaviour, to overcome resistance, and to get people to do things that they would not otherwise do”* (Krishnan: 2003. p.346). Authority has been defined in the following manner: *“authority means the probability that a specific command will be obeyed”* (Etzioni: 1962. p.4). Fiedler and Chemers (1984. p.100) have a different perspective on the concept of power and authority, suggesting that we should: *“remember that power and authority are not simply given to the leader. No leader has absolute authority, and all authority and power derives from the willingness of subordinates to accept the leaders’ right to lead”*.

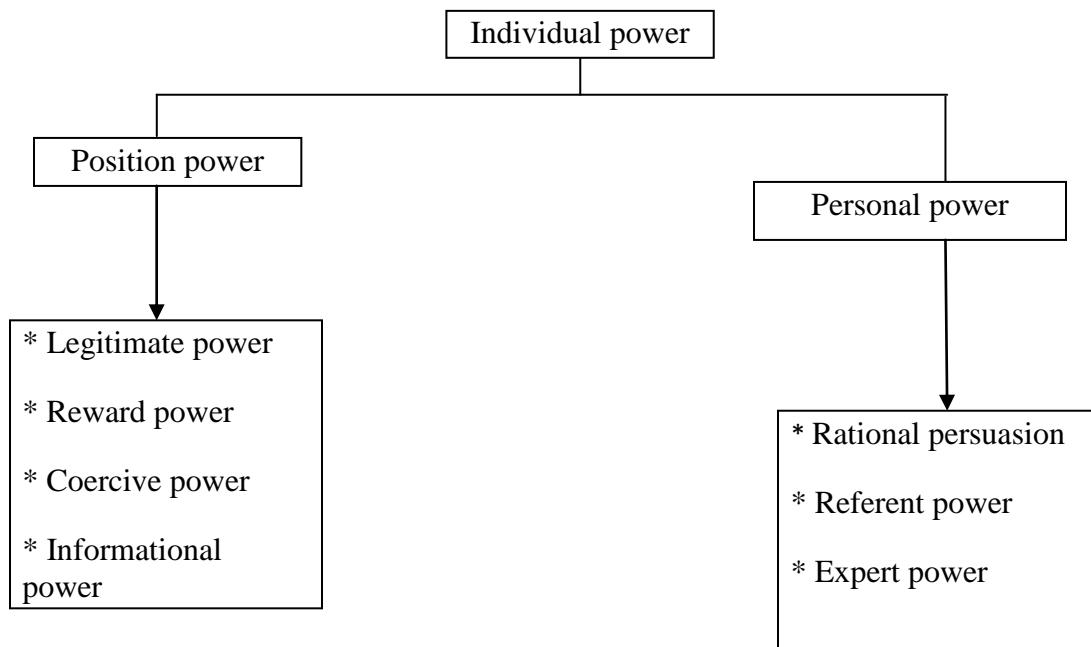
In hospitals, Scholten and Grinten (1998) have argued, there is no room for either unlimited professional autonomy or unlimited professional management because *“each individual in the organization has their own interests, beliefs, values, preferences, perspective and perception and their effectiveness will depend on how far their power oriented skills are acquired from personality and experience”* (Willcocks, 1998, p.130).

Brazier (2005) has argued that it is important for leaders to focus on increasing their expertise. Supervisors should make subordinates feel that they are valued, accepted and important to the supervisor (referent power), sharing their technical expertise, experience and knowledge with subordinates (expert power). He added that doctors are the clinicians

who have most experience and knowledge; therefore, their experiential authority will give them strong power to lead.

To summarise, Greenberg (2003) has introduced individual power, as shown in figure (3.1), subdivided into two sections: position power such as legitimate power, reward power, coercive power and informational power; whereas, personal power includes rational persuasion, referent power and expert power.

**Figure 3.1 Types of Power**



**Source: Greenberg et al (2003).**

This figure (3.1) indicates that power of clinicians, especially doctors, is more likely to take the form/s of informational power, rational persuasion and expert power. There is usually a balance between the power afforded by an individual's position and the power that someone can wield because of that individual's personality. Similarly, other clinical managers who perform both clinical and managerial duties have the same powers. Thus, power is not only for executives but also for others involved in leadership using their experience, knowledge and personal power.

In conclusion, power is an integral part of health care work. In hospitals and health care services we need a combination of all types of power; an ideal leader will possess knowledge and a strong personality. Doctors usually tend to have the greatest amount of power in health service delivery. However, it must be noted that even doctors' qualifications are not, by themselves, enough for them to be successful at management and leadership. It is necessary for clinicians, such as doctors, nurses and other AHPs, to be charismatic alongside their experience and knowledge in order to enable them to achieve their goals with the cooperation of their followers from other clinical and managerial staff.

### **3.5 Doctors as Leaders**

In many ways doctors are committed to being leaders due to their levels of experience and knowledge. However, does this qualify them to be leaders and physicians at the same

time? CL is reviewed by Smith et al, (2004) who suggests that CL is of paramount importance to doctors, perhaps more so than hospital facilities such as buildings, equipment, x -ray department, wards, reception area, hospitalised services and hotel luxuries. To emphasise the effectiveness of doctors' being leaders, Brightman (2007) argued that once a physician decides to practice management, such as assessment and planning processes, this enables them to generate options and take action more efficiently.

Kumpusalo et al. (2003) argued that physicians are often involved in health care management whether they like it or not. Surprisingly little attention has been paid in medical schools to the way physicians learn about administration, management and leadership. Forbes et al (2004) have pointed out that UK government reform and the reorganisation of the NHS in recent years has had many objectives, such as the involvement of hospital doctors in the management process in order to increase management and strategic practises. Aluisse et al, (1989) have argued that there has been a growing demand for the inclusion of management skills in the medical curriculum. These elements are related to the role of the physician to be a medical expert, a communicator, collaborative in approach, a health advocate, a learner, a manager, a scholar and a physician. These studies indicate that doctors have a great level of power in their hospitals, which is why they are required to perform CL more than others from AHPS. They are likely to face many conflicts with administrative managers due to the prominence of centralisation in CL. In conclusion, doctors consider that all employees in hospitals are working towards improving patient care.

Other authors, such as Letour (2004), Chrispin (1996), and Anderson (1994), have emphasized that physicians are mostly resistant to organizational change because they do not consider themselves to be ordinary employees. Physicians consider that the implementation of decisions is a vital part of clinical management and that they are in the ideal position to determine strategy. This provides a good point at which to discuss the relationship between physicians and management, exploring the rights and requirements that need to be satisfied in management and leadership.

In contrast to the above discussion, Willcocks (1998) indicates that there are tensions between different post structures such as hospital boards and clinical directorates; problems of centralization or conflict between central control and budgetary services. Furthermore, poor relationships among clinical director and clinical peers and nursing staff may enhance these concerns. It seems from Willcocks' findings that it can be difficult for doctors to become managers due to past and current conflicts with business managers (non-clinicians), which can form an obstacle to achieving results.

In order to summarize the function of medical management Mark (1994) has proposed that it should maintain efficiency through the removal of stress about the mechanics of the management process. Yet, there are many questions, which need to be answered in terms of medical management. How will management be perceived in those organizations where being the clinical director is necessary but not seen as really desirable? What messages are received by the professionals and managers when those



doctors are involved in management? What support is provided for those doctors who find themselves alienated both professionally and socially from their clinical colleagues because of full participation in the management role? What are the implications of managing on a part time basis? To resolve these problems, Mulec (2005) has argued that the combination of managerial and physician roles has shown itself to strengthen the position and agenda of the physician, promoting their professional interests. The non-medical manager is unable to deal with the work of a clinician. Instead, he should handle operational issues, leaving time for the medical managers to practice clinical work and focus only on strategic managerial issues related to medical practice.

It would also appear that doctors believe that they should be involved in clinical management due to their high levels of experience and knowledge. Their lack of managerial awareness can cause conflict with managers, because those with a managerial background often see themselves as being more skilled in management. Furthermore, doctors often find it difficult to combine their clinical duties with their managerial responsibilities; it is a real challenge for them to be given two missions at the same time. However, it would be impossible for managers or administrators to perform clinical functions.

The next section will examine the extent to which nurses have fewer opportunities than doctors to be involved in managerial responsibilities and the leadership process.

### **3.6 Nurses as Leaders**

It is well known that nurses constitute the majority of the clinical body. It is usual for the majority body of an organization to have the legislative right to take the responsibility of management. To highlight this issue, Millward (2005) noted that nurses and midwives deliver 80% of all health care and should therefore play a critical role in implementing the new NHS. The British Royal College of Nursing (RCN) is perceived, in the national nursing leadership programme, as a vehicle for leading the process of change, involving the introduction of bigger nursing roles.

There is strong evidence to suggest that nurses also have an important role to play in health care besides doctors. Obviously, nurses have more awareness of the patient's condition, as nobody is closer to patient care delivery than nurses. They strongly reflect patients' needs to the top-level management, this would facilitate health care delivery and help to minimise health risk (Preston and Clarke, 2000). Both Hancock (2005) and Burke (2004) suggest that CL is recognised as a potential cornerstone for the development of nursing and health care, with CL.

Conant and Kleiner (1998) have argued that increasing job satisfaction for nurses is one of the key challenges for those in the health care industry. One of the means by which satisfaction could be improved is by those with authority giving nurses a real role in terms of leadership. To enhance the nursing role of management, the RCN took up the call for nurses to become more involved in the management and leadership programme

and become transformational leaders (Bolton, 2003). For example, in 1994 RCN CL in Britain started to help clinical nurses (Hewison and Griffiths, 2004) in organized leadership positions to improve the quality of care through managing staff, managing the team, patient- centred care, net working and becoming more politically aware. In this approach, Both Stewart (1989) and McPhail (2002) have argued there is a correlation between the level of education, number of years practice, place of employment and personality type. It is often the case that nurses have an appropriate personality with high levels of professionalism.

Moreover, Utley et al (2011) emphasised that CL leadership is necessary for nurses to get job satisfaction and positive work environment, and that's why nurses are learning to be leaders to apply the concept of transformational leadership by improving the quality of health care. They added that nurses were taught process of inspiring followers to collaborate and work toward common goals to achieve success. The same for Cummings et al (2010) argued that leadership within the nursing workforce doesn't mean only a task completion but developing transformational and relational leadership are needed to enhance nurse satisfaction, recruitment, retention, and health work environments. In this vein, Macleod (2010) emphasised that nurses can make a hospital's culture by promoting positive attitudes and ethical considerations. Macleod has added that having a nurse leader as an active participant in hospital governance sends an important message to the hospital board in its highest level demonstrating a respect and value for their essential role in leadership. Furthermore, Lekan et al (2011) according to their paper entitled: Clinical Leadership Development in Accelerated Baccalaureate Nursing Students: An Education Innovation, they argued that there are some gaps

between the modules in nursing schools and the actual requirements of clinical practice. Therefore, the responsibility is getting serious for nursing students to deliver safe and effective patient care which needs severe concerns towards clinical leadership skills to the seniors by establishing effective communication, delegation of tasks and supervision skills. Accordingly, Walker et al (2011) defines clinical leadership in nursing setting by saying that it is *"a multifaceted process of identifying a goal or a target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals"*.

While we have established that nurse's form the majority of the clinical body and are very qualified in clinical settings and managing their followers. Also, it is important to note that they are also frequently qualified in the academic field. Many nurses hold postgraduate degrees, which enable them to be researchers and to gain their associations' trust in performing CL. Such nurses can easily maintain health care quality and improve health delivery due to their mature awareness of all clinical, social and psychological issues relating to patient care. Nurses have been given wide range of authority, as they are qualified and sufficiently trained in management and leadership during their association's training programmes. There is logic behind giving them more power, as they represent the majority of health care professionals and are the closest to patients' concerns.

At this point it is necessary to link clinicians' management and the level of health care quality in terms of clinical and managerial issues because, finally, management means a comprehensive field of quality in all aspects, not only those relating to health.

### **3.7 Clinical Leadership and Quality**

There is a connection between the behaviour of leaders and quality concept . It seems that the quality as an overall concept is not only the quality of products or industry, but extends beyond the overall quality of management, quality of processes, training and quality of communication. Of course, all of that are elements to the concept of high leadership. In this sense, Lee (2007) agrees with the transformational style in leadership, as he discusses the leadership in quality of communication, training, preparing managers and individuals. Furthermore, Camilleri and Ocalloghan (1998) said that quality of management is embodied within the quality of procedures, techniques and personnel. In the same approach, Rasasi and Harris (2007) said that quality of management means the actual leadership adopted the principles of process and rehabilitation which reflects on the achievement of the organization objectives. Health care delivery and health service management should not be reviewed without criteria and parameters to measure the performance of the clinical work in both the clinical setting and the managerial aspect.

There are many definitions of quality regarding the managerial process, qualification of staff, techniques, procedures, production, customer care and personnel. Jabnoun and Al-Rasasi (2005) and Harris et al (2007) have suggested that to implement quality in health

care organisations, some HRM practices are necessary in order to achieve their star rating. Malek et al have also pointed out that the British Standard Institute (BSI) defines quality as “*meeting customer requirements*”, However, Ovretveit (1992. p2) views the term in a more abstract manner, stating that “*it is an umbrella for contentious staff and organization development using new methods*”.

According to the European Foundation for Quality Management (EFQM) founded in 1988, Naylor (1999) suggests that customer satisfaction through leadership, driving policy and strategy leads ultimately to excellence in business results. Brown et al (2007) and Block and Manning (2007) emphasized that the goal of health care and education agencies is to promote the pattern of leadership in both sectors. In the health services, this means for example, adapting care services to ensure they are more patient focused.

As a result of this ethos, teaching, learning and assessment strategies are increasingly designed to help students become effective leaders and agents for change. Leadership development is not achieved by a curriculum, but instead by a comprehensive network of processes designed to support the continuing development of leaders outside the classroom.

However, the authors Bradley et al (2003), Hansson (2000), Davies and Walley (2002), White (1993) and Wilson (1987) have highlighted that total quality management (TQM) requires a partnership of doctors, managers and other AHPS to be effective. It is important that CL and quality are linked, as it will be impossible for clinicians to perform leadership without raising the quality of health care. The aforementioned authors believe

that matching international standards and criteria in both clinical and managerial arenas are the first steps to improving health care quality.

As a result, health service quality refers not only to the extent of health care but also the quality of the professionals' involved and their capacity for rational management and leadership. Therefore, many parameters and standardisation agencies focus on clinical quality as a strict and concrete process making quality the real factor of competition. Quality in the health service is more important than it is in other sectors, such as those of education, industry and commerce, because medical or clinical errors are often irreversible. CL means clinicians and personnel being trained in clinical settings and management at the same level. To emphasise the complexities of clinical and managerial quality, the next section will examine the role that ethical considerations play in CL.

### **3.8 Clinical Leadership and Ethics**

Basically, ethics is integral to transformational leadership as codes of ethics should not be separated from leadership style, because ethics as Cohen and Kol (2009) say eliminate disputes and disagreements among individuals at work. Furthermore, Siebens (1998) argues that ethics can be described as a system of religious, linguistic, legal and more general beliefs which individual workers can each subscribe to. The authors Carter (2001), Gangon (1999) and Peterson (2004) concentrated on this and argued that ethics turns leaders into wise men who dedicate themselves to achieving the highest levels of

satisfaction and professional behaviour among employees, in regard to honesty, trustworthiness, friendship and confidentiality.

Banerji and Krishnan (2000), state that ethics are an important element of hospitals because a shared code of ethics ensures an effective working atmosphere. For instance, Millward, (2005) emphasized that the British NHS seeks to provide high-class medical services through ethical principles, spread among clinicians at British hospitals. Additionally, Vera (2009) says that obeying the Hippocratic Oath means that the individual should adhere to the medical profession's rules and managerial duties.

Health quality programmes are not only focused on the service itself or the specification of clinical performance and diagnostic evaluation, but also on the effectiveness management. Cohen and Kol (2004) have argued that the relationship between professionals and their organisations should be recognised as complex because of the supposedly hidden conflict between the organisation and the values of the professionals. Quality cannot be divorced from ethics, rather the two are integral parts of the same whole; the meaning of quality care would not be complete without paying attention to total care management (TCM) because ethics are intrinsically linked to quality care.

Ethics is derived from Greek and Latin words (*ethikos and moralis*) to behave in one-way rather than another (Bem, 2001, p.20). It is usually closely related to concepts of family, religion, friends, culture and the ethical codes of professional associations (Bedeian,



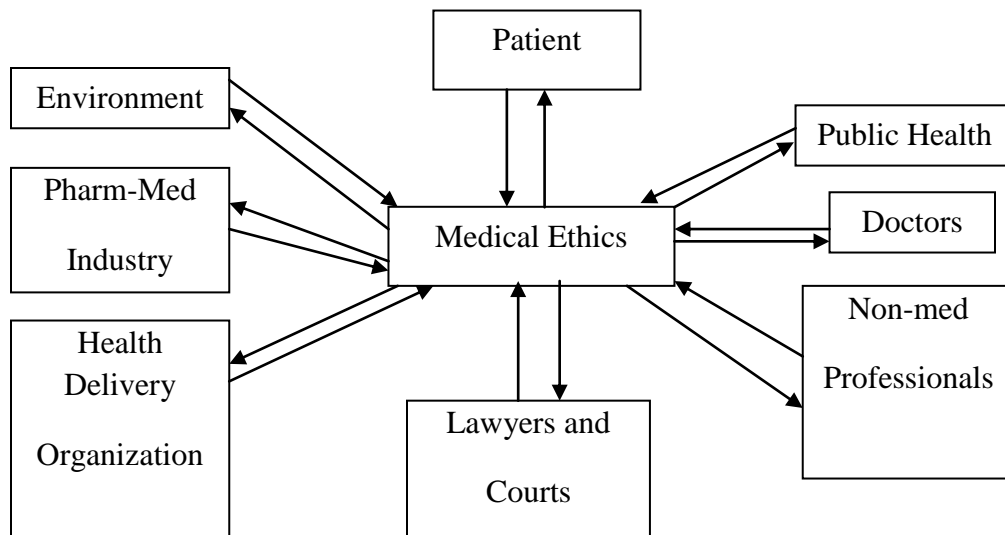
1986). Carter (2001. p.57) defines ethics as a “*framework stressing dignity and respecting for personhood*”, suggesting that ethics means behaving in a certain fashion according to values, beliefs, traditions, religion, culture, law and notions of dignity.

For these reasons, the above authors suggested that the behaviour of leaders should increasingly try to take account of ethical factors including corporate stewardship, accountability, spiritual values, trust, humanity and good stewardship. Leadership and ethics go hand in hand; an ethical environment is conducive to effective leadership and effective leadership is conducive to good ethics. In other words, effective leadership is a consequence of ethical conduct and ethical conduct is a consequence of effective leadership. Therefore, ethics and leadership function as both cause and effect. Most theories have proposed that hospitals should ensure an ethical atmosphere (Peterson, 2004) enabling leaders to establish organizational values as well as impose rewards and sanctions. Krishnan (2003) has established that ethical behaviour on the part of leaders should work towards the growth of their followers and address their real needs.

Clinically, many authors, such as Hamric (2001), Takala (1999), Siebens (1998), Roberts and Reich (2002), Kelly (2002), Fox et al (1998), Thompson (1998), Holdway and Kogan (1997), Palfrey et al (2006), and McFadzean and McFadzean, have discussed topics related to ethics. These topics have included issues such as veracity, privacy, confidentiality, friendliness, the relationship between law and ethics, processes of decision-making, the rights to refuse treatment, end of care, consent forms, truth telling

and disclosing errors. Similarly, Emanuel (2000) has discussed the structural ethics in medicine by defining health care values, as shown in figure 3.2, emphasising that ethics is surrounded by many important factors such as environment, patients, public health, doctors, lawyers and courts

**Figure 3.2 Medical Ethics Environment**



**Source: Emanuel (2000)**

In UK NHS hospitals there are distinctive parameters by which to measure the quality of health delivery, known as clinical governance; this constitutes “*a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*” (Walsall NHS Trust, Clinical Governance

Review, October 2002). Millward (2005) has emphasised that clinical staff are empowered to accept responsibility and accountability at all levels of the hierarchy. In practice, this involves clinical audits, risk management, user involvement, and evidence-based practice. Also it involves continuous professional development, management of performance levels, encouraging reflective practice, team building and team reviews.

To summarise, ethics is a parameter by which to measure behaviour and make a judgement on how successfully clinical practice is being applied. Ethics is strongly linked with quality and morals. There are no real benefits from medical developments if not combined with ethical considerations. The law is not always enough to resolve conflicts and problems within health service management, it is much better for clinical behaviour to be ethically conducted. A lot of important concepts are also necessary to construct effective CL, such as trust, confidence friendship, openness, privacy and truth. It is only by ensuring that these matters are dealt with that hospitals can hope to establish responsible clinical leaders and highly experienced followers.

### **3.9 The Combination between Transformational Leadership and CL**

It seems in general that transformational style is the most appropriate style in the medical field and hospitals. It is highly important to improve the clinicians' intellectual abilities in order to be capable of making sound decisions in the restless atmosphere of hospitals, full of emergencies and critical situations. Increasingly, the author Xirasagar (2008) states that command and control concepts are no longer good to controlling the behaviours

clinicians. Furthermore, codes of ethics, in which transformational style believes, make the clinical team understand and absorb the clinicians' individual needs; this creates a calm and appropriate atmosphere for making decisions, apart from randomization. In this vein, Rasdi (2009) adds that transformational style should take into account the individuals' needs and qualifications rather than legislative power and managerial positions. In other words, experience and knowledge is more significant than these classical issues.

Clinically, Kalra (2009) says that British hospitals (NHS) believes in the fact that hospitals' managements have become a challenge; to qualify clinical leaders in way that makes them capable of resuming big responsibilities . This agrees with Vera (2009) who stresses upon the fact that transformational style is a type of multiplicity in skills among clinicians in regard to technical and managerial responsibilities. She confirm that this type of skills make clinicians think in brainstorming technique, and consider their hospitals goals part of their priorities even if it were contradicting with their personal circumstances . In other words, the clinical agenda, written by the clinical team, formed from all clinical specializations, eliminate all individual differences due to the strong idea that all their experiences are highly important.

Transformational style is concerned with all the concepts of this study that discusses the clinical leader personality with their levels of experience and qualification in addition to how much scientific, legislative and technical power they have. Moreover, this type of leadership believes in cultural multiplicity in respect to religion, language, traditions and

customs, increases the patients' satisfaction. The clinical team is aware of the fact that culture is not less important than the clinical role of this team who are equipped with experience, sciences, and skills of management and leadership. They also know well that their thoughts and experiences are at their leaders' centre of interest. It is noticeable that transformational leadership attempts to spread leadership ethics that stresses upon the mutual respect. These aspects will have an important and effective role in creating the comprehensive culture of quality that does not look at management and technical services as a quantity. So quality improves the technological by enhancing the responsibility of adopting international concepts and certified measurements in medical service industry.

According to the mentioned literature of clinical leadership it can be concluded as seen in table 3.1( page 66-70) that clinical professions is being discussed within social, mental, cultural and administrative issues in order to demonstrate creative approaches to work through complex leadership .Health care professions such as physicians, dentists, chiropractors, optometrists, pharmacists, podiatrists, veterinaries, registered nurses, dieticians, health technologists, dental hygienists, health record technologists, radiological technicians and therapy assistants , it would be so difficult for them to do without institutional forms, associations and ethical codes. Also, the factors such as knowledge, human resource, process and academic institutions, as well as professional associations, began to be included in university modules as health service management.

The authors in this chapter emphasised that clinical leadership indicates that clinicians should share their knowledge and experiences in order to contribute positively towards

the successful development of the hospital. In other words organizational effectiveness of hospitals should be combined with clinical effectiveness. Also the concept of leadership rather than management has explained how hospital administrators often create cross-functional teams, including clinical and non-clinical staff drawn from different functional areas to deliver a high standard of health care. Basically, power is an important factor which means responsibility and accountability should match the balance between educational background and authorities. In health sector doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power, while others from nurses and AHPS are sharing their technical expertise, experience and knowledge with subordinates. Doctors practice management such as assessment and planning processes, this enables them to generate options and take action more efficiently. So medical schools through curriculum enabling them to increase management and strategic practises but they mostly resistant to organizational change and having some conflicts with clinical and non-clinical staff. On the other hand. Nurses reflect patients' needs to the top-level management, this would facilitate the concept of leadership due to the correlation between the level of their education and experience. They always try to apply the concept of transformational by demonstrating a respect and values as well as motivating other people to act. They also believe in supporting and motivating staff to achieve mutually negotiated goals.

Quality in health care sector means quality of communication, training, preparing managers and individuals. Furthermore it means quality of procedures, techniques and personnel as well as customer requirements. In other words, TQM requires a partnership

of doctors, managers and other AHPS to be effective. Furthermore, clinical ethics which can be described as a system of religious, linguistic, legal and more general beliefs in addition to professional behaviour among employees. Some further concepts such as honesty, trustworthiness, friendship and confidentiality are also included to match ethical codes of professional associations. The authors also emphasised that values, beliefs, traditions, religion, culture, law and dignity are important factors to shape clinical governance and audits.

Table 3.1 The indications of Clinical Leadership Literature

Factors	Categories and indications
Clinical professions	Social, mental, cultural, educational and administrative issues
	Complex leadership and management
	Multi- professional teams, self-respect, mutual appreciation
	Communicate effectively with clients, colleagues and families
	Minimize the stressfulness and conflict between doctors and nurses
	Codes of practice and ethics
	Managing all aspects of the health care profession
	Power of doctors and their professional associations

	Develop knowledge and competence in complex clinical situations
	Doctors, nurses and AHPS in promoting team work and social interaction among them
	The transformational leader to be charismatic,
Clinical leadership	Organizational and clinical effectiveness
	Interaction between the leader and his followers within transformational leadership theories
	Cross-functional teams, including clinical and non-clinical staff
	Clinical governance and high standard of health care.
Clinicians and Power	Responsibility and accountability to policy
	Chief medical staff and head nurse to become leaders
	Characteristics of the individual rather than educational degree to have a stronger influence
	The power of members from health authorities.
	Doctors have powerful pressure group as national associations
	Doctors have the strongest power in hospitals while others, from nurses to AHPS, have very little power
	Power derives from the willingness of subordinates to accept the leaders' right to lead".



Clinicians and Power	Expert power from experience and knowledge
	Position power such as: legitimate , reward, coercive and informational power
	Personal power includes rational persuasion, referent power and experience
Doctors as leaders	Practicing management such as assessment and planning enables them to do efficiently.
	Medical schools and curriculum to teach them administration, management and leadership
	Doctors are a combination of medical experience, communication and health advocate
	Mostly resistant to organizational change as they do not consider themselves to be ordinary employees
	Current conflicts with clinical and non-clinical staff
Nurses as leaders	They strongly reflect patients' needs to the top-level management.
	They are in a position to improve the quality of care through managing team, patient- centered care and becoming more politically aware
	There is a correlation between the level of education,

Nurses as leaders	number of years practice, place of employment and personality type
	Nursing workforce doesn't mean only a task completion but developing transformational and relational leadership
	Demonstrating respect and value for their essential role in leadership
Clinical leadership and Quality	Quality of management is embodied within the quality of procedures, techniques and personnel
	Quality of management means the actual leadership by adopting principles
	Clinical quality means customer requirements
	Clinical quality means also a partnership among doctors, managers and other AHPS to be effective
	Quality reflects the achievement of organization objectives
Clinical leadership and Ethics	Ethics means system of religious, linguistic, legal and more general beliefs
	It is the highest level of satisfaction and professional behavior among employees
	Something related to honesty, trustworthiness, friendship

	and confidentiality.
	Ethics would not be complete without paying attention to total care management
	Concepts of family, religion, friends, culture and ethical codes of health professionals
	Certain fashion according to values, beliefs, traditions, religion, culture, law and notions of dignity.
	Responsibility and accountability
	Clinical audits and risk management,

### 3.10 Interactions of Clinical Leadership Factors

Clinicians have traditionally only been qualified to lead clinical settings due to their practice and experience.

All professionals establish their identity through professional associations' support and the exchange of experience and information from the surrounding environment. For example, universities are responsible for clinicians gaining suitable management sciences to enable them to manage health care and become aware of how to take rational and professional decisions. As summarised in figure 3.3, the power of law and clinical associations' support are often not sufficient for them to effectively lead health sector.

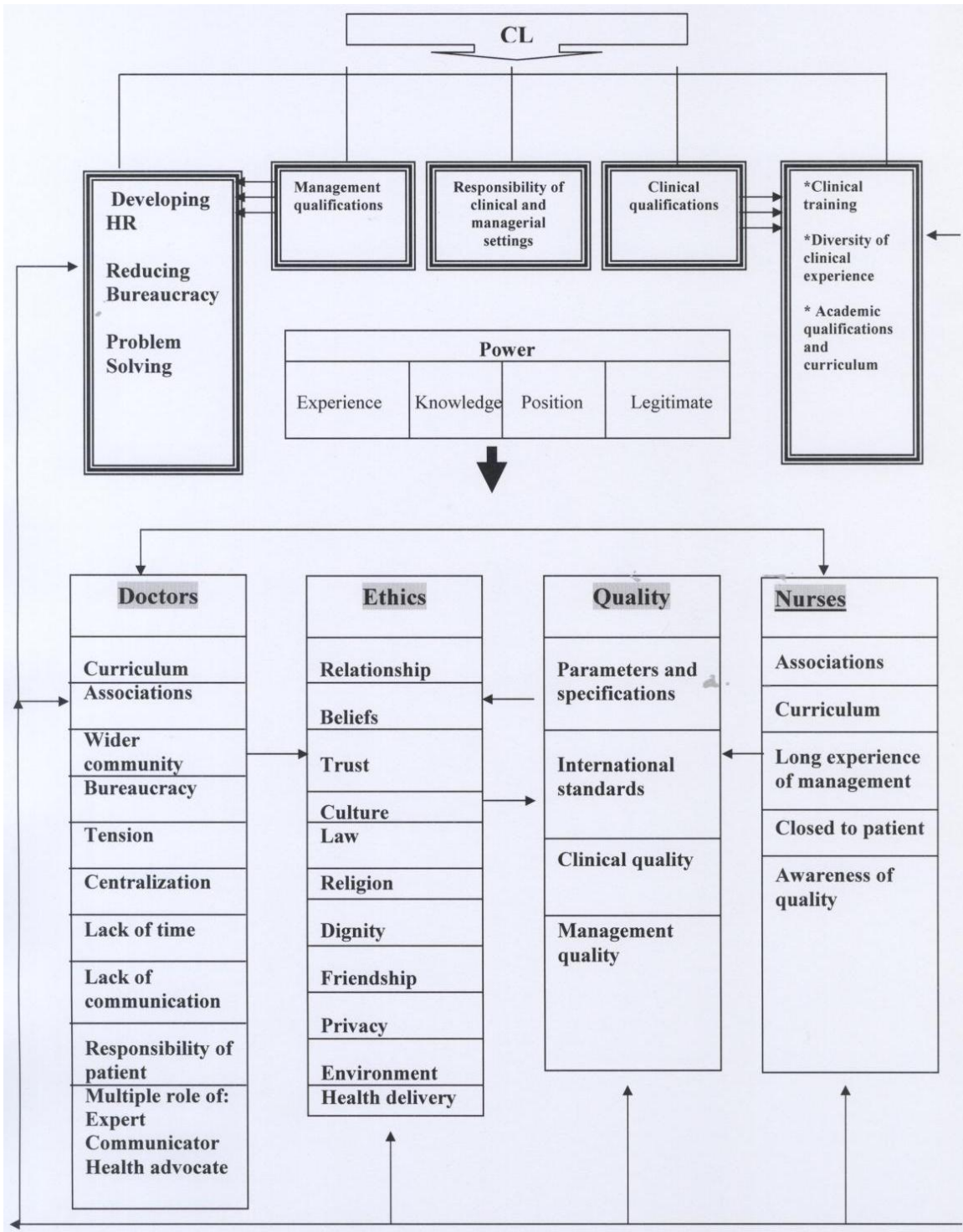
It seems that doctors have the strongest power in hospitals, often as a direct result of their academic qualifications, and clinical situation. The tendency of doctors to make individual, autonomous decisions, as well as tension created as a result of bureaucracy and centralisation, may contribute to the lack of communication between doctors and other hospital workers (clinical or otherwise). Unfortunately, hospitals often have no option other than to ignore these problems because, usually, doctors are the decision makers and policy planners in their institutions. At the same time, it is the responsibility of the health service to ensure that doctors are able to manage hospitals properly by providing them with management courses. But they cannot work alone; for example, effective teamwork concepts need to be adopted in conjunction with nurses and other AHPS, such as pharmacists and clinical technicians who are qualified in both clinical and managerial approaches.

Accordingly, the type of transformational leadership mentioned in chapter two may be the ideal way to implement a better relationship among clinicians because power can be distributed between all of them. It is evident that there is a strong interaction amongst clinical job descriptions for all clinical professions. Therefore, the aspects of consultation, intellectual sense and individual consideration are suitable environment to make decisions as mutual and sharing roles within open channels of communication. For example, there is no opportunity to exchange information within the health team considering only formal and written styles. In other words, the informal style may help to break down hierarchical barriers allowing individuals to get information in the easiest and shortest way, saving time and money as well as effort.

Matching health care quality is the mutual responsibility of all clinicians. Quality assurance programmes are not only the responsibility of quality officers, who are sometimes non-clinical staff. Also, transformational leadership means leaders who trust others directing them through mentoring, delegation and negotiation. Health care depends on these basics in order to construct a hierarchy that all clinicians feel satisfied to achieve the hospital's goals for the good of their patients.

In clinical transformational leadership, doctors are no longer the only decision makers in hospitals; nurses with even longer experience in hospitals cannot consider themselves the ones with the best clinical awareness of everything in hospitals, similarly, AHPS are not the only health technicians doing a job in separate and closed rooms without representation in top management. Transformational leadership means recognising everyone's experience; knowledge, position, training and academic qualifications, as well as taking into account ethical considerations, respecting cultures and norms, displaying loyalty for your hospital and maintaining open channels of communication. This open-ended form of power sharing is the real means by which to achieve effective and successful leadership.

**Figure 3.3: Interactions of Clinical Leadership Factors**



To summarise, it can be seen from figure 3.3 that CL could be achieved by implementing a fair distribution of power among all clinicians. For example, it should be recognised that doctors have neither enough management awareness nor enough time to practice CL, but their wide responsibility towards public and communities makes them able to take part in hospital and health care management. Also, nurses' experience and qualifications provide them with a comprehensive picture about the clinical industry, in particular, relating to issues surrounding quality, ethics and management skills, but these skills and abilities are frequently overlooked because of the favour that is shown to doctors. Other hospital workers, such as AHPS, have no clear role in health management and leadership because very little power is provided to them, and not enough management skills are taught to them as part of their curriculum, nor do they receive enough support from professional associations. Clinical quality and ethical management cannot be achieved properly unless there is much more awareness of the culture, religion, beliefs and social lives of team members.

### **3.11 Summary**

Hospitals and medical care providers all over the world are seeking to provide clinical and administrative training for medical personnel. Accordingly, there arises a need for clinicians to be given the necessary support in order to gain managerial expertise, without the overburden of bureaucracy. This empowerment will enable clinicians to fulfil their skills alongside the kind of development, offered by universities, other academic institutions and professional associations.

Doctors are considered more qualified clinicians in the medical services to manage hospitals due to their clinical experiences more than others. On the other hand, nurses are considered the biggest structure in hospitals that are clinically and practically qualified. The same is almost true according to AHPS of assistance medical profession in order to maintain the quality and ethics of teamwork as considered guidelines and parameters. The medical industry is primarily interested in international quality, both in clinical and administrative settings .Also, it is necessary to have ethical considerations where the medical profession is concerned.



## **Chapter Four**

### **The Jordanian Health Care System and the Emergence of Clinical Leadership**

#### **4.1 Introduction**

The main purpose of this chapter is to examine the emergence and development of clinical leadership in Jordanian hospitals. Health service management in Jordan is still a new concept in hospitals and health care centres, in both the public and private sectors. The introduction of Health service management can be seen as an attempt by the Jordanian Ministry of Health (MOH) and other international voluntary organisations, such as USAID and universities. The role of these organisations is to create a highly developed health system in which clinicians can perform their own management to match the requirements of a highly developed health sector. Therefore Jordan is the centre for Middle East patients, and its hospitals use the latest technical and complex surgical procedures as well as performing modern medical investigations at a global and regional level. Additionally, Jordan has more than 100 developed hospitals, equipped with the latest medical technology, as well as highly trained and qualified clinicians and clinical technicians.

The introduction to this chapter is presented in section 4.1; section 4.2 discusses the need for health service management and CL in Jordan. USAID participation in Jordanian health care management and CL is explored in section 4.3. The role of Jordanian curriculum towards CL is examined in section 4.4, whilst the role of professional associations and MOH towards CL and the current situation of Jordanian CL are discussed in sections 4.5 and 4.6. Summary of chapter four is given in section 4.7.

## **4.2 The Need for Health Service Management**

Jordan is located in the centre of the Arabian states. It is governed by a parliament and a constitutional, hereditary monarchy. Under the constitution, the King is the head of state, and as such, is vested with wide ranging powers, which he exercises through three state authorities: the legislative, the executive and the judicial (The Ministry of Information, 1978). The total population of Jordan was estimated at 5,350,000 in 2004 (Department of Statistics, 2004). Jordan's population is of a young age and there are no serious obstacles which may delay the forward development of its health services. For example, the country does not need a big budget to manage disorders associated with an aging population, such as cardiovascular diseases, hypertension, diabetes mellitus and bronchial asthma. Most of the current health service budget can go into infra- structure in the form of hospital development and reforms.

Health service management is still new in Jordanian hospitals at all levels. Health service decision makers are responsible for training their clinicians and non-clinicians - to perform the demands of health policy and strategy, concentrating on managerial and leadership capabilities, and matching patient requirements and satisfaction. Abdelhalim and Adwan (1997) have investigated patient satisfaction with medical care services in Jordanian hospitals, and have shown that training programmes on the topics of behaviour and communication should be made available for employees.

Though Jordan has many health care centres, hospitals and comprehensive clinics there is a need for a degree of reorganisation in the health care system in terms of HR, management, leadership, and planning in order to improve the service and match public demands. The complexity of the health care delivery system and the increasing role of the hospital sector require careful planning and management of human resources in order to achieve an equitable provision of health care. Both public and private approaches are managed by the MOH and

directed by many professional institutions such as clinical faculties and professional syndicates which try to enhance the quality approach.

In an attempt to describe the nature of health service management in Jordan, Hornby et al, (1998) argued that HR activities were limited in the Jordanian health care system and there appeared to be inadequate experience in the areas of recruitment, personnel and management. There was no formal continuing education system, and the relationship between health service provision and pre-service training institutions (medical and other health professional schools) was loose; in addition to this, the weak partnership between these institutions, health care providers and professional organisations (e.g. syndicates) was deemed to be inadequate

While Jordan has limited resources in some areas, in clinical terms it has many resources and plans to introduce a successful health service within the hospital environment in particular. Hospitals in both the public and private sectors are adequate to cover the Jordanian population and most of them introduce primary and secondary health sectors as well as educational and training services. Health and clinical institutions are struggling to strengthen the link between clinical associations and health colleges to improve the health situation in Jordan by ensuring training and educational seminars in an attempt to qualify HR personnel in both experience and management.

The MOH adopts a policy of health for all (HFA) which considers health as a basic right for every citizen. The supreme health council is mandated to formulate the general health policy. The council is chaired by the prime minister, the minister of health as a vice chairman and its membership is made up of involved ministers (finance, planning, labour and social development), the director of the royal medical services, deans of the medical schools, the heads of related professional associations and representatives from the different health sectors

(Alwan, 2005). This diverse membership means that clinical leadership and health service management are the mutual responsibility of both governmental and private sectors. This council works to improve health care delivery such as enhancing management and HR as a first priority.

The MOH drafted a strategy for advancing health care. The strategy was created to strengthen human resource development and promote national capacity, particularly in public health related fields such as health management, health care financing and health insurance. The strategy also identified initiatives such as upgrading health management and professional standards, strengthening partnerships between public and private sectors, implementing universal health insurance scheme, strengthening capacity in health economics, and maintaining Jordan's role as a centre for excellence in medical treatment in the Middle East and beyond. Furthermore, it sought to encourage all health institutions to comply with standard humanitarian approaches and medical ethics. The strategy defines the role of the MOH as planning, developing and monitoring the implementation of the health policy, providing preventive care and public health functions, as well as training, continuing the education of health professionals and, finally, promoting and institutionalising health research and technology development.

To achieve this strategy of HR training within Jordan, Banks et al (2000) have emphasised that hospital personnel in Jordan should not be denied training opportunities in both domestic and international issues; therefore workgroups suggest changes to the application of training. Furthermore, Al-Marayat (2000) indicates that management by objectives could be applied to managing health services by studying the upper and mid-level administrators of MOH to assess the knowledge and trends among the directors and chief departments at the central directorates. He revealed that the level of knowledge of the most advanced approaches in

management is less than the required level and it may be possible to apply management by an objective approach, even within a limited framework.

In this approach, Luna et al (2000) produced a paper describing health worker motivation at Al Bashir Hospital in Jordan in an initial effort to identify the major organizational, situational and individual factors associated with satisfaction in the job sector and to better understand the major constituencies (e.g. managers, workers, supervisors and patients). This study concluded that workers and supervisors are not generally aware of hospital goals and that managers are more likely to articulate the goals of the hospital. Employees overall are positive about working at Al Bashir Hospital, but their level of pride is not high. The highest level of pride comes from employees who are medical staff and they perceived their career prospects in a more positive manner than nurses or other hospital workers. Workers and supervisors disagree on the amount of openness that there is with management at Al Bashir Hospital. Workers perceive a low level of management openness while supervisors and managers perceive a high level of management openness. Clarity of communication about decisions was determined to have a positive affect by increasing the individual's sense of control in the work setting and improving personal effort orientation to work. Management openness and removing bureaucratic constraints were also thought to enhance motivation, the perception of management openness can perhaps be increased through better communication and increased dialogue.

This is evidence that trained staff and a qualified administration may attract patients in both local and international surroundings to have treatment in these hospitals, thus keeping Jordanian hospitals at the centre of medical practice in the Middle East. In the same vein, Nusairat (1998) states that during his investigation into the services of Jordanian private hospital care that factors such as hospital choice, quality of care, emergency services and the

hospital setting were found to be of relatively high importance. This would suggest that hospital administrators and staff in the private sector need to reorganise so as to reflect the importance of quality as a basic principle in hospital choice.

In his review of the strategy of the clinical sector in Jordan, Muasher (2005) discusses the national agenda of the Jordanian health sector. The paper proposed a long-term vision for Jordan to become a centre of excellence for the provision of health care in the Middle East. It was suggested that this vision could be achieved through protecting the health of citizens and promoting social security and justice, by providing efficient health care, restructuring the health sector, upgrading the standards of health care and strengthening quality control. Also the study was considering health as an economic value and a stimulant of the national economy and efficient management of health care.

In order to try and combat these problems, different commissions from the governmental, private and voluntary sectors have combined their clinical and administrative resources in an attempt to promote the managerial and leadership capabilities of health care commissions, such as clinical associations and USAID, in order to support the MOH responsibilities.

#### **4.3 USAID Participation in Jordanian Health Care Management**

The primary health care initiative (PHCI) is a five-year USAID funded project covering the period from August 1999 through to July 2004. The goal of this project was to increase access and demand for quality services at MOH primary health care (PHC) centre facilities across Jordan. In order to reach this goal, major inputs were identified and implemented by the PHCI project (in conjunction with the MOH) in order to improve the quality of care (PHCI, 2000, a). These inputs aimed to introduce and sustain quality assurance programmes, which

involved training PHCI centres staff, strengthening health communication and marketing, improving the health management information system and strengthening the capacity at a government level to conduct and utilize research.

This project indicates issues relating to health service management such as staff management, including maintenance of personnel; records containing job descriptions, information about training experiences and performance evaluation reports; opportunities for staff to participate in work planning, and staff satisfaction(PHCI, 2000, a).

The PHCI Programme (2001) concentrated on management standards, including job descriptions, client and provider rights, mission statements, accounting procedures and supply system procedures. Part of the strategy was to improve quality and strengthen PHCI managers in a variety of management skills, making them master trainers and management coaches.. The PHCI (2000:b) also discussed the objectives of the nursing education strategy, which were primarily to strengthen the knowledge and skills of nurses at PHC centres through targeting interventions in nursing education and training by strengthening central and govern rate capacities to plan, implement and monitor in-service training activities for nurses .

The PHCI (2002) also discussed the supervisor's perception of Jordanian health care, exploring the impressions of supervisors regarding their role in the Jordanian MOH primary health care system. A self-administered questionnaire was developed and distributed to 115 supervisors, which concluded that supervision is an important element in the successful management of any primary health care. To be effective, supervisors should be supportive and help staff to improve their performance and competence as well as successfully motivate them and assist in solving their problems.

The PHCI found that in most cases; there is no real planning for supervisory activities, no schedule for supervisory field activities and no supervisor's job description. There are also no written protocols or standardized field tools to monitor performance or guide the supervisory process. The study recommended the following ideas for discussion: defining the elements of an effective supervisory system in terms of inputs, processes and outcomes; defining the quality characteristics of each element of input processes and outcomes; setting quality standards or expectations for each element; developing and testing supervisory tools including checklists, planning and reporting; building the structure and communication channels to support the functions of the supervisors. USAID has emphasised that effective leadership is required in order to provide excellent patient care services, believing that leadership must come from a hospital's governing board and senior management including the hospital director, medical director, matron and administrator, as well as medical staff, to match these criteria (USAID, 2006).

USAID has also designed further guidelines for medical staff; physicians, dentists and other professionals who are licensed and permitted to provide direct patient care without supervision. These guidelines adopted processes to enhance their education, training and experience, and competence. Here are some examples of medical leadership and management in terms of experience, training and positional authority, matching policies and procedures to achieve clinical quality (USAID, 2006).

USAID emphasised that the nursing department is the largest single department in hospitals. Therefore, nurses must consider their role in health service management and clinical leadership. For example, a director of nursing/matron, who is experienced, has achieved higher educational preparation, has the ability to provide leadership and direction to the nursing department. Therefore, USAID steps have been delivered to develop the nurses' educational and managerial experience, as required by the job description in an attempt to



determine nursing standards consistent with national nursing standards of practice and their implementation by collaboration with physicians and other workers for patient care using a continuing training programme (USAID, 2006).

Factors such as human resources, communication, recruitment, training and the qualifications of staff in terms of both practice and education are the main components in achieving the standardization of clinical practice that is needed for CL. Furthermore, supervising, controlling, directing, ethical reviewing and establishing a quality directorate will increasingly enhance the real meaning of effective leadership for clinical and health care delivery. In other words, appropriate criteria and standards in health care will mean an increase in the quality of management. USAID has involved all clinicians in health service management and clinical leadership by establishing guidelines of management practice for health directors in health strategy and planning. Medical doctors, as managers in their hospitals, are also required to be provided with managerial abilities; there should also be more opportunities for nurses to become managers and strategic planners in order to reflect the needs and demands of the hospital's situation in all its aspects.

Therefore, health and managerial experience and cooperation between organisations and health care providers are a necessary process in promoting health care delivery. USAID is creating and developing health service management as a concept that consists of many supporting commissions and approaches such as training of staff and continuing education, human resources and personnel qualification and rehabilitation, planning and motivation, improving channels of communication and relationships between employees themselves and the upper level and strategic management. Many of these processes were intended to instigate a move beyond classical management styles towards the giving of more power to health workers to govern themselves.

It could be suggested that Jordan needs more programmes like those of the USAID organisation in order to continue the long journey towards achieving a high quality level of clinical leadership and health service management. The positive participation of Jordanian universities and professional associations is important in the successful continuation of the mission of USAID. So, the role of academic institutions embodied in clinical faculties in Jordan is very necessary to complete the mission of international organisations

#### **4.4 The Role of Jordanian Curriculum towards CL**

While CL or health service management already exists in the Jordanian curricula, it is not effective because there is no clear set of practices to be followed. It has been found that these clinicians need greater administrative abilities, such as the ability to understand the guidelines of leadership, the culture of clinical quality and ethics, to plan, strategies and be able to draw up policies based on rational and objective decisions. For example, Abu-Gharbieh and Suliman (1996) showed nursing educators disagreed with some beliefs in the faculty of nursing philosophy statement. Surprisingly, they widely favoured physicians' involvement in nursing education and, nurses placed significantly more importance on technical tasks.

The faculty of nursing at the University of Jordan reflects the concept of clinical leadership in its academic modules for undergraduate and postgraduate students. Abu Mughli and Zu'mot (2006: a) have designed a managerial course to introduce the student to management and clinical leadership concepts. These concepts are a necessary part of learning how to manage care and make appropriate decisions related to clients. The aims of the courses are to introduce students to the basic concepts, principles and theories of management and clinical leadership and utilise the knowledge in planning nursing care. Regarding cognitive and intellectual skills, the courses recognise the process, principles and strategies of problem solving and decision making in nursing, the principles of management and leadership in

nursing, and the knowledge related to decision making and problem solving process that is a necessary part of the nursing process.

In a similar vein, Abu Moghli, (2006: a) also designed a postgraduate managerial course for her masters' students, which discusses nursing ethics and roles. The course examines the implications of advanced practice and its effects on the development of the nursing profession in addition to the cross cultural and ethical issues that face nurses in providing care for their patients and families. The course covers many topics related to nursing including ethical theories, common morality theories, codes of ethics and ethical decision making. The course also provides guidelines for ethical decision-making.

Health service management is one of the mandatory requirements for the students of rehabilitation sciences at the University of Jordan. These students discuss principles and theories of management and their application to rehabilitation sciences and strategies of problem- solving and decision making. In addition to this they must learn the different theories and styles of leadership that are needed in order to act as an effective leader as well as the communication and group dynamics that are crucial to maintaining high morale among staff members and quality improvement in health care settings (Abu Moghli, 2006:b). Similarly, clinical leadership style has also been reviewed by Suliman and Abu- Moghli (1999), who explored the leadership styles of Jordanian hospital nurse administrators (transformational, transactional and laissez faire). This study is significant because the elements of leaders' style and behaviour may strongly affect the future of nursing in Jordan. The results showed that nursing administrators and staff nurses were consistent in their evaluation of transformational, transactional and, to a lesser extent, laissez faire leaders. Nurse administrators rated themselves as predominantly transformational, while their staff nurses rated them as predominantly transactional.

Al Qutob (2006), a lecturer in the faculty of medicine at the University of Jordan, introduced his students to the management of health organisation. This course presents the health services organisation management framework, describes the health service environment, addresses the structuring of health service organisations and introduces the topic of strategic planning and inter-organisational linkages for health services organisations. Additionally, structuring of health service organisations, strategic planning, health service communication and marketing, quality improvement, personnel management, motivation and leadership were the main elements of that module.

The importance of clinical leadership can be seen in the vision of the Nursing Faculty at the University of Jordan, the leading institute for undergraduate and graduate nursing education. The institute seeks to teach research and community services at the national and regional levels, preparing highly qualified professional nurses. The master and doctoral programmes prepare professional nurses for leadership roles in education, research and clinical specialisation (Faculty of Nursing, 2006).

The University of Jordan's Faculty of Nursing believes that the individual client is a bio-psycho-social and spiritual individual and that everyone is a unique entity entitled to respect, care and support. The individual has dignity, intrinsic values, freedom and responsibility for their own choice in seeking health care. Professional nurses utilise the nursing process to help the client to attain, maintain or regain the optimum level of health. They function in a variety of roles including care provision, communicating, educating, and counselling, in addition to advocating, conducting research, leading and acting as agents for change in partnership with other health disciplines (Faculty of Nursing, 2006).

In conclusion, health service management is becoming an increasingly prominent part of the university curriculum, enabling students to learn many managerial concepts in addition to

information about organisational structures and culture. Such courses are designed to encourage the building of strong relationships with health workers, and teach practicing ethics and ethical decision making, the ability to support behavioural changes and methods by which to improve leadership.

It is necessary to promote a link between theoretical and practical approaches within health service management as a hospital cannot split itself from its clinical institutions in order to achieve its philosophy. Clinical leadership became one of the more important university modules in training clinical individuals in how to manage the health sector in a comprehensive manner. These university modules consist of learning management theories of personnel, communication skills, health plans and strategies, organisational behaviour, clinical ethics and health care finance. Such courses and modules can be seen as a serious attempt to train clinicians to be able to guide the health industry instead themselves instead of regular businessmen and other managers from the non- clinical sector.

As a result of mutual activities being practiced by academic and professional organisations the government of Jordan (represented by the MOH) has become increasingly interested in creating standardisation within the area of health service management and in providing guidelines for those wishing to enter clinical careers in a professional capacity.

#### **4.5 The role of Professional Associations and MOH towards CL**

Health care organizations in Jordan, such as clinical faculties, professional syndicates and the MOH, have established parameters to adjust the quality of health services in terms of professional ethics and lines of communication. They have set up these parameters in order to enable clinicians to make rational decisions and to support their teams with enough knowledge and experience by encouraging them to meet international standards. For example, the Jordanian Nursing Council, JNC (2006: a) has recently created standards for accreditation

for nursing teaching purposes. These standards are intended to provide nurses and hospitals with professional guidance in an attempt to create and maintain the quality of a clinical environment that guarantees opportunities (experience, supervision and support) and enables the achievement of safe, competent and accountable practices. Regarding philosophy and objectives, the nursing division has a statement of philosophy, objectives and professional ethics including the adoption of a philosophy appropriate to Jordanian cultural beliefs and social values. One of these guidelines also reflects that the organisational structure is suitable for the nursing department and has a well-defined structure, which states the title of each position, functional relationships and formal lines of communication. In addition, nursing administration participates in planning, decision-making and formulating policies of the health agency and ensures that nursing leadership is provided with valid authority.

Also, the guidelines have indicated that an effective communication system should be available to facilitate appropriate discussion of all matters between nursing staff and other health care professionals indicating the use of effective communications skills to receive and disseminate information. Moreover, the nursing department is responsible for establishing and implementing suitable policies and procedures to supervise and guide the quality of nursing care.

Managerially, nursing administration is able to utilise available resources to achieve the required results such as determining the need for nursing personnel according to level of qualification, and skills mix in order to achieve the required standards, taking into consideration the followings issues: availability of expertise, number of patients, levels of nursing care, continuous learning, nursing workload, scheduled meetings, support employees, changes and progress of health care services. That means nursing administration promotes the advancement of nursing knowledge and the utilisation of research findings in collaboration

with health and educational institutions for the provision of education, practice and research opportunities for the nursing faculty. Furthermore, professional associations have concentrated on the presence of staffing plans ensures job security and satisfaction such as those related to appraisal and incentives, evaluation of personnel performance, encouraging teamwork, adopting participation strategies, and decision-making. Professional associations have not forgotten that nursing practice is based on standards of performance and codes of ethics designed to ensure the rights of clients and to provide safe nursing practice. The availability of a nursing code of ethics is paramount to ensure that nursing is strongly represented in ethical decision- making (Jordan Nursing Council: 2006, b).

Nursing leadership in Jordan has been reviewed by Milburn et al (2000) who identified Jordanian nurses' perception of leadership characteristics. A total of 19 registered nurses were selected from Al- Basher Hospital. This study found that staff members require more attention from their supervisors and suggested that greater effort should be maintained to help staff members to achieve their responsibilities efficiently. Instead of just recording mistakes, managers should try to offer solutions and attempt to be more supportive of staff members who are going through a difficult period. The following recommendations are offered such as the hospital administrators need to assess many factors embodied in the knowledge of management, value system, organisational commitment, improving the supervision system, exploring and meeting personal needs of managers and supervisors, involving staff in problem solving, involving staff in change process and encouraging open mutual channels of communication among the managers and supervisors. Also, the study revealed that hospitals need to adopt training programmes in leadership and communication for supervisors, managers and staff members, clarifying hospital policies and decentralisation. And, nursing educational institutes should emphasise the importance of leadership, theory and practice throughout the courses, as well as identifying the leadership qualities of nursing. Finally, the

study emphasised that the hospital should conduct studies to identify the effect of management and leadership behaviour on staff and patient outcomes and to identify the relationship between the managerial and leadership behaviour with the system elements.

The MOH is focusing on how clinical quality and ethics can be combined, in the belief that the health industry should move forward based upon these concepts. The central quality directorate in the Jordanian MOH (2006) is responsible for increasing the awareness and capacity of service providers to facilitate and monitor the implementation of performance standards in the ministry's facilities, ensuring the improvement of health service quality and increasing the satisfaction of clients and providers. The quality directorate believes in responding to clients' and service providers' needs, such as treating others with respect, being professional with others, being efficient in terms of resources and time, being effective in facilitating the desired health effects for clients and community, ensuring the confidentiality of information and privacy of care provided to clients, ensuring access to appropriate information and intellectual resources for clients, and updating knowledge and skills to maintain competence and a better service to clients.

In summary, there are many standards against which clinical effectiveness regarding health service management or clinical leadership can be measured. Many parameters are considered as standard in order to match local and international criteria. Clinical effectiveness in itself is not a sufficient marker by which one can measure the efficiency of the entire clinical sector, additional standards related to management are also useful when attempting to improve the quality of patient care and match public demands. For example, personal issues, such as clinicians' job satisfaction, personal characteristics and appearance, policies and procedures, are all important factors in specifying the level of health quality, emphasising that the health sector is also concerned with the quality concept. Health management should also be

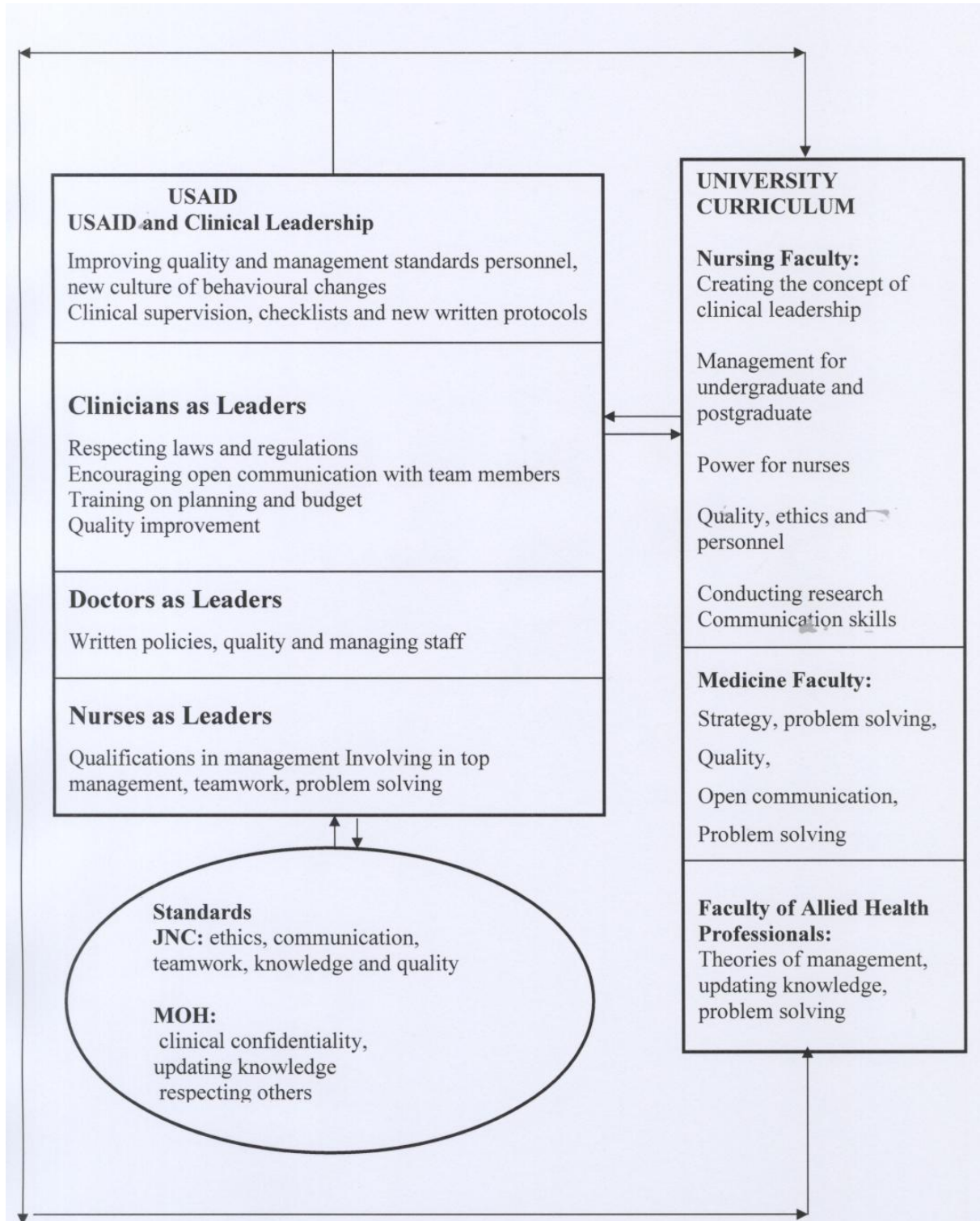


measured by strong and well-trained leaders and managers with enough experience and academic qualifications to be aware of planning and strategy concepts. There is comprehensive cooperation between local and international organisations regarding health care quality in Jordan, USAID, professional and clinical associations and syndicates as well as the MOH.

It can be seen that many clinical faculties have become more concerned with the behaviour of management within the health environment in order to improve the health care industry believing that the output (clinical students and clinicians) will practice their favourite management tools such as open communication, problem solving, and involving all clinicians (not only doctors) in clinical decisions once they are students. Faculties provide their students with updated knowledge of management and personnel issues, such as those relating to quality and ethics, as seen in figure 4.1. This situation should make it easier for local and international commissions such as USAID to continue the mission of utilising academic institutions as consulting and training organisations to train clinical students to be successful leaders and supervisors. Such institutions remind their students of the basics of laws, regulations and clinical ethics and emphasise that there is no difference between theoretical modules being taught in their clinical faculties and the real practice of clinical management, based on clinical quality as the first priority in terms of patient and health service management demands.

Local organisations such as the MOH and clinical syndicates, are also working with international commissions in order to control and formulate general criteria and thereby create standardisation in the area of clinical work, particularly with regards to an increasingly humanistic manner of dealing with patients and clinical colleagues.

**Figure 4.1: Participations of Local and International Health Commissions in Clinical Leadership in Jordan**



According to the above figure (4.1), it can be seen that the effectiveness of health service management and clinical leadership in the health sector in Jordan and Jordanian hospitals as a

result of local and international efforts such as USAID, professional syndicates for clinicians, MOH and clinical faculties, such as medicine, nursing and others to promote clinical leadership concepts, in terms of qualifying and training clinicians to be leaders.

After reviewing the roles of different commissions in both local and international contexts, the current situation may introduce some gaps to be filled in the future in an attempt to create CL in Jordan by considering its related obstacles.

#### **4.6 The Current Situation of Jordanian CL**

Based on the previous empirical studies, we can say that Jordanian hospitals need to pay attention to health workers' levels of job satisfaction and create better communication channels between the multiple levels of their organisations in order to facilitate the smooth delivery of the health service. Rules and regulations should be understood in detail by health workers in order to eliminate professional stress during work. It is necessary to work within a leadership concept to achieve goals rapidly. Furthermore, the pride levels of clinicians are an important factor in enhancing the idea of clinical leadership. At present it is often the case that only doctors feel much pride in their hospitals while nurses and AHPS feel unhappy. It is clear that power and authority is still concentrated with doctors, which may cause future problems for the growth of clinical leadership. In fact, Saif (1996) indicated that physicians were preferred to head the hospital, while the administrators preferred a director from their ranks.

To emphasise this issue, Al-Gazi (1995) and Al-Shalabi (1999) pointed out that job satisfaction amongst nurses and physicians in Jordanian hospitals. The data indicated that the strongest determinant of job satisfaction was working conditions and improving opportunities, salary, working conditions and autonomy would help to increase the level of job satisfaction

for both physicians and nurses. In this vein, the study by Harahsheh et al. (1998) aimed to investigate the relationship between motivation and nursing performance in Jordan. It also aimed to determine the main factors that influence nursing performance. The results showed that nurses with longer experience rated items related to vacation higher than those with short experience. In conclusion, nurses with higher levels of responsibility pay more attention to issues of staff motivation and needs.

Furthermore, Al-Ajeel (1998) conducted a comparative study aimed at identifying the levels of job stress experienced among staff nurses at MOH and private sector hospitals. The study observed certain weaknesses in the application of job descriptions for staff nurses that contribute towards a higher level of stress among staff nurses, damaging their relationship with colleagues. Continuing in this vein, Suliman and Abu-Garbieh(1996) have argued that Jordanian nurses are generally dissatisfied with working conditions, payment, nursing and hospital administrators' support, and professional growth and development.

Jordanian hospitals and the health care industry in general, have some problems that need to be addressed. There is a shortage of knowledge regarding clinical leadership and health service management in Jordan, there is a lack of empirical studies which could allow Jordan to benefit from the experience of foreign countries, such as the UK (National Health Service), as mentioned in Chapter 3. Furthermore, the hospital goals, laws and regulations are not always clear for most doctors and clinicians; this negatively affects the relationship between clinicians and hospital management in terms of strategy, planning and other administrative issues. Also, medical staff or doctors have the highest levels of power and authority in the hospital environment, with most hospital authorities working in their favour. In contrast to this, other clinicians, such as nurses and AHPS feel lower levels of job satisfaction due to their limited authority and the low level of support they receive from top management. Basically, there are some professional conflicts between doctors and nurses in terms of the

extent of doctors' authority and there is also evidence of conflict between clinicians themselves and top management, which may negatively impact upon, or even effectively close, communication channels.

It can be seen that other clinicians are rarely involved in decision-making in terms of hospital goals and strategies and there is a lack of partnerships amongst clinical commissions and clinical faculties. Nurses also have some conflicts with their supervisors. While supervisors rate themselves as transformational, followers rated them as transactional managers. That means clinical teams in Jordanian hospitals need some training regarding personnel and management issues, in particular concerning relationships with their clinical and administrative colleagues, communication skills and knowledge. Finally, there is a gap between Jordanian and European countries, such as the UK, in terms of clinical leadership and health service management quality and most gaps concentrate on the personnel dimension.

According to the mentioned literature, table 4.1 (page 98-101) emphasised that there is a need for health service management in Jordan because it is still at all levels and HR activities were limited with inadequate experience in the areas of recruitment, personnel and management. It seems from the literature that health service management are the mutual responsibility of both governmental and private sectors. Unfortunately, supervisors are not generally aware of hospital goals and that managers are more likely to articulate the goals of the hospital because management still be driven in a bureaucratic manner. This is much sensitive for Jordanian government because Jordan is subjected to be a centre of excellence for the provision of health care in the Middle East. So this step needs high standards of health care and strengthening quality control.

As a result USAID project was to increase access and demand for quality services at MOH. To reach this goal, major inputs were identified such as training, strengthening health communication and improving the health management information in order to get high standards of health care .Furthermore, job descriptions, client and provider rights, mission statements, accounting procedures and supply system procedures were also investigated for development. Unfortunately, USAID found that there are no written protocols or standardized field tools to monitor performance or guide the supervisory process.

Jordanian curriculum embodied in health care faculties is reflecting the concept of clinical leadership in their academic modules for undergraduate and postgraduate students. These modules concentrate on sensitive approaches such as intellectual skills, strategies of problem solving and decision making and principles of management and leadership. These university modules consist of learning management theories of personnel, communication skills, health plans and strategies, organisational behaviour, clinical ethics and health care finance. These actions and interventions were shared with professional associations and MOH in order to establish parameters to adjust the quality of health services, in terms of professional ethics and lines of communication with enough knowledge and experience. The main aim for these associations is encouraging health care to meet international standards.

Table 4.1 Indication of Jordanian Literature in Clinical Leadership

Factor	Categories and Indications
The Need for Health Service Management	Management is still new in Jordanian hospitals at all levels
	There is inadequate experience in the areas of recruitment, personnel and management
	Health service management are the mutual responsibility of both governmental and private sectors
	Both upper and mid-level administrators of MOH assess the knowledge and trends of health service management
	Supervisors are not generally aware of hospital goals
	Low level of management openness
	High level bureaucratic setting
	There is a long-term vision for Jordan to become a centre of excellence for the provision of health care in the Middle East
	Continuous upgrading of health care standards and strengthening quality control

USAID Participation in Jordanian Health Care Management	The goal of this project was to increase access and demand for quality services at MOH
	It aims to introduce quality assurance provide training and strengthen health communication
	Developing management standards, including job descriptions, client and provider rights, mission statements, accounting procedures and supply system procedures.
	There is no real planning for supervisory activities, no schedule for supervisory field
	Also no written protocols or standardized field tools to monitor performance
	Focusing on nursing/matron, who is experienced to achieve higher educational preparation
	Controlling and directing ethical approach within effective leadership
	Enhancing quality of management by establishing guidelines of management practice
The Role of Jordanian Curriculum towards CL	Faculty of nursing philosophy placed significantly more importance on technical



	tasks
The Role of Jordanian Curriculum towards CL	The faculty of nursing at the University of Jordan reflects the concept of clinical leadership in its academic modules for undergraduate and postgraduate students.
	Establishing managerial course to introduce cognitive and intellectual skills
	Enhancing the knowledge related to decision making and problem solving
	These university modules consist of learning management theories of personnel, communication skills, health plans and strategies, organisational behaviour, clinical ethics and health care finance
The role of Professional Associations and MOH towards CL	Establishing parameters to adjust the quality of health services in terms of professional ethics and lines of communication
	Encouraging international standards.
	Providing hospitals with professional guidance in an attempt to create and maintain the quality of a clinical
	Developing professional ethics including the

	adoption of a philosophy appropriate to Jordanian cultural beliefs and social values.
	Professional associations have not forgotten the standards of performance and codes of ethics.
The Current Situation of Jordanian CL	Physicians were preferred to head the hospital, while the administrators preferred a director from their ranks
	Nurses with higher levels of responsibility pay more attention to issues of staff motivation and needs
	There are weaknesses in the application of job descriptions for staff nurses
	Jordanian nurses are generally dissatisfied with working conditions, payment, nursing and hospital administrators' support.

#### 4.7 Summary

Jordanian health strategy aims to strengthen the human resources of the health care sector in order to promote health management, and aims to achieve professional standards in many areas such as medical and nursing ethics, planning, continuing education and training. USAID as a funding organisation has been created to increase the quality of the health service at the

MOH and to contribute to the development of health care personnel regarding training, motivation, better communication, supervisory support, provision of management, and to support clinicians with behavioural changes and improve the clinical leadership concept. Health institutions have a serious contribution to make towards improving Jordanian clinical leadership. For example, clinical and health care faculties in Jordanian universities have provided management and leadership curricula to introduce students and candidates.

Health guidelines are being given to clinical institutions and health care organisations, like USAID, the quality directorate at MOH and professional syndicates, to adjust the clinical work according to international standards.

## **Chapter Five**

### **Methodology**

#### **5.1 Introduction**

Four samples were adopted in this research consisting of four Jordanian hospitals, two of which are academic and teaching, one is public and the fourth is private. This selection was made to identify the effectiveness of CL in Jordanian hospitals reflecting the objectives and research questions and the main concepts of CL. Research paradigm was explained in detail to reflect the impact of this paradigm on this type of study. Therefore qualitative approach suits this type of explanatory research. All managers who have high supervisory missions, such as general managers and heads of clinical departments in medicinal, nursing and AHPS departments were involved with an open-ended interview as mentioned in appendices A and M. Content analysis as a formal approach was used in qualitative data analysis.

#### **5.2 Research Design and Paradigms**

Research design, as clarified by Punch (2005), refers to all issues involved in planning and executing, starting from identifying the problem through reporting and publishing the results and the strategy, whether quantitative or qualitative, within the framework. In this context, Zikmund (2003: p. 65) defines research design as “*a master plan specifying the methods and procedures for collecting and analysing the needed information*”. Furthermore, according to Nachmias and Nachmias (1996, p.98) “*it is a programme that guides this investigator as he or she collects, analyses and interprets observation*”. Creswell (1998) has argued that designing research should facilitate the clarification of the study purpose, which is exploratory, descriptive and explanatory

(Robson, 2002). Babbie et al (2003) have argued that an exploratory research project is useful when the research questions are vague or where little theory is available to guide predictions.

According to Bryman and Bell (2003, p.23), paradigms are a “*cluster of beliefs and dictates for scientists in a particular discipline influence what should be studied, which research should be done and how results should be interpreted*”. To achieve such an approach, the main paradigms will be examined in order to select which are the most suitable for this study. Kumar (1996) details two paradigms; the first one is called the systematic, scientific or *positivist approach*, which is rooted in the physical sciences; the second paradigm is known as the qualitative, ethnographic, ecological or *naturalistic approach*.

Research paradigms are explored in some depth by Hussey and Hussey (1997) who argue that paradigm (table 5.1) refers to the progress of scientific practice based on people’s philosophies and assumptions about the world and the nature of knowledge. So, there are different research paradigms which can be labelled positivistic (quantitative) and phenomenological (qualitative) or mixed.

**Table 5.1: Positivistic and Phenomenological Paradigms**

Positivistic design	Phenomenological design
Tends to produce quantitative data	Tends to use qualitative data
Uses large samples	Uses small samples
Concerned with hypothesis testing	Concerned with generating theories
Data is highly specific and precise	Data is rich and subjective
Location is artificial	Location is general
Reliability is high	Reliability is low
Validity is low	Validity is high
Generalizes from sample to population	Generalizes from one setting to another

**Source: Hussey and Hussey (1997)**

It can be detected from table 5.1 that reliability and validity may be considered low or high depending on the use of the paradigm as an attempt to get balanced

measurement. To explain phenomenological paradigm, Hussey and Hussey (1997) stated that phenomenology is the science of phenomena, which is the fact or occurrence that appears or is perceived. It concentrates on understanding human behaviour from the participants' own frame of reference. Qualitative approach: in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e. the multiple meaning of individual experiences, meaning socially and historically constructed, with the intent of developing a theory or pattern). The researcher collects open-ended, emerging data with the primary intent of developing themes from the data. According to the assumptions illustrated by Creswell (2003), this study begins with a broad survey in order to generalize results to a population and then focuses in a second phase on detailed qualitative, open-ended interviews to collect detailed views from participants.

Zikmund (2003) goes along with Kumar's opinion (1996) that qualitative research is explanatory research which may be conducted to diagnose a situation, to create alternatives or discover new ideas. In the same vein, both Strauss and Corbin (1990: p. 17) have defined qualitative research as: *"a research that produces findings not arrived at by statistical procedures or other means of quantification. It can be referring to research about persons, lives, stories, behaviours, organizational functioning, and social movement or relationships"*. Furthermore, Hakim (1987) states that the great strength of qualitative research is the validity, which can be defined, according to Zikmund (2003: p. 743) as *"the ability of scale or measuring instrument to measure what it is intended to measure"*.

Thus, the researcher has established many questions intended to enrich the significance of this concept and its related factors. In the following section I will investigate more about the type of instrument, research methods and the mode of collection data which could be used, as well as the rhythm of data treatment. The researcher also selected the qualitative approach to emphasize certain issues. The reasons for adopting this methodology are outlined below:

- The researcher needs to conduct interviews with managers and most senior staff or those who are involved in managerial supervision such as general managers and heads of clinical departments
- The nature of this study consists of behavioural aspects, which could normally be presented as open-ended questions.
- Many resources of data collection can be easily gained, such as books, articles, journals, magazines, reports archives, published statistics, company's annual reports, newspapers, in addition to films, videos, internet, letters, essays and personal notes (Punch, 2005 and Hussey and Hussey, 1997).
- Many of the researcher's own views can be easily gained in an open-ended interview reflecting the hidden ideas that the researcher did not intend to investigate. In other words, a lot of ideas will be added to enrich the investigation of CL being practiced in Jordanian hospitals, discovering the role of each participant in this mission.
- The high level of validity is useful to deliver distinctive research that is applicable to the health care industry.



The question appeared here is how this study can be analyzed within qualitative approach? To answer this question, Hussey and Hussey (1997) have argued that the aim of study is to demonstrate the main concept of content analysis, which is a research tool used to determine the presence of certain words or concepts within texts or sets of texts. Therefore, content analysis provides formal approaches to qualitative data analysis. Also it is presented as a diagnostic tool for qualitative researchers, which they use when facing a mass of open ended material. In this approach, Bryman and Bell (2003) have acknowledged six steps in qualitative research by demonstrating research questions as a first step and selecting relevant subjects as a second, then collecting the relevant data by conflicting interpretation and meanings as the third step. The fourth step is the interpretation of data by providing guidelines for the classification and organization of the data. The fifth step is to tighten the research questions and collect further data and, finally the sixth step is coming as writing up findings and conclusions.

In this study, there has been a qualitative analysis for the interviews through analyzing the contents, where statements motioned in the interviews have been read in a conscious and careful way, with a lot of attention being paid to linguistic and academic contexts, as such, it becomes easier for the researcher to understand the subject accurately. Then, all the statements in the interviews were discussed in a scholarly manner to serve the goals and methodology of the research. The researcher stated some further comments before and after every statement in an attempt to standardize and make clear the meaning of any difficult terms. Deep discussion of the research factors has been undertaken in order to make the analytical approach concrete and meaningful. Therefore, the researcher could reach their own individual

recommendations before the final discussion. The initial results or statements which were derived from the interviews have been combined with the methodology and the literature as well as previous studies mentioned in chapters two and three.

The next step, after combining the mentioned statements in the interviews with the literature, was to have the researcher link the Jordanian story (the fieldwork of study) with the outcome of these statements, in order to make comparisons between the concept of clinical leadership as a global approach and the specific Jordanian experience in its local setting. In an attempt to comprehend and understand the meanings of the statements the researcher combined these concepts with the Jordanian culture and the factors of the study. Also, these results and justifications were applied to the real status of the Jordanian health sector. Furthermore, the researcher attempted to explore the organizational role regarding the Jordanian MOH and its regulations as well as to explore the USAID role in developing the health sector in Jordan. Also the role of academic and clinical colleges in Jordan and all related clinical associations were seriously considered to reveal the managerial and medical role in developing the concept of CL in Jordan.

The new developed models motioned and elaborated as diagrams in chapter seven show the results of qualitative analysis to come up with final results and recommendations. The research findings have combined with limitations as well as exploring the contribution of clinical, academic and managerial aspects. Next, recommending subjects and topics that should be subtracted in the future, to help in the development of future health service provisions in Jordan.

In this research, the introduction discusses the main research problem and the research objectives (as derived from the literature). Chapter two demonstrates and discusses the meaning of leadership concepts. The clinical leadership concepts in chapter three have also been derived from the sociology of clinical professions, in an attempt to link the research factors found in the literature with the 'real' story and the health care system experience in Jordan as stated in the fourth chapter. Therefore, the methodology embodied qualitative approach has been adopted in chapters; five and six. The research discussion in chapter seven aims to construct the outcome of qualitative approach to be linked with the research questions and objectives. This chapter investigated the benefits of Jordanian experience and all related factors such as the role of international organization and local ones represented by MOH .In addition to the roles of academic and clinical faculties in Jordanian universities and clinical associations. Chapter eight concludes by highlighting the most important implications of this study; and by discussing the academic and managerial, as well as clinical contributions made by the study. It also suggests some valuable recommendations that will prove useful for the future of the health sector in Jordan.

### **5.3 Clarifying Research Factors, Questions and Model**

After reviewing the literature, it is now possible to identify the concepts and factors to draw the research the research questions of CL, according to indications and impressions of these concepts. In this context, Smith, (1991, p.129) says that research model is "*a concrete mechanism for joining theory and method and it's a vehicle by which the researcher demonstrates precisely how he measured study variables*".

There was an attempt to link together literature meanings and implications and creating a mutual language, which would prove useful in formulating questions useful on CL. Accordingly, figure 5.1 illustrates the role of each factor in hospital management and the importance of clinicians as successful leaders in delivering a highly advanced style of CL called transformational leadership as dependent variable.

It seems from the figure 5.1 that transformational leadership (as dependent variable in this thesis) adopted by Bass and Avolio (1994), Jackson (1998) and Gaughan (2001) highlighting that that in order to be effective organizations needs visible leadership. They added that development of leadership skills in the health care industry is derived from the interaction between the leader and his followers within transformational leadership theory. It is a psychological and psychological and socio-biology behaviours according to Seniore et al, (2011) and guidance and reinforcing behaviour that supports a leader's favoured achievement orientation (Cole et al, 2011). transformational leadership definitely creates the culture and climate by stretching boundaries of the organization and enabling its workers to participate in a shared vision and strategy as stated by the authors Godiwalla et al. (1997), Cooney et al. (2002), Manning and Robertson (2002) and Brazier (2005) who also proposed that it is a vital factor to improve employee satisfaction and enhance skills for the profession.

There are four dimensions of transformational leadership (Utley et al, 2011) revealing the meanings of its components. For example individualized consideration means knowing employees and showing concern for employee's needs. While intellectual

stimulation is encouraging employee creativity and problem solving as well as learning, in addition to providing opportunities for creativity. Inspirational motivation means doing best and recognizing quality work performance. Finally, idealized influence is acting as a role model and demonstrating desirable behaviours.

Thus, according to indications of literature in both chapters, two and three, it seems that the independent factors or variables: leaders, culture, team and communication derived from the literature in chapter two. The remaining independent factors are doctors, nurses, AHPS, clinical quality and clinical ethics derived from chapter three as stated in figure 5.1.

The leadership skills in the health care industry is derived from the interaction between the leader ( the first independent variable of this study) and his followers within transformational leadership (Gaughan, 2001) and the power of leaders has a positive impact on social behaviours shaping and guiding human behaviour according to Fisher et al (2011) and Rucker et al (2011). Furthermore, the authors, Sydow et al (2011), Brazier (2005), Dierendonck (2002) and Thacker (1997) emphasised that knowledgeable agents embodied in experience and knowledge are the power to lead others by developing and exchanging relationships with different subordinates. Therefore, the researcher suggested the first question as follows:

*Q1: Which type of power do clinicians have in Jordanian hospital? Is it positional or informational?*

To emphasise the characteristics of the second independent variable, clinical culture (fig 5.1), it is a social approach for both leaders and followers according to Park and Tim (2009) consisting from custom, norm, tradition and knowledge as

well as beliefs, attitudes and values which give meaning to the organization (Mackenzie :1995, Brooks :1997, Block and Manning :2007). Also it's the leadership behaviour which can be also emphasised that culture means external adaptation and internal integration according to Schein (1985). This type of independent variables doesn't mean any clinical indications such as patient situation nor criteria of medical norms but it's the social behaviour among clinicians and their hospitals once they practice leadership within clinical setting. Thus the second question of this study is: *Q2. What is the main purpose of clinical culture that clinical leaders in Jordanian hospitals need to implement?*

There is visible relationship between leaders and followers to shape leadership in clinical setting. To discuss the impact of the third independent variable, clinical team (fig5.1), it was argued by the authors Landsberg (2000), Bezzina et al. (2001) and Storey and Buchanan (2008) said that leadership requires team members to understand and respect each other when implementing and evaluating decisions. It has different and several knowledge (Van et al, 2011) and social responsibility (Stones and Grantham, 2009) responsible to improve quality of working (Ayoko and Callan, 2010) and collaborative behaviour (Carmeli et al, 2011) because there visible relationship between teamwork and overall project success (Yang et al, 2011). In this approach, Schippers et al. (2008), Schippers, (2009) Gillespie and Mann (2004), Bamford and Griffin (2008) and Hur et al (2011) pointed out that transformational leadership attempts to transform followers by stimulating them to go beyond self – interest. Team means collectiveness by and enhancing a common goal and mutual vision and shared values with leaders. It is transformational that may develop the purpose; organization; leadership; climate; interpersonal relations; communications

and composition. Accordingly, the third question was established, *Q3* which type of clinical team do we need to strengthen the CL in Jordanian hospitals?

The fourth independent variable is clinical communication (fig5.1) and its impact on CL. To clarify this issues according to the literature review in chapter two and how this factor affects the meaning of leadership, The authors Seifre (2001), Thacker (1997) and Bell (2007) highlighted that ccommunication is increasing teamwork productivity and providing a work atmosphere in which employees can feel appropriately motivated and creative as argues. It can be seen from their indications that the factors of leader, team and culture are being involved in leadership concept. Others such as Daft (1999), Miles and Mangold (2002), Wilson et al. (1996) and Tourish and Hargie (1996) said that open communication enables subordinates to generate solutions for problems and express their own opinions and thoughts. Yang et al (2011) has added that team communication is the uniform of team. That's why the fourth question stated: *Q4*. What type of clinical communication do we have among clinicians in Jordanian hospitals? Is it strong or poor, formal or informal?

By investigating the fifth independent variable, clinical ethics (fig5.1) was described by Siebens (1998) as a system of religious, linguistic, legal and more general beliefs which individual workers need to have honesty, trustworthiness, friendship and confidentiality as well as the highest levels of satisfaction and creating leaders or wise men (Carter: 2001, Gangon: 1999 and Peterson: 2004). Therefore Krishnan (2003) emphasised that ethical behaviour on the part of leaders should work towards the growth of their followers and address their real needs. Clinically, Banerji and Krishnan (2000) and Emauel (2000) stated that it is important for hospitals to share

code of ethics in order to ensure an effective working atmosphere useful for different factors such as health environment, patients, public health and doctors. In this area, Hernandez et al (2011) has also added that there are some theories are emerging with leadership such as value driven concentrating on ethics and values. These theories called ethical, spiritual and authentic leadership. In this sense, Zhu et al (2011) identify how authentic transformational leadership develops group ethical climate and follower moral identity to enable individuals to create ethical complexity and behave fairly. For this reason the fifth question has been existed as follows:

*Q5: Does clinical ethics reflect the strength of CL in Jordanian hospitals?*

Quality (the sixth independent variable explained in figure 5.1) has no far distance from the ethical considerations and the relationship among clinicians, to shape transformational leadership. In this approach, the importance of quality in health care setting has been revealed by the authors Bradley et al (2003), Hansson (2000), Davies and Walley (2002), White (1993) and Wilson (1987) highlighted that total quality management (TQM) requires a partnership of doctors, managers and other AHPS to be effective. The goal of health care and education agencies is to promote the pattern of leadership in both sectors according to Brown et al (2007) and Block and Manning (2007), and quality of management means the quality of procedures, techniques and personnel in which the actual leadership reflects on the achievement of the organization objectives (Rasasi and Harris: 2007 and Camilleri and Ocalloghan: 1998). Also, Lee (2007) emphasised that transformational style believes in quality towards communication, training, preparing managers and individuals.



Therefore, the sixth research question has been established, *Q6: Does clinical quality reflect the strength of CL in Jordanian hospitals?*

The role of clinicians in transformational leadership, embodied in the independent variables (doctors, nurses and AHPS as stated in figure 5.1) were discussed separately. Regarding doctors, Goodwin (1998) stated that they have powerful pressure group as national associations and hospitals as members of health authorities. This is because they do have the most experience and knowledge giving them strong power to lead (Brazier, 2005). For this reason CL is so important to doctors more than other hospital facilities (Smith et al, 2004) and it's now necessary to include management skills in the medical curriculum (Aluise et al, (1989). Furthermore, the authors Letour (2004), Chrispin (1996), and Anderson (1994) revealed that their decisions are a vital part of clinical management. Thus, the seventh question is reasonable to be existed in this thesis, *Q7: Is it possible to consider doctors as ideal leaders and managers in Jordanian hospitals?*

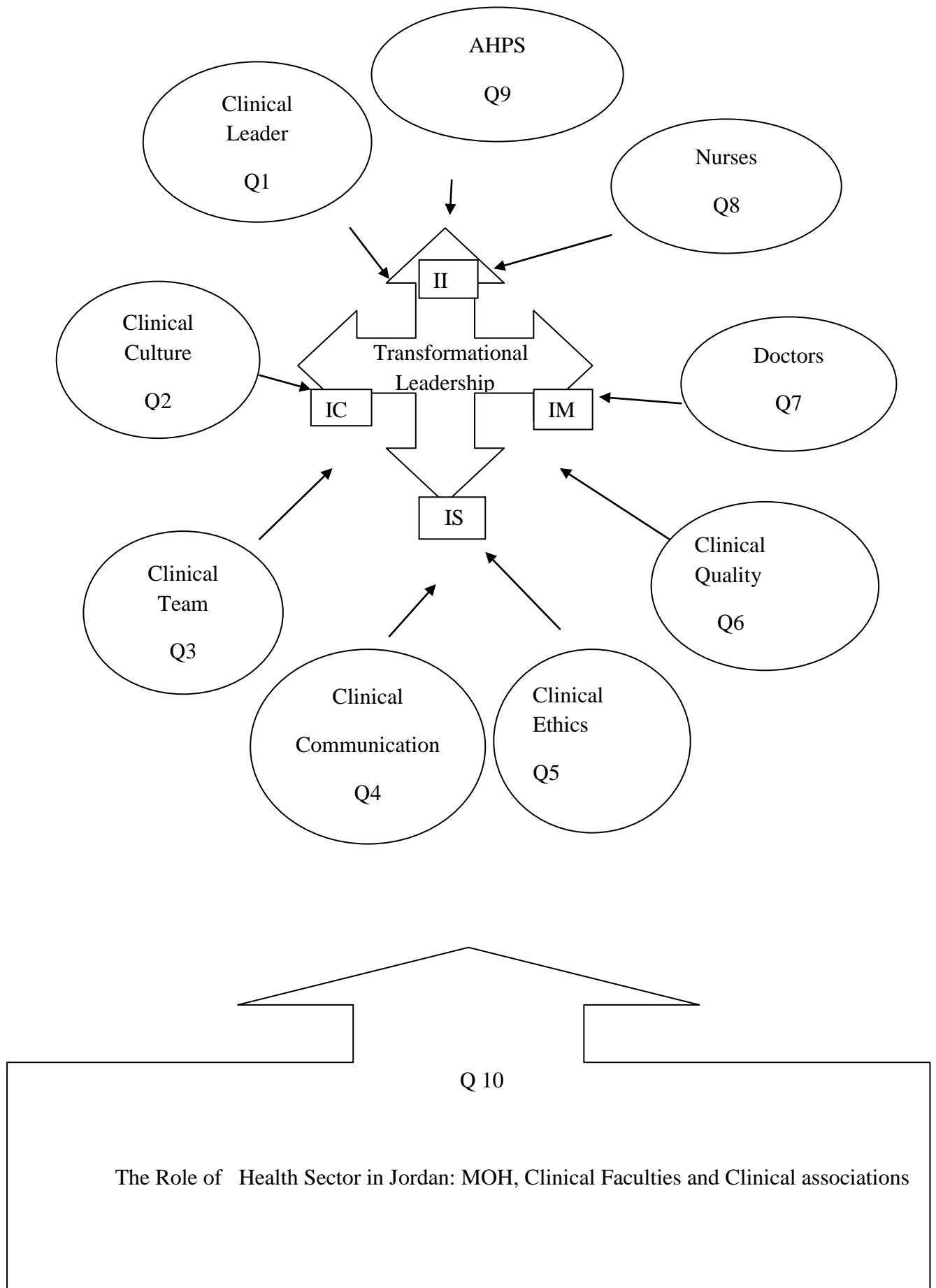
Nurses as the eighth independent variable have also a role in leadership. Interestingly, it seems from the literature in chapter three that nurses have serious participation in health management who deliver 80% of all health care and should therefore play a critical role (Millward: 2005) .Moreover, Preston and Clarke (2000) and Hancock (2005) and Burke (2004) said that CL is recognised as a potential cornerstone for the development of nursing and health care granting them more satisfaction and key of challenges (Conant and Kleiner, 1998) by improving quality of care through managing staff, managing the team, patient- centred care (Hewison and

Griffiths, 2004). They are powerful resources embodied in level of education, number of years practice, place of employment and personality type (Stewart, 1989 and McPhail, 2002) and that's why CL leadership is necessary for nurses to get job satisfaction and positive work environment within the concept of transformational leadership by improving the quality of health care (Utley et al.: 2011 and Cummings et al.: 2010). Accordingly, there is a diversity of nursing skills that may have serious interaction with transformational leadership regarding managerial and behavioural approaches. For this reason, nurses were considered in leadership by asking the eighth question, *Q8: To what extent are nurses involved in Jordanian hospitals' leadership?*

The same thing for other clinicians such as AHPS (the ninth independent variable in this thesis) to reveal the story more, it is a tangible role in diagnostic evaluation and managerial issues. In this approach, Heiberg and Helljesen (2002), Hancock (2005) and Buchanan et al (1997) emphasised that the top management in hospitals such as the head nurse, chief medical staff, and other directors of the organization, should move to become leaders. Thus, Glover and Hughes, (2000) declared that health service should be demonstrated by qualified health technicians rather than true medical technocrats capable of managing all aspects of the health care profession to enable individual practitioners to develop knowledge and competence in complex clinical situations (Cutcliffe et al, 2001). For these reasons the ninth question was involved to clarify the role of AHPS in health care setting: *Q9. What is the role of AHPS to perform CL in Jordanian hospitals?*

Finally, the last question of this research derived from the indications and categories according to table 4.1 in the fourth chapter. It is revealing the role of Jordanian health sector embodied in MOH, clinical faculties and clinical associations. Thus the tenth question is: Q10 *what is the role of Jordanian health sector institutions to shape the clinical leadership in Jordan*

Figure 5.1: The research model



## **5.4 Primary Data Collection**

The empirical study explores the main issues of Jordanian CL. These issues will be clearer when more investigation - represented as overviews, perspectives and facts necessary to shape the research instruments – have been carried out. The data collection methods are in-depth, face-to-face interviews as mentioned in both appendices A and M, in addition to an analysis of current health documents in Jordan. Arabic language was adopted during conducting interviews to ease its understanding, to have no scientific bias, not to waste time in translating them. Also, losing meanings and objectives would be difficult, although most clinicians are proficient in English, but some of administrative concepts might be difficult to be understood.

Regarding the qualitative aspect, the interviews were also conducted in Arabic (appendix M), in order to accelerate the answer and giving no chance to think of what to say, and not affect the meaning. Some of them are graduates of Western and Jordanian universities in which teaching clinical specializations; such as medicine, nursing, pharmacy and laboratories, has been in English.

Subsequently, these interviews were translated into the English language (Appendix A), so as to help the researcher in comparing the academic reality and literature aspect, and to publish his study in the international library

### **5.4.1 The Interview Instrument**

By looking at a definition of what an interview is we can predict that a free atmosphere concerning the giving of information by participants is necessary to reflect the research flexibility. In this context, Kumar (1996, p. 109) defines the interview as: *“Any person to person interaction, between two or more individuals with*

*a specific purpose in mind. It can be flexible when the interviewer has freedom to formulate questions and flexible interviews classified according to the degree of flexibility”.*

The semi-structured interview has been reviewed by Robson (1993) where the interviewer works out a set of questions in advance but is free to modify them based upon his perception of the most appropriate context and conversation. He can change the wording, give explanations, leave out particular questions or include additional ones. In this work, participants or interviewees are practitioners in the clinical profession who reflected the practical facts, stories and tangible ideas in free discussion. They have been met according to some agendas and tangible evidences derived from their real experiences as managers or supervisors.

Piloting was seriously considered in this research as two interviews were conducted with supervising clinicians from different hospitals. The main aim of this pilot was to establish if there was any useful feedback concerning the contents and wording of the interviews, as well as to assess the reliability and validity of the research as a whole. Some of the respondents recommended different changes and comments to strengthen the consistency of the research goals and questions. After this, the final draft was made; taking into consideration the recommendations of the pre-testing stages including the pilot work. The interview was designed in Arabic and distributed to decision makers and supervisors in Jordanian hospitals. The interview questions were written and presented in simple language, avoiding scientific ‘jargon’ making it easier for the interview subject to comprehend. It was also adjudicated and managed by PhD holders and other specialties in health service management before being distributed in an order to confirm that all the terms mentioned were clear and well

expressed; in an effort to reduce ambiguity as much as possible. Also the adjudicators checked that the terms employed in this interview match those routinely used in clinical the environments and hospital departments that were included in the study. Moreover, the terms adequately reflected the respondent's job descriptions for clinicians such as managers, doctors, nurses and AHPS.

#### **5.4.1.1 The Interview Questions Schedule/Protocol**

First of all a covering letter from academic supervisor has been sent to four Jordanian hospitals to request access for data collection purposes (Appendices from B - E). After that the approvals from these hospitals were issued by giving the researcher the eligibility to access for academic purposes only as mentioned in appendices F – I. Also the Jordanian minter of health has been informed (Appendix J) to access the hospitals, and the approval has been also given from him to succeed this study (Appendix K). To translate the research objectives and questions, it is necessary for the researcher to interview supervising clinicians at a director level. Participants will be expected to answer open-ended questions in 50 minutes) and express their own words after an introduction of a brief background of definitions to familiarise them with the research concepts as well as providing them with the main ideas of CL. The interviewees comprised 38 managers from 4 Jordanian hospitals; two of these were academic and teaching hospitals, the third was public, while the fourth was private (Appendix L). The objectives of the qualitative interviews were to discover the views of those managers, heads of departments and clinical sections towards the factors of CL. These positions are distributed as shown in table 5.2 and Appendix L.

**Table 5.2: The Distribution of Clinical Interviewees from Top Management and Heads of Departments**

Hospital	Doctors	Nurses	AHPS	TOTAL
	University of Jordan ( JUH)	1	4	4
King Abdullah (KAH)	5	4	2	11
Princess Basma (PBH)	4	5	3	12
Jordan Private (JPH)	2	3	1	6
<b>TOTAL</b>	<b>12</b>	<b>16</b>	<b>10</b>	<b>38</b>

Table 5.2 shows the profile of Jordanian hospital managers in different clinical positions and the percentage of each hospital's employees who contributed to the qualitative interviews. For example, 9 managers (24% of the total respondents) were interviewed from JUH, 11 from KAH (29%), 12 from PBH (31%) and, finally, 6 (16%) from JPH. Thus, different questions have been prepared for them to reveal the nature of each factor governing CL in their hospitals. Most of the managers hold high academic qualifications, such as master degrees and PhDs, especially in the two academic hospitals, as their managers and heads of departments also teach in clinical colleges in Jordanian universities.

The whole sample consists of clinicians in these hospitals with supervisory responsibilities such as directors and assistant directors and heads of departments.



General Managers and directors have been chosen as a separate category in an attempt to investigate their opinions as the primary decision makers in both clinical and managerial approaches. The heads of departments from doctors, nurses and AHP were chose to have the diversity of opinions, why CL is increasingly important to be shaped according to different titles and job description.

Regarding the interviews, the groups of respondents from clinicians were interviewed in Arabic (Appendix M) in order to make it easy for them to understand the administrative and clinical terminologies. Electronic recorders were used to ease the analysis of the interviews as this enabled the researcher to listen and analyze the responses more than once. As soon as the researcher completed gathering the interview recordings, he started to write them down and expose them to professional translators who converted them into English with the researcher's assistance. This was done in order to minimize and avoid (as far as possible) any academic bias or mistakes. At the final stage the interview, the texts were scrutinized by PhD holders in English literature from England in order to again minimize the bias. Afterwards, all the interviews texts were written up and analyzed and discussed in the thesis.

### **5.5 Criteria of Business Research**

Bryman and Bell (2003) have argued that there are three prominent criteria for the evaluation of business and management research: reliability, generalization and validity. These concepts have been reviewed in detail by Robson (1993), Nachmias and Nachmias (1996), Smith (1996), Punh (2005), Babbie (1998), Hussey and Hussey (1997) Bryman and Bell (2003). Research findings may justify the interference, which represents something more than the specific observation on which it was based.

Sometimes it involves the generalization of findings from sample to population. In the same manner, Hussey and Hussey (1997, p.58) define generalization as “*the extent to which you can come to conclusion about one thing (often population) base on information about another (often a sample)*”. In this research, this study can be generalised because the Jordanian regulations regarding providing of health care and the job description for all clinicians are the same. Furthermore, most of plans and the criteria of development are similar. Reliability, according to Smith (1991), refers to biased or non-random errors, while validity (Nachmias and Nachmias, 1996, p.5) is concerned with the question “*Am I measuring what I intend to measure*”? Nachmias and Nachmias outline the three basic kinds of validity, each of which is concerned with a different aspect of the measurement situation.

- A- Content validity: the relevance of an instrument to the characteristics of the variable; or it is a degree to which a measure covers the range of meanings included within the concept (Babbie, 1998).
- B- Empirical validity: if a measuring instrument is valid, there should be a strong relationship between the result it predicts and the result it obtains, when measuring the same or related factors.
- C- Construct validity: this kind of validity is established by relating the measuring instrument in a general theoretical framework.

Bryman and Bell (2003) have a different classification of validity; they divided this concept into different categories: internal validity and external validity. Internal validity is the question of whether a conclusion incorporates the causal relationship

between two or more factors, while external validity is concerned with the question of whether the results of a study can be generalized beyond the specific research context.

As a result, this research is valid to be conducted according to the followings:

- The biggest hospitals have been taken to be a representative sample according to the bed size state. Therefore it is possible to generalise the findings of this study on the entire population and it can be said that external validity was met as well.
- An extensive literature review, organisation documents and the Jordanian experience of CL were discussed in detail to investigate all the surrounding ideas of the topic. So, content validity was met.
- The selection of measuring instrument and the use of multiple sources of evidences may give the exact meaning of construct validity for this type of research.

### **5.6 Populations and Sampling (Jordanian Hospitals)**

Before starting to do the field work it is necessary to recognize that the population and the sample of survey have a common comprehensive idea. There must be a representative sample in terms of culture, people and their interests, language and level of education.

### **5.6.1 Research Population**

The total population of Jordan is 5,350,000 capita. The country has 97 hospitals with a bed capacity of 9820 distributed in 12 main cities and directorates. Amman, the capital, has 48 hospital and 5384 beds; Irbid: 16 hospitals and 1526 beds; Zarqa: 8 hospitals and 898 beds; Balqa: 5 hospitals and 532 beds; Karak: 6 hospitals and 373 beds; Mafraq: 4 hospitals and 229 beds; Aqaba: 3 hospitals and 199 beds; Maan: 2 hospitals and 194 beds; Madaba: 3 hospitals and 159 beds; Jarash: 1 hospital and 135 beds; Ajlun: 1 hospital and 105 beds. The last city is Tafila with only 1 hospital and 86 beds (MOH Annual Report, 2004)

According to the previous figures, we can say that the health system in Jordan includes the following sectors:

A- The public sector includes (MOH) 29 hospitals and 3606 beds, (RMS) 10 hospitals and 1801 beds and Public University Hospitals with 2 hospitals and 988 beds

B-the private sector consists of 56 hospitals and 3569 hospitals (MOH Annual Report: 2004).

### **5.6.2 Sampling**

The rationale behind sampling should mirror the characteristics of the population a whole (Miller and Brewer, 2003). This requires three requirements: a clear definition of population; a complete listing of all elements of the population; all elements should be statistically independent. Thus, in a positivistic study, Hussey and Hussey (1997) have emphasized that a representative or good sample is one in which the results obtained for the sample can be taken to be true for the whole population. It is possible

to generalize from the results, which should be unbiased, and large enough to satisfy the needs of the investigation being undertaken. Four Jordanian hospitals, the sample of this study, were chosen (table 5.2) to be representative of academic, public and private hospitals according to bed status (1492/9820 =15% of the total population). JUH a hospital of 600 beds and KAH 388 beds, where PBH is 204 beds and JPH with 300 beds

These represented the biggest and most familiar hospitals in the Kingdom of Jordan where the international standards and criteria are adopted, and these hospitals are considered as decision makers regarding health care planning and strategy in Jordan consisting of the most familiar clinicians and professional surgeons in particular. Furthermore, these hospitals have very useful agenda and guidelines to be analysed such as annual reports as a series. Additionally, there are a great number of academics who are aware of clinical and managerial settings are working there. As a result, it is easy for the researcher to diagnose the real and current situation of health care management and CL as the main aim.

Moreover, teaching or academic hospitals were involved in this research because the respondents of these institutions hold a high level of both clinical and academic qualifications. That means that their contribution is valuable for this research in terms of both theory and practice. For example, the contribution of public hospitals may only represent the managerial and clinical approaches with only a little scientific and theoretical background being considered as the basics of academic research. Moreover, the private sector was selected in order to have some more diversity. Also,

private hospitals are considered to be the 'real' leaders of the health service sector in Jordan and neighbouring Arab countries.

Therefore, the researcher adopted the semi-structured interview was according to Appendix L shows that the number of respondents to 38, distributed between 4 hospitals, the majority of them from PBH (12 respondents and 31 %). This was because the researcher spent most of his time in that hospital, as he lived in the area. He also has strong relationships with some clinicians working there. JPH has the lowest participation (6, 16%). The highest number of doctors interviewed was from KAH (5 doctors), as the majority of them were interested in CL and some of them had attended many courses concerning health service management, which lead to them having more of an interest in research concerning the clinical environment.

Unfortunately, the researcher only met one doctor at JUH willing to be interviewed. This was because most of the doctors (who are also working professors and lecturers) were too busy as a result of the fact that the study coincided with an exam period. Five nurses took part in the interviews conducted at the PBH, which related to the level of concern of the nursing staff in this hospital. Four members of the AHPS were interviewed in the JUH as this hospital has many clinical departments including sub-sections that practice medical and surgical procedures. This is because this hospital is also an academic, teaching hospital that conducts a great deal of clinical research and possesses both, a large number of laboratories and working technicians. On the other hand, only one technician from JPH agreed to be interviewed. Most of the AHPS and clinical technicians in the private hospital refused to be interviewed due to managerial stresses being put on them regarding conducting this type of clinical research.

To summarise the strategy of this research, the introduction discusses the main research problem and the gaps as well as the main ideas of leadership in clinical setting and the Jordanian story towards this concept. The sociology of clinical professions has been discussed in an attempt to have leadership factors. These gaps and ideas have been linked together in order to get research questions

Research paradigm approach was discussed using qualitative approach with a semi-structured interview which suits this type of explanatory research. All managers who have high supervisory missions, such as general managers and heads of clinical departments in medicinal, nursing and AHPS departments were involved with an open-ended interview. The interviewees comprised 38 managers from 4 Jordanian hospitals; two of these were academic and teaching hospitals, the third was public, while the fourth was private. The whole sample consists of clinicians in these hospitals with supervisory responsibilities such as directors and assistant directors and heads of departments. General Managers and directors have been chosen as a separate category in an attempt to investigate their opinions as the primary decision makers in both clinical and managerial approaches. This study as qualitative approach is valid because the sample has been taken from the biggest hospitals to be a representative according to the bed size state. This means that findings could be easily generalized on the entire population. Also, external validity was met due to an extensive literature review and the Jordanian experience of CL was discussed in detail to investigate all the surrounding ideas of the topic. Furthermore using of multiple sources gives the exact meaning of construct validity for this type of research.

In this approach, the researcher links the Jordanian story to the fieldwork of study with the outcome of interviews' statements, in order to make comparisons between the concept of clinical leadership as a global approach and the specific Jordanian experience in its local setting. Jordanian MOH and the role of USAID in Jordanian health care as well as the role of academic and clinical colleges in Jordan with all related clinical associations were seriously considered. Thus, the literature meanings and implications and creating a mutual language were linked together which are useful in formulating research questions. Accordingly, figure 5.1 illustrates the role of each factor in hospital management and the importance of clinicians as successful leaders in delivering a highly advanced style of CL called transformational leadership as a dependent variable.

The sixth chapter shows the most important statements from those interviewees with the biggest frequencies that have been taken to get a deep discussion. Also their own words were organized according to the research factors and questions using grounded theory by classifying the data according to categories and subcategories. Accordingly, these categories and classified ideas will be developed into clear concepts and factors which have been discussed in the literature chapters and the research model revealing dependent and independent variables. Then the seven chapters will discuss these initial findings according to research questions and the indications of the Jordanian story in clinical leadership and providing health care. These indications and findings will be also discussed to differentiate between the real global literature and the local setting in Jordan towards clinical leadership in order to have academic contributions and research recommendations.



## **Chapter Six**

### **Qualitative Analysis**

#### **6.1 Introduction**

CL can be defined as: the performance and practice of leadership in the health sector and in hospitals by the clinicians themselves according to the interview questions in Appendix A. Accordingly, this chapter aims to achieve the research objectives: to identify the extent to which clinicians perform their role towards CL in Jordanian hospitals according to their clinical background; to explore the type of power and authority that clinicians have when practicing CL; to differentiate among clinicians in terms of leadership effectiveness; and to explore the obstacles of CL in Jordanian hospitals.

The main aim of this chapter is to reflect the opinions of doctors, nurses and AHPS on certain questions regarding CL in Jordanian hospitals. For example, in the methodology chapter, it was detected that the main idea of the qualitative method is to explore the findings from qualitative semi-structured interviews derived from the detailed comments of hospitals' managers with clinical responsibilities. This chapter will discuss the answers given to the eight questions of my research according to their job title and their clinical and managerial missions.

#### **6.2 Discussion of the Research Factors According to Interviewees' Own Words**

Appendix L shows that the number of respondents to the semi-structured interview was 38, distributed between 4 hospitals .This study will cover the definition of leadership or CL, the

types of authorities given to clinical leaders as well as the culture of the hospital environment, to create CL. In addition to this, the study will examine how clinicians work as a team to shape the preferable channels of communication. Clinical quality and clinical ethics that may contribute the style of leadership will also be discussed. Finally, the concept of Jordanian CL in hospitals, clinicians' attitudes towards practicing CL and the obstacles which CL may face in the future will be presented.

### **6.2.1 The Definition of Leadership**

Clinicians mentioned leadership, they tend to see doctors as managers and leaders; they have never thought that anyone else has the capability to lead medical institutions. Moreover, it seems impossible to them that anyone else such as AHPS can manage hospitals and clinical staff; in their view, only doctors have the ability to do this. This means that the concept of CL in Jordan is not yet commensurate with international managerial and clinical standards; leadership is sometimes defined as management; goal-management and methods of communication. Interviewees indicated that power was necessary for clinicians to be responsible leaders; they also believed that they could not make rational decisions without open channels of communication. They understand that the biggest barrier for them to achieve successfully was doctors, who are being granted the power all the time. Definition of leadership according to Jordanian clinicians is power and delegation to achieve hospital goals while nurses believe in decision making more than doctors.

There is a diversity of definitions of leadership focusing on the strong charisma of a leader who lead others within open channels of communication. Leaders are also required to believe in creating a suitable atmosphere by being concerned with team interests. They prefer to take a role analogous to a multi-skilled helper, who can persuade their team members, and build a

functioning and ongoing relationship between theory and practice. On the other hand, nurses and AHPS are more capable of managing their team than doctors, because they have clear communication channels as well as the flexibility of practical atmospheres among them.

Some managers discussed leadership in terms a strong personality with a high level of education level. They also mentioned the importance of a leader having behavioural characteristics as well as physical and psychological characteristics and a healthy emotional balance. For this reason, one of them stated that *"I have no managerial background but I can say that it is the strong personality of a leader and the experience of behaviour made your followers follow you easily"*. (Director of NSG Surgical Dept: King Abdullah Hospital). There is no doubt that knowledge and education refine those leaders in a magical way that leads other people to following them and accepting their pieces of advice.

Others see themselves who are able enhance and develop the levels of health service management by tackling centralization. Some managers believe that leadership seems power because once you have power then you can lead others, asking them to obey your orders and achieve the organization's goal. One of doctors interviewed stated that *"Leadership is the power of leaders starting from selecting highly-qualified team members, educational and technical"* (Assistant Director for Medical Affairs, King Abdullah Hospital).

Others believe that giving enough authority and delegating responsibility to followers is a mechanism which may develop conscientiousness and encourage people to participate in the hospital's goals to a greater degree. One of the AHPS members interviewed remarked that *"Leadership means concerning and organizing goals in a logic manner to be applicable and having initiative and creative thoughts totally different from previous ones"* (Director of

Pharmacy, King Abdullah Hospital). The clinician's rational decisions and knowledge have created an integrated and calm atmosphere in hospital management through achieving the goals easily and competently.

Some clinicians concentrated on the ability to create an atmosphere of teamwork. To emphasise this idea one of the clinical supervisors suggested that: "*Leadership means creating a suitable atmosphere, having spiritual and charismatic characteristics*". (Chief of Paediatric Department: King Abdullah Hospital). Hence, it's a leader's obligation to support his team members from in order to enrich the team's ideas.

It can be seen from the interviews carried out that many thought that leadership should be a partnership between leaders and subordinates. Many of them defined leadership as paying more attention to team members than themselves. One of the leaders interviewed emphasised that "*Leadership means creating more than control and serving others more than concerning of you as a leader*". (Director of Operation Theatre: King Abdullah Hospital).

Moreover, leadership is a science and an art at the same time. For example, in universities, the term 'leadership curriculum' describes a partnership between theory and practice. In this context, one clinical manager said that "*Leadership is a set of skills which need to be continued and trained more to enhance the concept of development which strongly depends on feedback and getting opinions from others*". (Assistant Director for Administrative Affairs: Princess Basma Hospital). Therefore, practical applications of management theory can only be understood fully once they are applied to the hospital itself, thus linking theory with practice.

Next, it is necessary to discuss the actual attributes required to make good clinical leaders, who will promote health care delivery. Thus, the first questions in this research are entitled: Which type of power do clinicians have in a typical Jordanian hospital? Is it positional or informational? These questions will be answered in detail.

### **6.2.2 Clinical Leaders**

The characteristics of CL and the power of clinical leaders have been discussed in detail in order to diagnose the meaning of leaders, and the related factors enhancing the effectiveness of CL in Jordanian hospitals. Most of them declared that experience and education, combined with delegation and friendship may come first. Many interviewees state that they believe that the real power should be given to team members themselves through consultation. Mostly, power is given to doctors according to their superior clinical expertise and positions as managers of the clinical sector. Doctors might possess much more clinical knowledge than nurses and AHPS might have; which makes doctors decision makers rather than others. It seems that the consultation in making decisions among the clinical team members comes from nurses AHPS rather than doctors. For example, nurses and AHPS understand each other very well indeed and they are the ones who clash with doctors when they don't agree with their decisions.

In this vein, one of the medical consultants stated that *"Generally speaking the power is strongly related to your mission and if you have more experience and education you will get it"* (Consultant Orthopaedic/ Jordan Hospital). It can be noted that making managerial decisions at hospitals is aided by a combination of qualities, including: knowledge, expertise, and academic qualifications.

Delegation and friendship are the familiar characteristics of most clinical leaders because the distribution of power will strongly deliver rational decisions, rather than being guided by an individual opinion. Thus, one of them argued that *"To be a leader or manager is not everything in leadership or management. Leaders cannot do all things on one hand; delegation is very necessary in management, so centralisation must be replaced by friendship, which leads to persuading subordinates if we are looking for leadership in its real meaning. There are many responsibilities which cause managers to be exhausted and busy but the matter is different for the leaders who already delegate to followers to deliver decisions"*. (General Director: Princess Basma Hospital).

Trust also ensures that decisions become the responsibility of all clinicians in the team, not only leaders. To strengthen this issue, one doctor said that *"The most important issue for the leader is to make clear decisions and be able at the same time to resolve problems "*. (Chief of Anaesthesia: Department, King Abdullah Hospital). Naturally, therapeutic works depend upon trust; not every single thing depends upon what is written only. Trust here means personal trust, trust in pieces of information, and trust in the practical aspect.

There should be less emphasis on the individuals .One nursing supervisor pointed out that power should be shared in between counselling and autocratic. For example, he stated that *" For me, I prefer to play the consultation type while dealing with my subordinates and sometimes you see that it's preferable for me as a leader to pass on my opinion because I have no alternative or I have no extra time for more discussion as a result my decision is being considered as autocratic, so I'm sorry for that but I have no option"*. (Director of NSG Surgical Dept: King Abdullah Hospital).

Therefore, team members are also required to be trained to become leaders by adopting consultation methods and tackling bureaucratic systems. In this context, one AHPS in Jordan Private Hospital stated that *"Authority cannot be derived from fears and threatening, I prefer to have a power how to love my subordinates and enter their hearts. I would hate to be a policeman, but prefer to practice consultations rather than routine and bureaucratic managerial issues"*. (Supervisor of Endoscopies Dept: Jordan Private Hospital). This does not mean that bureaucratization does not exist in the consultative aspect. For example, consultation does not depend solely upon the personal understanding but on the followed rules and basics, which are based on the hospital's management and philosophy.

Leadership indicates that if you want to be a leader, you should be a facilitator of objectives according to the opinion of one consultant surgeon who argued that *"I'm a leader of surgeons and they are professionals. I have no direct authority over them but try to be facilitator of objectives "*. (Director of Surgery Department: King Abdullah Hospital). This does not mean that doctors, though they do have a great deal of power, are better than their co-workers, such as AHPS or nurses.

All types of authority are preferable for some clinical leaders who believe that shared decisions should be protected from faults and errors. Unfortunately, discrimination between top and a lower professional level is one of the obstacles to CL, as one nursing director said: *"CL and government are alike; we have to have all types of authorities to deal with different situations. For example, if you need to chat with people at the lower level your behaviour will be different from when you do the same thing with your friends and colleagues from the same level of position or job title. "* (Deputy Director of Nursing: Jordan Hospital). The reason why clinicians have difficulty in dealing with each other can be tracked down to the differences in

positions and ranks. This is regrettably derived from organizational cultures that do not encompass the team spirit, although all clinical levels are different, they are all interrelated. For instance, doctors cannot dispense with nurses whose job titles are definitely less than doctors

Accordingly, what is the type of clinical culture? Which should be available to help clinical leaders? The indication of the second question in this research is revealed: What is the main culture that clinical leaders in Jordanian hospitals need to implement?

### **6.2.3 Clinical Culture**

Culture is very important hospitals because and considered as an umbrella term for everything related to both clinical and managerial approaches describing general norms, quality and attitudes within the team. In other words, clinicians consider this concept to be the main link between external and internal environments. 'Clinical culture also describes how laws and regulations in the hospital environment, in an attempt to facilitate understanding of the main philosophies of health care services. It is not true that the hospital does not need the external world; its rules, values, ethics, thoughts and customs.

It would be easy for clinical leaders to say that the aim of culture is to put themselves in the patient's situation, as one of the interviewees said: "*Put yourself in the patient's situation and use the knowledge to become powerful one day*". (Deputy Director of nursing in JPH). This means that clinical team members should respect each other and, cooperative behaviour should form the basis of their relationship. In this sense, culture may mean learning how to



deal with different situations leading to good decision making depends knowledge, traditions, customs and science.

It is now the case that many leaders try to respect their teams as they believe that this makes them feel wanted and thus increases levels of productiveness; as one clinician stated: *"The culture I always try to apply to my nursing team is sharing their interest and solving problems together, even their own concerns. I always try to enable them to feel that Sister Buthaina, their nursing supervisor, is their eldest sister not only manager"*. (Director of NSG Surgical Dept: King Abdullah Hospital). Moreover, hospitals pay attention to their employees' needs, personal problems, and demands, in order to create the kind of harmony needed to leave behind any dispute or disagreement related to job titles or ranks.

Culture also means that rights and justice have increasingly become a high priority. Many clinical managers believe that some changes need to be made in a gradual fashion to improve the health, as one of medical consultant emphasized: *"Rights and justice should be our priorities to practice our clinical profession as well as ethics, otherwise all measurable behaviour will be infected"*. (Consultant Orthopedic: Jordan Hospital). Hospitals' culture is not restricted to regulations and rules only, but it pays attention to ethics.

The hospital culture is in a healthier condition in Europe due to the general belief in change as a useful means for positive development and progress. A former graduate of the European system commented that: *"The smooth culture concept is easier in European countries than in Jordan as here we need a long time to persuade others of change"*. (Director of Surgery: Department, King Abdullah Hospital). It is highly important to give ourselves the chance of merging with other cultures in the world; we should avoid living and thinking in isolation, as this openness might lead our hospitals to become more civilized.

The absence of teamwork sense might be considered as the main obstacle in achieving an effective work culture in Jordanian hospitals. The present situation is exemplified in the comments of one quality co-ordinator, who commented that: *"I'm struggling to tell other clinical staff as quality co-ordinator, that you should always work with others from all specialities to develop the job and quality but here, it may impossible, as we have no teamwork in a real concept. For example when I send notification for a certain department I will receive much feedback from them as individuals not a group"*. (Quality Co-ordinator, University of Jordan Hospital). It could be said that teamwork is the most important concept in clinical culture, as it would be impossible for a clinical team to work effectively separately.

While the concept of teamwork is yet to be fully embraced by staff working in Jordanian hospital, many believe that diversity may also enhance the knowledge and experience. To emphasize this issue one clinical supervisor said that *"As a clinical team it's preferable to have diversity of cultures to gain new culture, different language and new traditions and norms in which give clinical job a nice taste"*. (Head of Anesthesia Department: King Abdullah Hospital).

So, the question now is: Which type of team member most closely matches the needs of the clinical culture and will be able to become an effective clinical leader in the future? The third question in this research discusses the role of the clinical team in CL: Which type of clinical team do we need to strengthen CL in Jordanian hospitals?

#### **6.2.4 Clinical Team**

Clinicians consider their specialty as an integral part of their identity enables them to enhance the health service for the better. The clinical staff members' culture, academic qualifications, their various experiences along with their thinking philosophy are considered as a whole.

Hence, universities, academic, cultural and intellectual associations, syndicates, academic qualifications and years of experience are the main engine that runs the clinical team.

An alert personality is the most important character for clinical team who believes that long experience is not everything in hospitals, but a general awareness of everything, such as law and instruction, rights and duties, is very useful for clinical teams. In this context, one nursing supervisor said that "*Clinical teams have to be creative and have a non-routine style so an alert personality is the most important character. For me, I cannot do all things alone; I strongly need their education and experience to make a decision*". (Deputy Director of Nursing, Jordan Hospital). From this place we figure out that knowledge exchange and workshops are almost vital in updating the medical field.

Furthermore, teamwork means accepting criticism to assure that anybody, whether team members or group leaders, is subjected to discussion. Also, criticism within the health care sector is needed in order to identify the best behaviour and managerial intervention. For example, one of the clinical leaders said that "*You cannot work with a team who doesn't accept criticism because anybody who refuses to be criticised has to be excluded from the team structure*". (Director of NSG Surgical Dept: King Abdullah Hospital). Development is not possible without diagnosing the mistakes and misunderstandings that arise among the team members, and benefit from the previous experiences, whether they were positive or negative.

Diversity and specialisation are necessary for a hospital to work, according to one medical consultant who says that "*Clinical qualifications and experience as well are very important when making right decision as our medical diagnosis strongly needs both*". (Chief of Emergency Dept, Consultant Medicine: Jordan University Hospital). Moreover, team

members in the clinical sector and hospital environment will be responsible leaders with charisma and have authority and confidence together to achieve hospital goals." *As a clinical leader you always require a qualified team but there is something more necessary than this, it's to support them and give them more authority and power to be productive because you need somebody who comes after you in case you are leaving one day".* (Assistant Director for Medical Affairs: King Abdullah Hospital).

The next section will emphasise that clinicians will need specific types of communication to pass their clinical opinions and decisions in both formal and informal styles, in order to achieve hospital goals. Accordingly, the fourth question is: Which type of clinical communication do we have among clinicians in Jordanian hospitals? Is it strong or poor, formal or informal?

### **6.2.5 Clinical Communication**

Managers believe that communication allows for the exchanging of information between departments and the tackling of unnecessary bureaucracy. Communications in hospitals or in medical sectors in general differ from communications in other sectors like banks, establishments and factories. Actually, there is a kind of harmony between clinical communication, emergency and working within the same team.

Sometimes, informal communication does not suit clinical communication if we need to match standardisation and clinical criteria, as there is not enough time for friendship and socialisation to develop in the clinical environment. Doctors have no conflict with others in communication while both nurses and AHPS still have some conflict. Regarding general managers, it seems that they adopted one type of communication to match their hospital goals.

The formal communication will remove the meaning of the clinical task." *Sometimes, I like to practice formal relationships with others as friendship does not always suits our clinical situation and your power will be necessary to let your decision be effective*". (Director of Radiology: King Abdullah Hospital). Formal communication is normally connected with the managerial, governmental and official concepts which prove that bureaucracy sometimes reinforces the medical information transmission .On the other hand, personal relationships do not contradict with formal communications; it facilitates it and turns it into informal communication.

There were many obstacles in gaining information from different hierarchical levels due to bureaucracy. In this context, a clinical doctor said that *"I prefer the written communication and documents to protect myself because nothing can be missed in oral ones. The norms of clinical aspect are to have written and documented communication that may have many obstacles. For example if you need to pass letters and documents to be reviewed by top management that will require a long period and this is the main factor to cause the communication system in hospital to be non effective"*. (Chief of Emergency Dept: Consultant Medicine, Jordan University Hospital). It has been concluded that the clinical communication between different departments is slow. This reinforces that formal communication needs specific policies and procedures to be more effective in delivering information.

It can be seen that, in the health service, friendship and informal styles are the most popular approaches among clinicians because decisions cannot be made with closed and difficult communication. To emphasise these basics of communication, one general director said that *"As a general director I prefer to have direct communication with all employees in this hospital to enable me to diagnose the real situation .For example, it is my desire to spend hours in emergency and admission units to be informed what is going up in reality"*(General

Director, Princess Basma Hospital). This assistant shared his opinion emphasising that *"The information exchange is very important; without this issue we cannot make clinical decisions in such closed and tough communication"*. (Assistant Director of Administrative Affairs: Princess Basma Hospital). Formal communications in Jordanian hospitals are highly essential, as for instance official documents, correspondences, and reports help in increasing the speed of decision making among the same team members.

The problem for hospitals could be embodied in communication because weak relationships with other clinical departments are identified as a possible problem. For example, one clinical director said that *"The descending communication from the top levels cannot be controlled while communication with the team members from the same level or bilateral is always better"*. (Director of Operation Theatre: King Abdullah Hospital). It is noticeable that the clinical communication is considered to be normally bilateral if we are concerned about coordinating the different clinical management in order to put the formal and informal communications together.

It seems that both verbal and written communication is useful for hospitals as being case specific as to which type is preferable, according to a medical consultant's opinion: *"Any type of communication will be good if you match your goals as a clinical leader"*. (Consultant Orthopaedic: Jordan Hospital). The clinical team members are sometimes characterized with flexibility, as they tend to get rid of any dispute in opinions with their co-workers.

Doctors still consider themselves the only decision makers and nobody can disagree once the physician has adopted an opinion. They ignore any comments derived from other clinicians

who are not doctors. To confirm these obstacles a good proportion of leaders made comments such as the following: *"mostly the decision is for managers and meetings are only held for routine purposes. Unfortunately, our style here is still weak because we have got conflicts between doctors and other clinicians and there is a clear gap of misunderstanding"*. (Supervisor of Medical Nursing: Jordan University Hospital). Doctors at Jordanian hospitals tend to prefer official speeches with nurses and AHPS so they can impose their power over them, while others prefer the informal communication. Again, doctors are the main obstacles preventing smooth communication. In this approach one of the AHPS has stated that *"Unfortunately, doctors always put obstacles in communication channels and they always reply to others from different clinical areas in a superficial rhythm "*. (Director of Nutrition: Princess Basma Hospital).

Thus, how can we consider that health service management and CL can be described as distinctive in quality and what factors help clinical settings to be like this? Furthermore, the first part of the fifth question in this research may discuss the nature of clinical quality towards CL: Do both clinical quality and ethics reflect the strength of CL in Jordanian hospitals?

### **6.2.6 Clinical Quality**

Comprehensiveness was the main target of interviewees, not only as far as clinical issues were concerned but in terms of also managerial and human resources. Jordanian hospitals management work hard to connect all the related management affairs together, in addition to technical affairs. Hospitals' managements believe that all staff works must meet the international standards of quality, because it's the responsibility of all levels of the hospital hierarchy and bureaucracy. Hospitals have a comprehensive programme of quality which means accreditation or successfully matching management orders according to international

standards. High Quality service is attained from individual's behaviour first, then from equipments quality; it cannot be achieved if there is no creativity and ingenuity in management style or there is no technical, social, managerial, psychological and personal advancement in the clinical team.

Clinical managers believed that quality came as a result of international demands for accreditation *"We have got quality only for the accreditation programme and just to match the top-level satisfaction"*. (Director of NSG Surgical Dept: King Abdullah Hospital). Quality is behaviour rather than a practical appliance aims to obtaining certificates and letters of accreditations.

However, quality means productivity and stability of management; if those at the top levels are obliged to apply quality themselves, then those on the lower levels will do so. For example, one clinical supervisor stated that: *"Quality alone is not enough but must be combined with integrity and culture that may lead to hospital success. There are specialising committees in quality as we are looking forward to get accreditation and doing according to international standards"*. (Director of Surgery Department: King Abdullah Hospital).

Bureaucratic orders weaken clinical quality; it would be more beneficial to involve all staff in decision making. In this vein, one clinical supervisor said that *"There is a huge gap between us and Europe, for example, let me say that quality is the mode of centralisation here and there is a conflict between bureaucratic centralisation and quality, so top managers share their thoughts with the lower levels!"* (Chief of Anesthesia Department: King Abdullah Hospital). It seems that there is a difference in western cultures when we talk about quality management; quality in the west is considered a system that follows a certain policy and a definite philosophy.



In order to improve overall quality levels, financial support is strongly required. For example, one of the participants in the survey said that if you need something good and useful you have to pay more: *"I'm the quality coordinator in this hospital; quality requires huge financial resources and we do not have enough money "*. (Quality Coordinator, University of Jordan Hospital).

There are many obstacles to achieving quality within the health care industry, such as budgetary issues and legislation. In a similar fashion one clinical manager commented that: *"According to my own point of view, we didn't start. As an academic hospital we are suffering from legislation and instructions being considered as obstacles to achieve quality "*. (Director of Nursing, University of Jordan Hospital).

Guidelines and criteria of leaders' behaviour should be measured carefully to create a calm atmosphere for CL. Ethics are those guidelines which are discussed in detail according to second part of the fifth question in this research: Do both clinical quality and ethics reflect the strength of CL in Jordanian hospitals?

### **6.2.7 Clinical Ethics**

Ethics also refers to the laws and regulations and, clinicians stated that it should be considered as the guidelines of clinical issues in Jordanian hospitals. Ethics is the standard that measures the employee's behaviours in hospitals; it is the true reference that connects individuals with the medical institutions such as hospitals. It is extremely hard to separate the technical part from the managerial, social, behavioural, clinical side. There is an obvious relation between leadership at hospitals, as employees normally tend to ask themselves some of these questions when they interact or deal with others; is this a moral deed or an immoral one?, Does it please our greatest God? Does it comply with religion, customs and traditions? The relationship

between leaders and followers is not governed by written material but by the ethics learned in childhood.

There is no place in the health service industry for discrimination in terms of ethnicity, language, religion or colour. Health work should be built on an ethical framework that seeks to respect others, whether clinicians or patients; as one of the AHPS participants pointed out: *“We have to respect others' norms and traditions as we have different cultures and need to respect them?”*. (Supervisor of Endoscopies Dept: Jordan Hospital). Hence, the respect of medical laws and hospitals' regulations might not come from a written agenda but from the kind of relationships between workers.

Unfortunately there is very little academic interest in teaching ethics in educational and academic institutions. *“Unfortunately some corruption has happened recently in the medical profession as a result of strange behaviour so medical ethics have to be taught in universities as compulsory modules”*. (Consultant Orthopaedic: Jordan Hospital). Ethics in modern technology era has to have an academic reference, because sciences organize any case affairs rather being uncontrollable. It is important to set modules to be reached to workers in the medical field.

The exchange of advice and consultation among clinicians is important in creating a successful workplace. For example, the director of surgery revealed that there is a great deal of cooperation in their daily behaviour in theatre, stating that *“Honesty is the most important ingredient of clinical ethics and this term should be enhanced by cooperative efforts between clinical staff and management”*. (Director of Surgery Department: King Abdullah Hospital). One of the most important clauses of ethics at Jordanian hospitals is cooperation between medical services providers, thus to activate the concept of clinical teamwork and break barriers and job titles differences among them.

Ethical committees need to be established in order to eliminate discrimination among hospital staff. In this context one of the doctors said that *"Sorry to say that there is no criterion to judge or measure ethics as it's coming from our traditions as well as religions"*. (Supervisor of Medical Nursing: Jordan University Hospital).

Ethics was judged as an important standard by which to measure the success of the clinical mission. One of the interviewee's stated that: *"Clinical ethics always reflects the community culture. Here most clinicians apply clinical ethics to law and legislations' considerations not because they like to do so"* (Head of Paediatric Department, King Abdullah Hospital). It is the responsibility of hospitals and the health sector in general to construct committees and specialised groups who can work to provide solutions for problems. As one of the assistant directors at King Abdullah Hospital commented: *"Our hospital has established something called an ethical committee consisting of law consultants and professionals "* (Assistant Director of Medical Affairs, King Abdullah Hospital).

### **6.2.8 Doctors, Nurses and AHPS to be Leaders**

Doctors, nurses and AHPS, declared that clinical management has to be a partnership amongst them, as no group of staff knows the demands of management any better than another unless they possess academic qualifications related to business. The next section of this chapter will explore and attempt to try to differentiate among clinical leaders (such as doctors, nurses and allied health professionals).

### 6.2.8.1: Doctors as Leaders

In Jordanian hospitals, doctors are sometimes resistant to the role of manager, believing that their main mission should be directed towards clinical and therapeutic issues. Many of them declared that they have some conflicts with managers in hospitals because these managers have no clinical background. That's why they are considering themselves the best candidates to seize managerial posts, this in addition to their therapeutic tasks. The sixth question of this research has been directed to doctors in order to gain their opinions towards CL.

It seems hard for doctors to see nurses and AHPS as managers at Jordanian hospitals. The most useful opinions have been derived from doctors in four different Jordanian hospitals, suggesting that Jordanian hospitals need scientists but not managers. If the hospital has no alternatives, they have to support and train them with administrative and academic courses.

Doctors are not prepared to be managers or leaders. They are only prepared to serve their clinical areas, such as those of surgery and pathology because management sciences are not included in their university. That is why academic institutions, in cooperation with clinical ones, are becoming aware of the need to establish new specialisations for doctors and clinicians, called health service management. If doctors start working as managers there is a distinct possibility that they will overstretch themselves and that this will have a negative effect; as one medical doctor noted: *"Management as a science has its requirements and conditions. Here, we need the scientific doctor but not the manager doctor. So, management is for others not for doctors, because we need doctors in medicine and theatres more than managerial offices and strategic positions"*. (Orthopaedic Consultant: Jordan Hospital). The idea that doctors lead hospitals seems extremely complicated; doctors declare that it seems hard for them to be familiarized with financial and managerial issues. If doctors are to practice management it is useful if they have got managerial qualifications as one participant

suggests: *"Doctors have to be educationally qualified to lead hospitals. They have to hold business or health service management qualifications "*. (General Director/Princess Basma Hospital). Courses that are useful in this capacity include those that cover issues such as management, budget planning, organisational behaviour, finance, health strategy and other matters related to health service management.

*" It's good for doctors to be managers but they have to be qualified in management at the same time because management is a real art which can be involved in medical curriculum to ease the managerial mission for them"*. (Assistant Director of Administrative Affairs: Princess Basma Hospital). Making medical services management one of the prerequisites of obtaining medicine degree at universities might reinforces the doctors' ability of being managers, but on the other hand, management courses are not enough unless these doctors study MBA or PhD in Management.

However, this issue can cause trouble for doctors and hospitals due to the fact that doctors involved with management may be able to devote less time to medical practice; as one of the doctors commented: *"There are no successful alternatives for doctors to be clinical managers or general directors for the mean time as they are the most knowledgeable. But the question is, is it worth investing doctors in management and asking them to forget their science of medicine to practice management?"* (Head of Paediatric Department: King Abdullah Hospital). It is hard for doctors to forget their responsibilities as doctors and attend management.

Diversity in terms of management is being practiced in several hospitals to match followers' needs and interests. There is currently a degree of conflict between clinicians, especially doctors and that in top management; as one of the medical doctors emphasised: *"For example,*

*in the UK there is cooperation between doctors and management and working together to success the hospital management but here we still have conflicts among them due to semi closed channels".* (Director of Surgery Department: King Abdullah Hospital). It seems that there is in Jordan a complicated agreement formula between doctors and management that is because doctors refuse to take orders from them, on the other hand, distractive or regular managers do not trust doctors' management at all.

### **6.2.8.2 Nurses as Leaders**

Nursing reality in Jordanian hospitals is extremely gloomy because doctors are always reflecting superiority. This is the tragic outcome of the general policy that the managers, who are primarily doctors, adopt in the medical field. In spite of the rich knowledge the nurses have, not only in Jordan, but all over the world, nurses suffer from not having enough authority. This section will attempt to answer the seventh question in this research which is concerned with the role of nurses towards CL in Jordanian hospitals

Most nursing leaders from top management were fully agreed that nurses constitute the majority of the clinical body. Furthermore, they are qualified enough to take on this increased authority, often having the support of nursing institutions and possessing university qualifications starting from bachelors to PhDs in nursing management and leadership. Nurses have the biggest department in hospitals, operating on different levels with different specialisations and specialities.

Many of the nurses interviewed said that they did not have enough awareness of their rights and duties: *"Unfortunately the administration module for nursing is being taught in the wrong way for them as they do not have enough awareness of their rights and duties".* (Deputy

Director of Nursing, Jordan Hospital). In fact, there is no doubt in that nurses know their rights and duties, but the hospitals' common culture made them feel oppressed.

However, they are the real and trusted eyes for top management in designing effective strategies for the hospital to be successful in the future; as one supervisor stated: *"We are the real coordinators between patients and top management as we are the majority of clinical staff. So nurses will be good managers; for example, nursing institutions are giving high managerial qualifications, such as master, and PhD programmes. Nurses have a good and comprehensive clinical vision and the thing is different for doctors who are focusing only on physical issues"*. (Supervisor of Medical Nursing: Jordan University Hospital). Nursing involvement in management is not new, and it is important that they gain in this area in the immediate future: *"Nurses are the best talkers should be involved in strategy as we do have steps in nursing management or professional hierarchy starting from the lower level then middle and top nursing management "*. (Assistant Nursing Director: King Abdullah Hospital). Nurses have proved to be knowledgeable, well-informed, hard-workers, and experts in their field. The knowledge and sciences the nurses have learned at their universities have not enabled them of being powerful, but made them hard workers and good employees.

Increasingly, nurses reported that they have much more awareness of the public demands of the health sector and Jordanian hospital care delivery in general. To confirm this issue, one nurse said that: *"Nurses have more awareness and publicity than other clinicians"* (Director of Operation Theatre, King Abdullah Hospital). The social role that the nurses play is far more important than the doctors' and clinicians'. Nurses are more closed to patients than anyone else; they are aware of their fears, worries and suspicions and they know well their patients' medical facts.

Now the question is: Are doctors and nurses the only people able to practice CL, can nobody else share the clinical management and responsibility, or can others from AHPS do so with the same effectiveness and accuracy?

### **6.2.8.3 AHPS as Leaders**

AHPS revealed that they are the source of diagnosing tests and clinical evaluation. Their limited representatives in top management are an impediment to them becoming decision makers in health care. The eighth question in this research is entitled: What is the role of AHPS to perform CL in Jordanian hospitals?

One of the AHPS interviewed suggested that: *“All clinical positions and AHPS should be given managerial roles in strategic representation as doctors”*. (Supervisor of Endoscopies Dept: Jordan Hospital).

It was felt that although a greater level of balance between AHPS and doctors should be created. This would be difficult because doctors were likely to feel superior to those in AHPS. It does not help that doctors are in charge of management strategy: *“Unfortunately, doctors are always managers and this is our culture. I believe that there is something to be called medical manager and administrative manager doing together to create something like balance. For example if we have only doctors in management that will cause bias for doctors and may digest others”*. (Pharmacy Director: King Abdullah Hospital).

It is important to consider whether doctors can manage their professional issues alone without AHPS. As one radiography specialist noted: *“Management should be mutual among all clinicians to enable all to feel responsible. Unfortunately doctors themselves see that it's*



*impossible or difficult to receive orders from the bodies from non medical staff*". (Director of Radiology: King Abdullah Hospital). It seems that Jordanian hospitals need representatives from all their departments in top management: " *Thoughts have to be received from AHPS not only doctors they have to be voices in top management (Director of Nutrition/ Princess Basma Hospital)*. AHPS are experts that cannot be dispensed when it comes to many medical solutions. In fact, the ideas of quality control, ethics practicing comes out from here and this in order to reform the works of clinical managements

AHPS do not want all the power in hospitals but neither do they want doctors to retain it all. This matter, managerially and clinically speaking, is highly complex. Authority distribution among clinicians embarrasses managers and decision makers who are responsible for medical services development. Development here means technical, managerial, social, cultural and medical one in Jordanian hospitals.

The next section of this chapter will discuss the meaning of CL according to clinician's views as separate positions, doctors, nurses and AHPS, because each position can see CL in terms of the nature of clinical responsibilities and different duties as well as managerial demands upon each post

### **6.3 Comparisons among Clinicians in Jordanian Hospitals towards the Research Findings**

Those in AHPS believed in achieving goals and strategies and vision more than others, particularly doctors who had the least interest in these issues. At the same time, doctors were decision makers and responsible for implementing hospital strategy to a much greater extent

than nurses or AHPS. There was good participation from AHPS in delegation and tackling centralization. AHPS also thought linking cultural and clinical concepts was important to CL. Unfortunately, nurses showed the lowest response towards working with the concept of autonomy and applying rights and justice

Nurses have a higher level of interest in cultural diversity than others. This may be because the nature of their work demands being open to all clinicians and different clinical departments. However, AHPS demonstrated that they believed in qualification diversity, working ethically and faithfully, and respecting laws, regulations and legislations more than others. AHPS also emphasized that they are the clinicians who pay the most attention to accuracy. Nurses also share their interest by respecting diversity and addressing the importance of non-routine style, possessing alert personalities and high levels of creativity. Regarding communication, AHPS preferred formal and informal communication to be implemented at the same time, where doctors adopted flexible communication to match goals and gain information. Unfortunately; nurses have the most conflicts among different levels of hierarchical positions.

Quality was discussed seriously by AHPS who declared that quality, as a comprehensive management system. They believed that quality should be involved in hospital policy and strategy, where doctors are the main obstacle to clinical quality because they believe in bureaucracy. In the ethical approach, doctors declared that ethics should be taught in the university curriculum; they were the clinicians most focused on honesty. AHPS are the clinicians who have the strongest natural belief in the importance of ethics. Finally, nurses took ethics as their first priority in combining justice with their colleagues' interests.

In spite of the clinical and administrative qualifications of many hospital employees, CL may face obstacles in its efforts to increase the practice of health service management in a suitable manner in the future. The next section discusses what some of these obstacles may be in an attempt to reveal the reasons behind the potential success or failure of CL.

#### **6.4 Obstacles in Implementing CL in Jordanian Hospitals**

It is difficult for CL to be practiced smoothly due to the centralization of the head management or MOH policy. In addition to this most clinical leader, either doctors or other supervising clinicians see that the power of hospitals is considered as the main obstacle. So, if doctors consider themselves successful leaders, then why do other clinicians consider them an obstacle in the way of management?

Nursing staff are often frustrated by an old, outdated culture of clinical management led by doctors; as one nursing manager stated: *"Nurses are frustrated because power is only given to doctors and they feel that they are still followers and it's so difficult to be a leader one day"*. (Deputy Director of Nursing: Jordan Hospital). AHPS also complained that they only got to practice ordinary managerial positions rather than the strategic missions that doctors were involved in: *"Culture is the main obstacles in our hospital, as we still believe that doctors have to be managers"*. (Pharmacy Director: King Abdullah Hospital).

In many cases, communication, which is the most important factor in strengthening the relationships among clinicians in both personal and professional issues, is getting worse due to centralization and the rigidness of the written method: *"There are no severe obstacles but honestly communication needs to be developed and I know it has been needed for a long*

*time*". (Director of NSG Surgical Dept: King Abdullah Hospital). Lack of effective communication prevents the hospital from functioning in a truly modern way as there is little opportunity to discuss ways forward.

In the case of private hospitals, doctors are often the owners of these hospitals and so supervise the whole strategy. All managerial decisions are theirs and those in AHPS are considered subordinate: *"Mostly, the directors of private hospitals are the owners and it's difficult to manage hospitals far from government policy and there is no specific policy for these hospitals to create more development in their strategies and vision"* (Consultant Orthopaedic, Jordan Hospital).

In some cases doctors seem to be resistant to involving others in management processes. Sometimes, those on the middle level of hospital hierarchies, such as front line managers, are discouraged from sharing in the hospital's vision due to the fact that their clinical and academic qualifications are not equivalent to those of doctors. According to one nurse: *"Clinical community is so complicated, and there is no chance for clinicians to be good leaders, because they will face many challenges preventing them to practice this behaviour, even they believe in that style"*. (Assistant Nursing Director: King Abdullah Hospital). It seems that a person who has a scientific qualification in health management receives orders from higher entities like doctors who are specialized in one stream only which is medicine, not health management; this fact is a crucial barrier.

Hospital boards do not match the demands of all clinicians in hospital strategies, because managerial stability is often absent. The usual distribution of board members in Jordanian hospitals is unfair; involving only doctors and a very limited number of AHPS. There is also

very little cohesiveness when it comes to management. It is often the case that every new manager or director will ignore decisions taken by previous management: "*Decision makers are working in a theoretical image and they have no real practice in the field, and we have no recreation in the right concept to get rid from our continuous stress*". (Director of Operation Theatre: King Abdullah Hospital). Management is often too unstable; one manager noted: "*We have no stability in management, so every new manager is always coming with his own thoughts*". (Director of Radiology: King Abdullah Hospital). Managing Jordanian hospitals haphazardly can be attributed to a lack of coordination among different departments whose clinicians hold quite variable expertise.

It is still ambiguous as to what makes an effective workplace culture in Jordanian hospitals; the need to create new norms which may break down the barriers between hospitals and communities is untested. One clinical doctor commented that "*There are no clear criteria or protocols to measure the effectiveness of our job*". (Chief of Emergency Dept, Consultant of Medicine, Jordan University Hospital). Most of the managerial and some clinical decisions are being carried out according to the beliefs of managers and supervisors, rather than attempting to match international standards. This system is open to favouritism and corruption, which is likely to have a negative effect on hospital administration.

Unfortunately, MOH may grant their colleagues sensitive reflect negatively clinicians. In his discussion of this issue, one of the Chief of the clinical committees said that "*We have two types of managers to be supported and empowered from the top management in the ministry of health and the second type is non- supported who have very limited resources and simple power as well*" (Chief of Medical Committees). In addition, favouritism (intermediary) in

assigning employees is as dangerous as favouritism in promotion and upgrading or in giving authority to those who do not deserve it.

Centralization is one of the main obstacles that prevents most clinical and health service plans from going forward. *“Centralisation is one of our main obstacles so most decision makers have no enough idea about what is going in the real clinical environment”* (Assistant Director of Administrative Affairs, Princess Basma Hospital). As long as there is favouritism and failures in communication, centralism shall remain an obstacle to progress.

Autocratic managers are seen as strong and effective in controlling and influencing others; as one of the clinicians suggested: *“Sorry to say that people here consider that democratic leaders are weak while autocratic leaders are strong and respected. For example, we appreciate managers who punish and some managers like this style”*. (Quality Co-ordinator, University of Jordan Hospital). It is not permitted that a single individual be both the “governor and the executioner” when applying managerial concepts.

## **6.5 Summary**

It seems that CL in Jordanian hospitals didn't make progress to the required level as stated in the interviews conducted by clinicians. It is also clear that leadership significances have not replicated the literature clearly. Hence, clinicians don't actually apply the concepts of international leadership such as transformational and collaborative and some several theories, and that doctors in Jordanian hospitals have captured the lion's share of leadership and powers, but they are not sufficiently aware of the goals of hospitals. Accordingly, we found that centralism and bureaucracy are the most common problems. Clinicians believe in managers to enhance the informal concepts and open channels communication between

hospitals and their local communities. Therefore, clinical teamwork benefited from high levels of experience and knowledge regarding both clinical and administrative settings. We clearly notice the effort made by universities, professional-clinical unions, and international organization concerned of training those mentioned on the basis of leadership and management.

However, quality is not subject to the internal standardization in hospitals, as they don't set any clear written agendas, guidelines or ethical codes. Once again, doctors are considered to be the "real" leaders in Jordanian hospitals in accordance to the classical culture followed by MOH .On the other hand, nurses and AHPS are ruled by doctors who have complete powers, which led to widen the gaps between doctors and their colleagues.

It is noticeable that nurses and AHPS have high levels of experience, full knowledge and academic preparation, but they are specifically excluded from getting distinguished career prepared them to clinical decision-making related to Jordanian hospitals' strategy and plans. On the other hand, AHPs are the more clinicians in compliance with the concepts of quality and ethics that lead to advance and develop the medical services, but they don't hold senior administrative positions. Furthermore, MOH did not make great efforts to remove all CL obstacles in Jordanian hospitals.

## **Chapter Seven**

### **Discussion and Analysis**

#### **7.1 Introduction**

Many issues will be explored such as CL behaviour and international standards concerning ethics, quality, communication, and culture have come to determine the way in which clinicians serve their hospitals. This change has placed a greater emphasis on encouraging team work and by exploring the differences between theoretical aspects in literature and the real practice of CL in Jordanian health care. This chapter will also cover all of the objectives of the study and answer different questions discussed in the introduction and methodology chapters, detailing all of the informational data derived from the qualitative interviews.

This chapter contains fifteen sections. Sections 7.2 to 7.11 describe the characteristics of existing factors and important issues which contribute to shaping CL. Section 7.12 has been designed to compare CL among clinicians in performing CL. Obstacles to the future development of CL are discussed in detail in Section 7.13. Section 7.14 discusses the research questions and goals and, finally, Section 7.15 is a summary, explaining some of the implications of this chapter

#### **7.2 Discussion of CL as a Concept**

CL is an international concept that is adopted in many civilized countries. It consists of important factors such as; open communication, ethical considerations, and team work spirit and charismatic leaders. In fact, the Jordanian reality in hospitals is different, this because clinicians'



cultures differ so much when applying the leadership principles. The codes of ethics and quality for example are adopted in our customs and traditions, but they are not written as principles and rules, in order to refer to them when necessary. There is a gap between the literature indications in chapter two and three that Gaughan (2001) determined that the development of leadership skills in the health care industry is derived from the interaction between the leader and his followers within transformational leadership theories. Furthermore, Utley et al (2011) discussed transformational leadership by revealing the meanings of individualized consideration and intellectual stimulation as well as inspirational motivation doing best for quality work performance. While idealized influence is acting to demonstrate desirable behaviours. Also Hernandez et al (2011) emphasised that ethics and values are grouping in ethical and spiritual as well as authentic, these elements are shaping transformational leadership. In this sense, Sydow et al (2011) and Brazier (2005) stated that knowledgeable agents and technical expertise for subordinates is a power to lead. Also, positional power seems necessary according to Dierendonck (2002) and Thacker (1997) to develop and exchange relationships with different subordinates. That means the leadership factors in Jordanian hospitals has some lack of power and ethical considerations, but has some team characteristics such as knowledge and technical experience. In other words, the factors of leadership in Jordanian hospitals are insufficient to shape this concept.

Doctors consider themselves the superior managers, who are normally busy with technical issues that are concerned with medical affairs. However, they are responsible for managerial aspects because they are on the top of the hierarchal strategic apex. AHPS and nurses with limited power respect the rules and regulations. In fact, those clinicians practice CL successfully and effectively, although they are not required directly to do this. The education that nurses and

AHPS have beside their technical experiences turned them into managers, leaders, and decision makers'. This contributed to the creation of a quiet and convenient atmosphere when performing clinical tasks combined with clear communication channels within the clinical teamwork concept.

Jordanian literature emphasized doctors still have the same classic authorities and personalities within 'great man' style. They believed that their physical characteristics and knowledge could make them leaders in their hospitals. This highlights one of the main problems facing CL in the Jordan due to the bureaucratization of professional work (Mulec, 2005) as indicated in chapter four. Jordan's governmental commissions are becoming more aware of the need to establish effective health service management. For example, Jordanian MOH were intended to increase the awareness of clinical staff through training programs cooperatively with professional associations and academic commissions in order to involve health service management in their academic curriculum. International commissions such as USAID have improved the quality of leadership within the health environment by respecting law and regulations and establishing guidelines concerning health management.

It seems that there is a clear weakness in Jordanian universities curriculum, no open communication channels with all medical departments in Jordanian hospitals. Therefore, there was not capable of creating a concept of quality and ethics within leadership system in Jordanian hospitals. On the other side, the managerial qualifications the clinicians have, in addition to their clinical and academic qualifications, had not developed health service management. Thus, figure 7.1 is coming to amend some behaviour towards CL as a concept.

**Figure 7.1: The Most Important Elements Shaping CL**



Figure 7.1 demonstrates that CL can be easily achieved in Jordan through the distribution of power to all clinicians, whether they are doctors, nurses or AHPS. This will help to construct a greater sense of teamwork based on shared decision making and valuing ethical considerations within standards of quality and strict performance of clinical missions. The transformational style cannot be achieved by adopting a strict and formal relationship. Open communication and the sharing of clinical information among all relevant clinical departments, is needed to fully empower clinicians.

### **7.3 Discussion of Clinical Leaders**

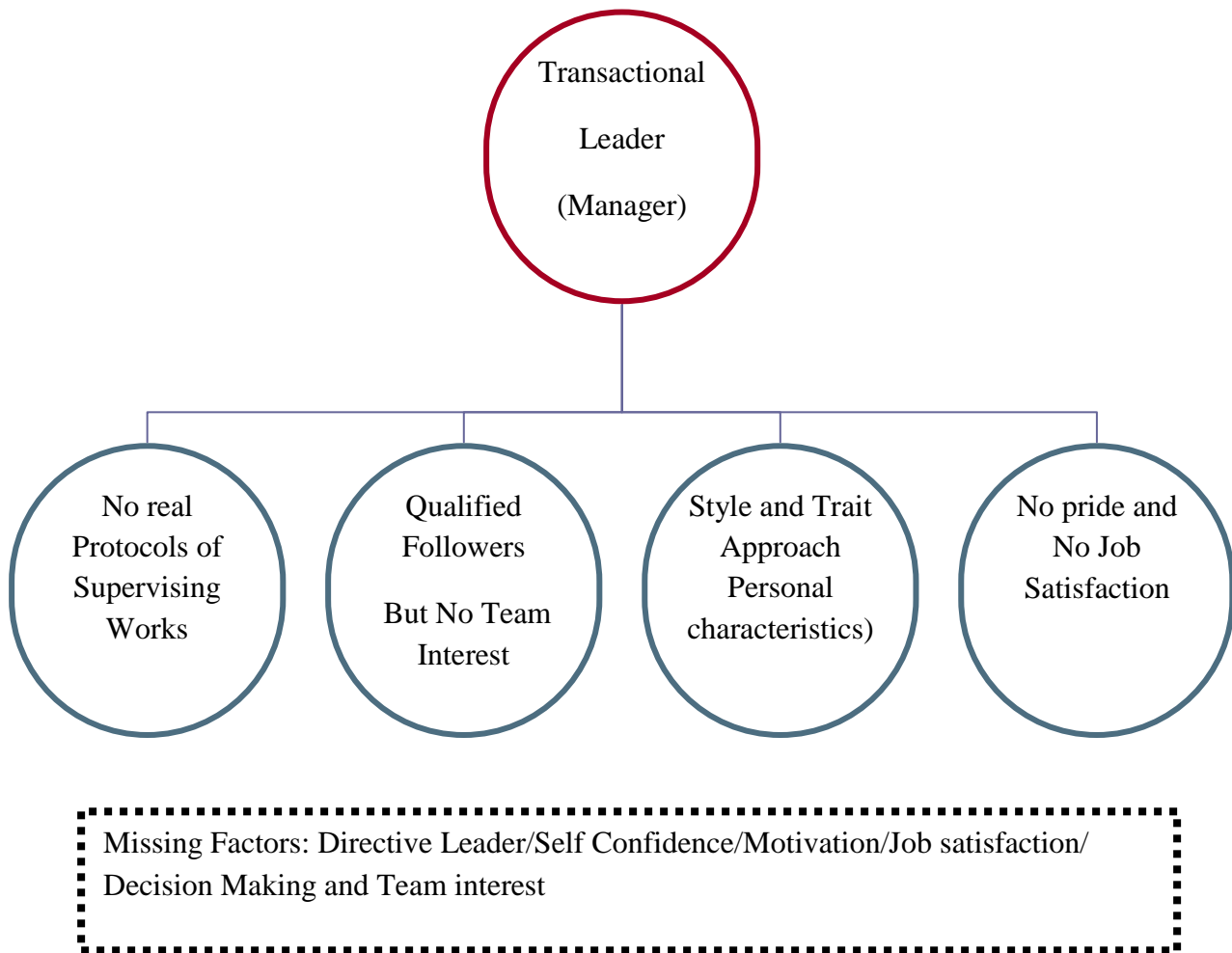
Clinical qualifications (i.e. Bachelor, Master and PhD) have supplied those clinicians with new managerial and technical techniques they have not expected to have. There is delegation in Jordanian hospitals, but, unfortunately, doctors delegate only to other doctors. On the other hand, other clinicians such as AHPS and nurses tend to delegate to other clinicians freely without caring whether they are doctors, nurses or AHPS. Clinical leaders in Jordan have found that consultation is based on technical and personal relationships.

The literature of Sullivan (1990) and Bedeian (1986) and Podsakof et al. (1990) also indicated the need for participative and supportive leaders with an emphasis on motivation and an increase in rewards for the active participation of followers. Situational theory in the literature means that leaders are working according to power and influence as well as their personal characteristics. Also, knowledge and ability of team members are necessary to deliver rational decision-making. To confirm this, Sutherland (2008) says that the health organizations should adopt knowledge, sciences, and innovation. Consequently, the principles of transformational leadership agree with Bergman (2009), who emphasizes that the emotional and cognitive balance with clinicians shall be the responsibility of hospitals management.

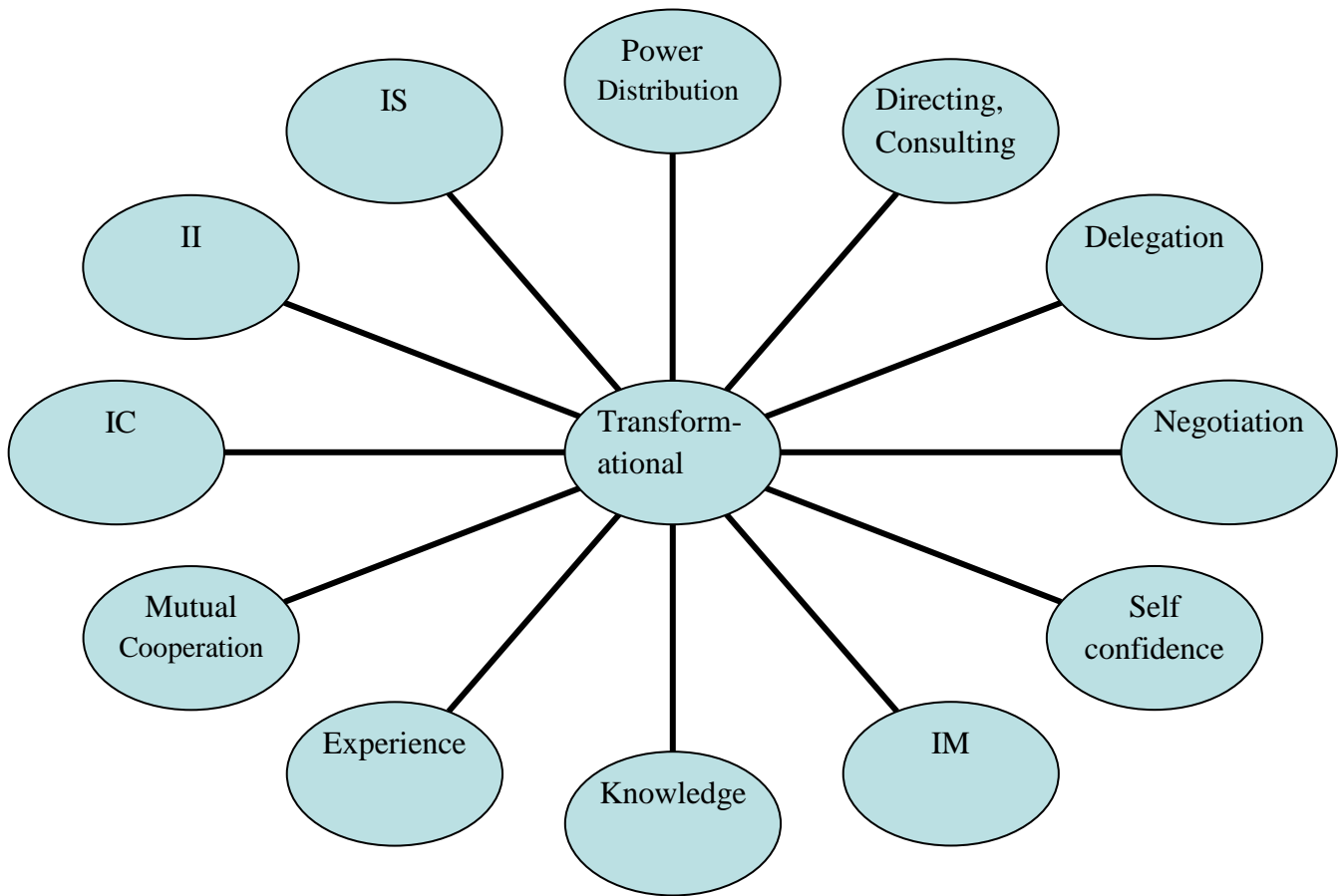
It seems that the leadership in many Jordanian hospitals is not consistent with what is stated by Sullivan and Williams (2007), who say that transformational leadership must be applied in the hospitals in order to achieve the individuals' visions and expectations. Clinical team members in Jordan have not distinguished characteristics as Rasdi (2009) stated that the individuals' creativity stems from the intellectual and environmental pluralism related to the organizations in

which individuals work. Jordan hospitals are often dominated by the trait theory which depends on characteristics of managers and in some cases may take the variables in contingency and sometimes transactional.

To summarise, there is a difference between transformational and transactional CL, as mentioned in figures 7.2 and 7.3.

**Figure 7.2 Transactional Leaders in Jordanian Hospitals**

According to figure 7.2, it may be difficult to introduce CL in Jordanian hospitals because there is a tendency for leaders to adopt a transactional rather than transformational style. This means that management often uses direct orders, which ignores the team's interests and its motivations. Moreover, there is no protocol or written guidelines to justify why CL should be transformational even though the health service needs such a style to be widely adopted in order for all clinicians to perform their responsibilities. Therefore, public and private as well as international, commissions are developing figure 7.3 in order to better understand the requirements of transformational leadership.

**Figure 7.3 Transformational Leaders**

By looking again at figure 7.3, it is evident that leadership means that both leaders and team members should perform their leadership tasks responsibly with mutual decision making that respects each individuals' participation. It is also necessary for the transformational leader to provide his followers with intellectual issues influence them and motivate them within a fair distribution of power. Transformational leadership is needed in health service management and hospitals in particular, to give an opportunity for all clinicians to be leaders. This style of leadership means supporting team members. For example, self-confidence and motivation are not only achieved through monetary support or prestigious job titles, but also through individuals having pride in their jobs and being allowed greater autonomy. The critical experience of team members and diversity of clinical knowledge are necessary tools to construct CL.

#### **7.4 Discussion of Clinical Team**

According to the interviews, Jordanian clinical team members were characterized with different skills and diversity. For example, wide expertise and detailed knowledge have been noticed. Universities and professional associations reinforced this concept through training courses that shall improve them in all clinical, managerial and leading aspects as well as ethical and quality standards. In addition to communication that enables clinicians to acquire information from different scientific sources.

Hospitals' management believes that human resources investment is the real investment. For example, there are research centres in Jordanian universities that improve human resource that works in health care service to reinforce the concept of health services management. Hospitals are not satisfied with what universities present in its courses and curriculum, so they tend to depend on management training within the hospital environment and connecting this with the western expertise. In addition, there is a mutual cooperation between professional associations and clinical faculties; this makes a connection between clinical (technical) approaches and practical ones, understanding the clinical profession basis, ethics and standards. Fortunately, universities, institutions and associations are not the only sources of clinical management training; individuals train one another to be clinical leaders, through electing some committees of those who are equipped with vast experience (seniors) to train who have less experience or knowledge (juniors).

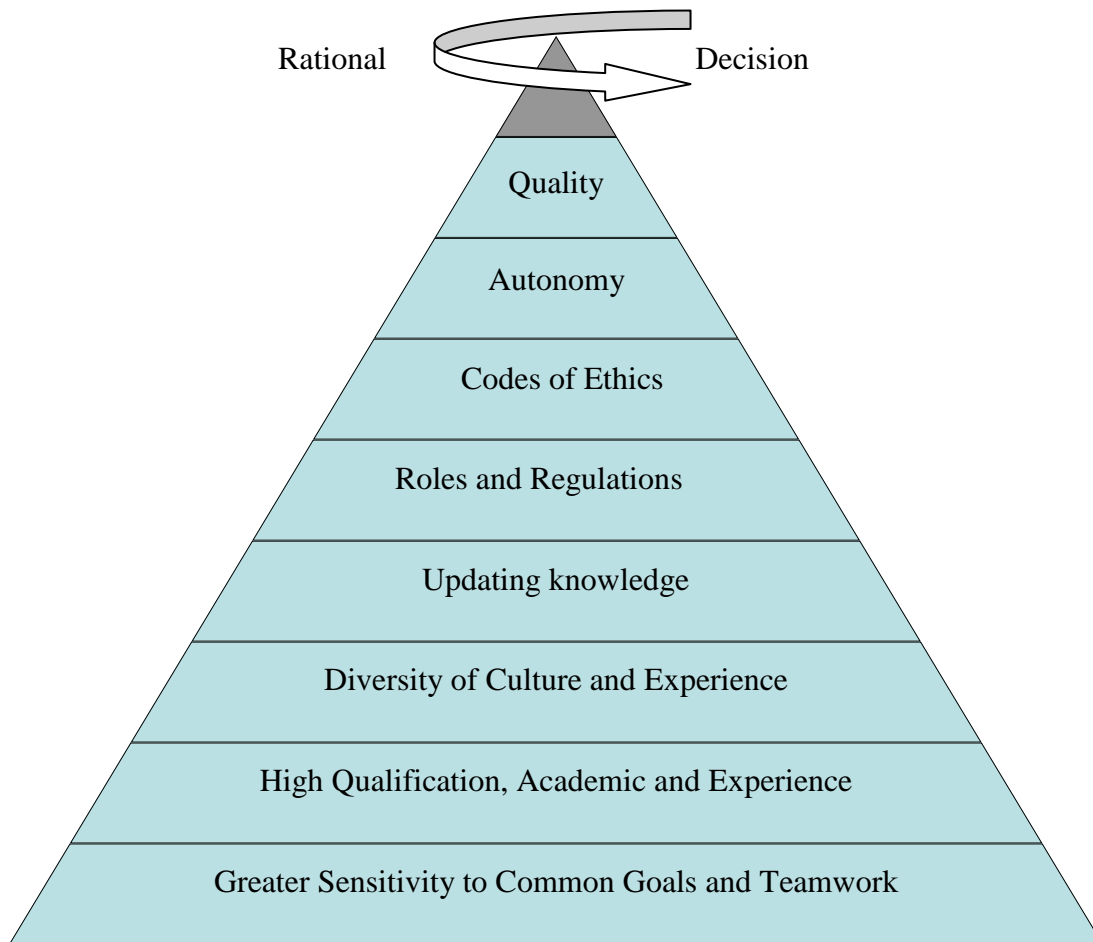
Authors such as Townsend and Gebhardt (1997) have identified the ability for self improvement of staff members in terms of technical and professional as well as ethical considerations. Konu and Viitanen (2008), Bamford and Griffin (2008) have pointed out that the philosophy of shared leadership means decentralization and creating an empowering environment as well as ensuring



that the team works together. On the other , team means different and several knowledge and perspectives of group members according to literature (Van et al, 2011) and social responsibility (Stones and Granthan, 2009) responsible to improve quality of working (Ayoko and Callan ,2010) and collaborative behaviour( Carmeli et al ,2011) having visible relationship between teamwork and overall project success (Yang et al ,2011).This sense is fully agree with Jordanian organisations either governmental or educational to enhance the leadership in health care setting. This means that the diversity and collaborative aspect is an indication of highly developed leadership such a transformational style

It can be noted from the interviews that there is a gap between the Jordanian health system and the European ones; this can be referred to the clinical team itself. This difference is due to the fact that the European system tends to give a great deal of authority to the clinical team. But there is weakness in the authorities being given to the Jordanian clinical staff because of centralism that limits the freedom of these individuals technically. Thus Figure (7.4) is coming to represent the attempts of national government and international sources to ensure that clinical staff are standardised globally.

**Figure 7.4: The Hierarchy of Clinical Team Characteristics**



This triangle emphasises the specific requirements that are needed to construct a transformational clinical team. Figure 7.4 shows that diversity of experience that a good team will possess; more essential elements include quality, ethics and respecting the laws and regulations of the health sector. A truly transformational clinical team cannot be easily created. Critical steps should be taken gradually, such as intensive training and increasing the experience of team members, in order to reach the optimum quality of health care. The globalisation of health care may help to encourage countries to achieve a standardised health service quality, something which cannot be achieved without a highly mature clinical team.

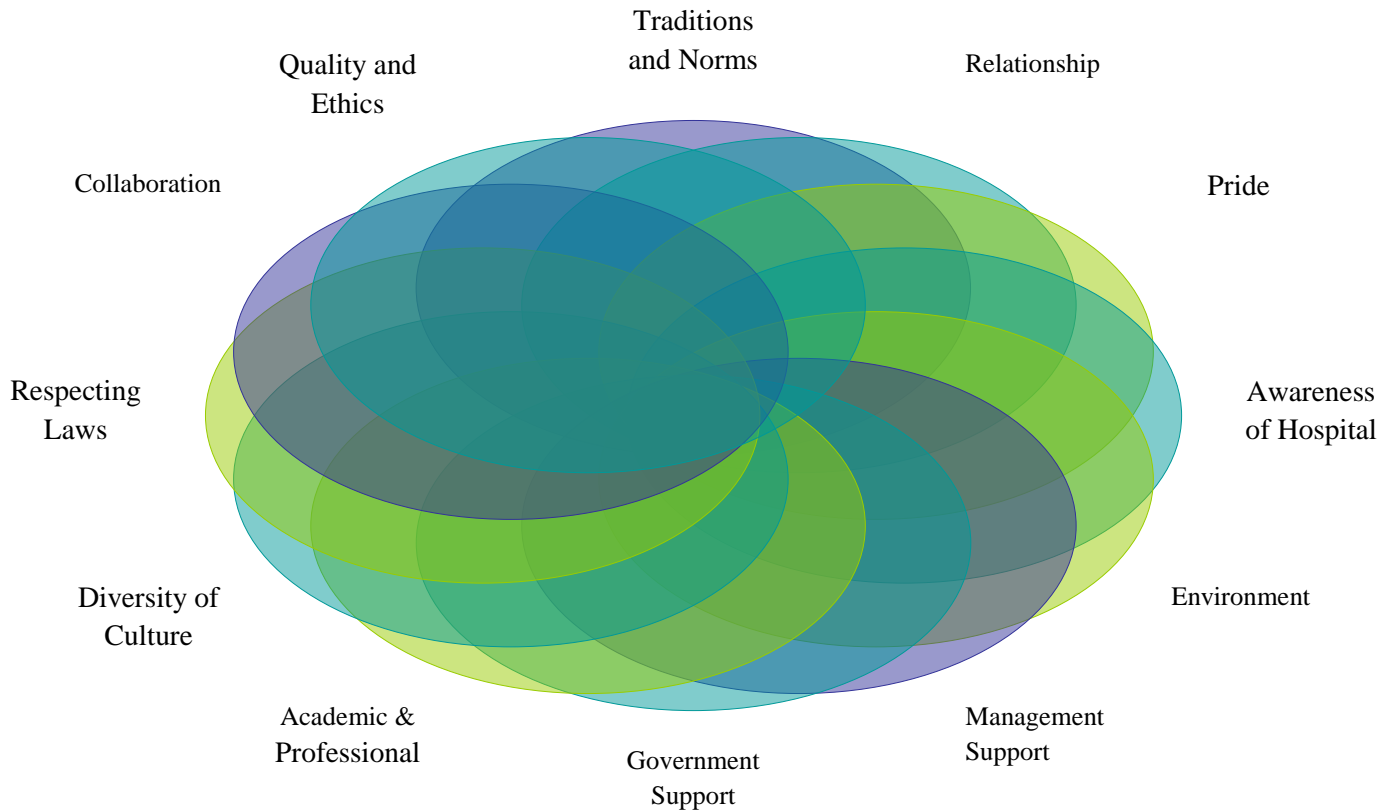
### **7.5 Discussion of Clinical Culture:**

Work culture in Jordanian hospitals means respecting codes of ethics and social traditions in Jordanian society. This also means respecting co-workers, patients, the hospitals' laws and regulations. All the aforementioned contribute in shaping the cultural reality in Jordanian hospitals. Culture, as they think, does not mean supreme qualifying, but it means feeling with Jordanian citizens and clinical concerns in Jordanian hospitals

Jordanian clinicians believe in diversity and cultural differences in language, religion, customs, values, plans, and different techniques, just like western hospitals in Europe and Britain. For instance, this diversity shall provide Jordanian hospitals with new expertise. Hospitals have an important role in creating harmony within the one team members, melting differences between them, paying attention to their personal concerns and issues inside the hospital and outside. The establishment of cultural clubs, concerned with clinicians' affairs, shall create medical, scientific and social atmospheres that help them in performing their work properly.

Also, associations of doctors, nurses and AHPS write down the cultural reality, which develops the career. USAID has struggled to persuade clinicians that knowledge in clinical work alone is not enough to provide successful health care; the terms of quality, communication and respecting laws combined with more coordination between clinical staff and management are also necessary. For example, professional conflicts among clinicians and managerial staff will produce many obstacles making it difficult to develop clinical service.

The health culture in Jordanian hospitals believes in creating a convenient atmosphere for Jordanian clinicians. This idea adheres with the literatures of Park and Tim (2009) who say that ideology in any sector should focus its attention to technical, social, cultural and economical issues. In fact, Jordan has become a competitor on the level of markets in neighbouring Arabic countries in providing medical care with the diversity of culture. In respect of managerial aspect, Jordanian hospitals have worked hard to overcome the managerial aspects to go side by side with technical aspects. Moreover, Rasdi (2009) has said that the work of organizations should take into account organizational-related, individual-related, managerial-related and person-related issues. Similarly, Park et al, (2009) elaborate on this and say that health management and training clinicians on health services, managerial point of view, are cultural factors that should forego the managerial and technical aspects. Figure 7.5, emphasises the need for clinical culture for both clinicians and their surrounding communities.

**Figure 7.5 ,The Need for Clinical Culture**

According to Figure 7.5, it can be seen that clinical culture is an open concept and comprehensive consisting of laws, norms, traditions, ethics and quality and diversity as well as experience. All these elements should be considered as essential keys for hospitals to meet their goals with the collaboration of governmental and local or international health commissions. It is the responsibility of all sectors, both clinical and non clinical, to establish a new culture and develop existing systems based on justice and respect of laws and clinicians themselves. Diversity in participations is needed to ensure calm and productive environment, and it also protects the clinical area from potential conflicts between top management and clinicians as well

as amongst clinicians themselves. Guidelines are not only useful for controlling clinical work but they are also needed to encourage co-operation between hospitals and communities. These guidelines would integrate Jordanian hospitals into a universal culture

## **7.6 Discussion of Clinical Communication**

The interviews conducted with those clinicians provided that there is no openness in communication among different medical units and managerial levels .For example, reading patients' lab results is not restricted to doctors only; pharmacists, nurses or even radiographers might need to read them too. Nurses and AHPS are deprived this role; the doctors have this right and do not have the willingness to share it with anyone else. In this sense, formality governs communication within Jordanian hospitals due to bureaucracy and delay. Clinicians should do something about it; they should strengthen personal relationships among themselves in hospitals to strengthen their technical relations on one hand and facilitate communication on the other.

Doctors at Jordanian hospitals try to isolate themselves from other clinical team members; this is due to their sense of pride. Unfortunately, this makes their personal relationships with clinicians weak and fragile. Some might say that doctors' limited time does not enable them to participate in clinicians social activities, or merge with them and get to know them, this could be considered a type of lofty communication that Jordanian hospitals really need. This cannot be justified at all; because doctors who are the leaders and managers of different medical units should have a strong influence over their followers.

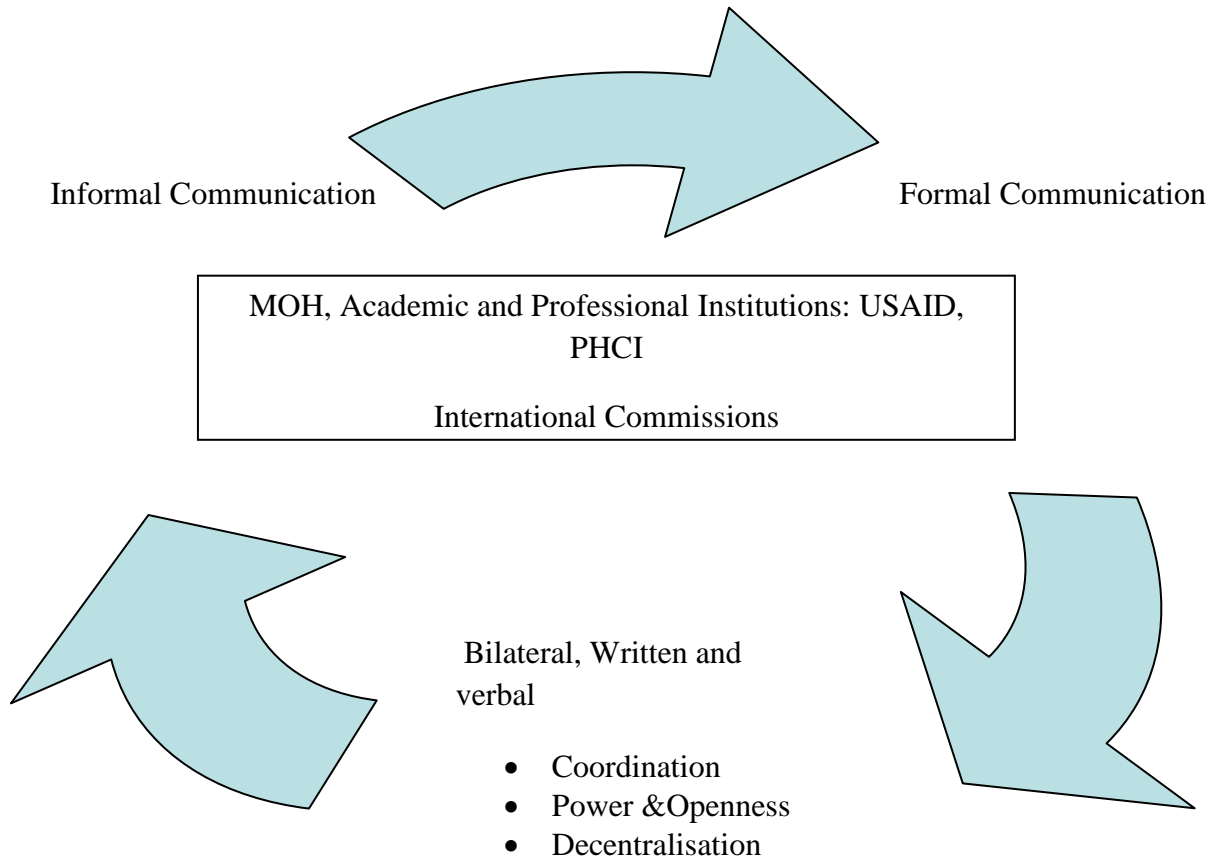
Dierendonck (2002) Daft (1999), Miles and Mangold (2002) agree with what has been reported by respondents, emphasising that communication amongst clinicians means doing away with conflict and misunderstandings. Clinical communication must emphasise essential elements such as brainstorming ideas, resolving conflicts and obtaining information from different clinical areas and hospital departments among all clinicians regardless of their job title or the level of power they have. Daft (1999), Miles and Mangold (2002), Wilson et al (1996), Tourish and Hargie (1996) have all emphasised the importance of sharing different types of information across functional and hierarchal levels.

Jordanian literature has covered some of the recent attempts to deal with these problems. The MOH has sought to encourage collaboration and communication between staff and directors. This is in order to develop the relationships among them and increase the effectiveness of health care. For example, this could be done by encouraging a more informal relationship between doctors and other staff members that would help to achieve a more integrated health care system with a greater level of open communication. Other international commissions, such as PHCI, are also playing a role in strengthening the concept of Jordanian clinical communication by enhancing the relationship between the public and private sectors regarding experience and successful initiatives.

If we examine the literature in chapter two we can notice that there is a gap between these indications and reality of Jordanian hospitals; this is because of centralism and doctors' authority that often hinder the existence of open communication system. Accordingly, figure 7.6 could be considered to present the most appropriate shape for clinical communication, it shows the need to

concentrate on the importance of both the formal and informal at the same time in order to strengthen each. The formal achievement of clinical missions is dependent upon strong relationships with different clinical departments at a personal or professional level through bilateral contact and the exchanging of information by verbal and written procedures. More coordination is needed to provide open channels of communication, rather than strict centralisation, as the instructive method is considered as one of the main obstacles for clinical communication. Power should be redistributed more fairly as clinicians. We can see therefore, that effective clinical communication is vital for clinical settings.



**Figure 7.6 Clinical Communications in Hospitals**

### 7.7 Discussion of Clinical Quality

It seems from the interviews that the managements of Jordanian hospitals consider applying the concept of overall quality must not arise from the fear of systems, laws, regulations, penalties and other tools of pressure. It should arise from the clinicians' human and social conscience.

Therefore, coding system must be developed to observing quality concept inside our hospitals. For example, written rules and guidelines that are considered as a judgment key on the policies

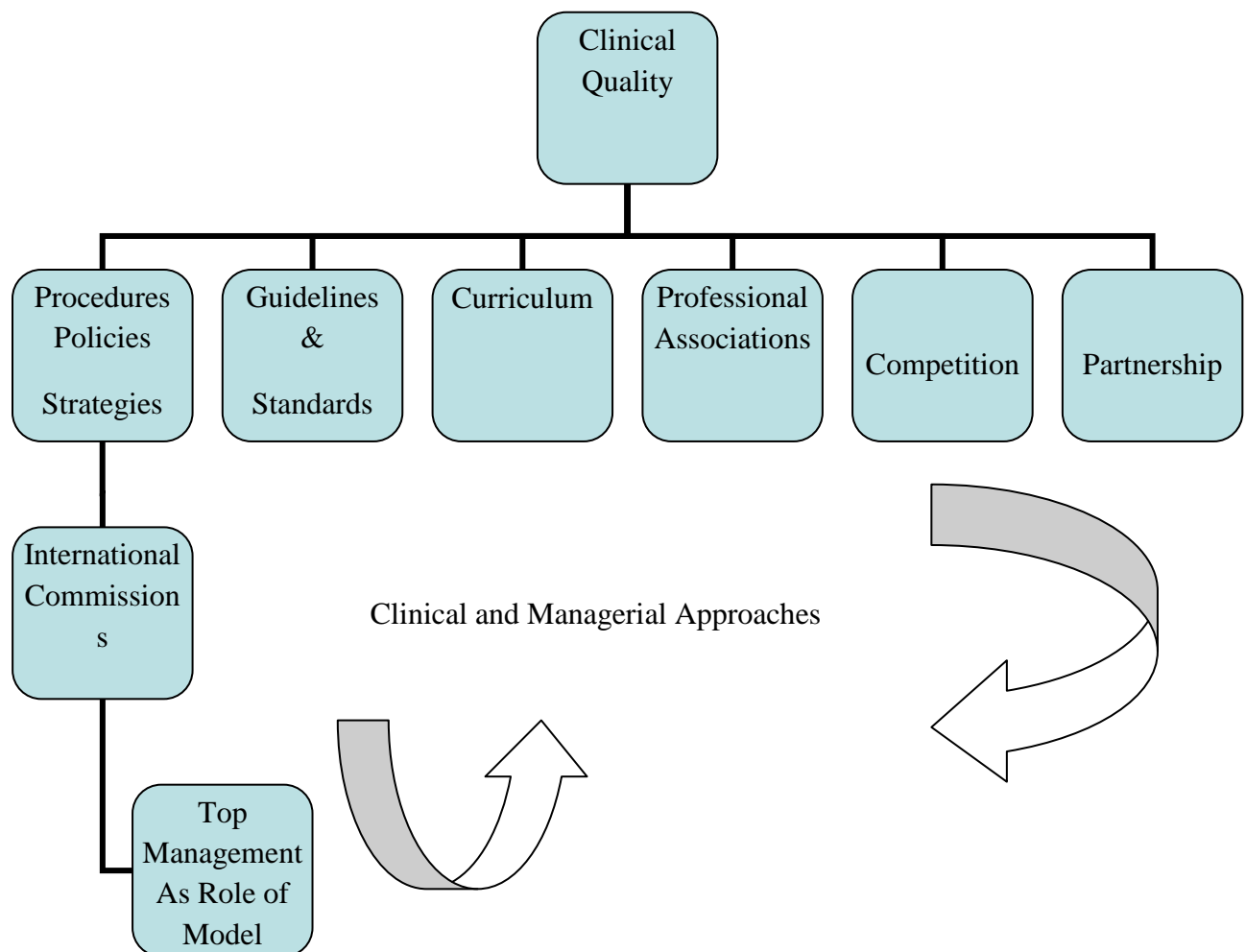
and procedures. In other words, Jordanian hospitals cannot achieve overall quality, unless clinicians have a real acknowledgment of its importance and social attention, considerably more than technical issues. Quality is currently not taught separately in specific modules as educational materials, although it can enhance the productivity of management. In the case of health care, TQM requires a partnership between doctors, nurses and AHPS regarding technicalities in an attempt to have parameters, which can measure the effectiveness of clinical work and the managerial approach at the same time (Jabnoun and Al-Rasasi, 2005 and Wilson, 1987). Thus, the quality in Jordanian hospitals still lacks comprehensive aspect and pays attention to technical aspect only.

In reality, comprehensive quality especially in management facilitates the clinicians' jobs; as they become capable of practicing their works easily and smoothly. This could be seen because there are guidelines and supervising points of view that reinforce the technical side. Alahmadi (2009) comments on this and says that management quality shall reflect upon the technical side and sound decisions shall achieve technical success. Managements at Jordanian hospitals lack managerial and technical quality which contradicts with Som's (2009) point of view that highlight comprehensive management quality at hospitals, as the surrounding community and the patients themselves. Vera (2009) does not harmonize with the culture of the Jordanian medical sector. She says that patients should have a great deal of priority with respect to quality; this shall not happen unless there is a strong managerial and leadership system.

This means that quality in Jordanian hospitals is not a uniform to cover the management body as indicated from Rasasi and Harris (2007), Camilleri and Ocalloghan (1998) and also Lee (2007) who said that that transformational style believes in quality towards preparing managers and individuals.

In the third chapter, the figure 3.4 indicates that quality is a real international scale to examine the managerial and medical aspects of hospitals. As is shown in Jordan literature, clinical professional associations have taken an important part in translating clinical quality into reality. For example, JNC introduced many useful practises such as controlling the criteria of nursing with managerial and leadership approaches. Moreover, clinical faculties do not teach adequate courses in this area. In conclusion, here is a proposed model (figure 7.7) of clinical quality that might be applied to Jordanian hospitals; it presents the most important obstacles to improving clinical quality.

**Figure 7.7 Model of Clinical Quality**



It can be seen from figure 7.7 that clinical quality cannot be applied properly unless top management and international commissions are involved. It is essential that academic and professional institutions create written guidelines, such as policies and procedures that encourage clinical effectiveness, and help to eliminate dangerous and irreversible clinical errors. However, the experience of the private sector is needed, because private hospitals have traditionally been more interested in quality as a first priority in order to stay afloat in a competitive market. Strong competition amongst Jordanian hospitals to gain accreditation concerned with clinical and administrative approaches.

### **7.8 Discussion of Clinical Ethics**

During interviews conducted with them, clinicians suggested that there should be an accessible ethical system in Jordanian hospitals. They also suggest that the system's guidelines should take into consideration the medical, managerial, social, psychological, behavioural and economical dimensions. If there were a system of ethics, all team members would assume the responsibility altogether as a teamwork. The system of ethics means that participation and cooperation will contribute to the fulfilment of the organization goals.

As a result, ethics are fundamental parts of leadership realization. Rules and regulations are not sufficient in settling disputes and resolving problems, but alternatively written agenda and behaviour codes is better to be adopted. In fact, it is hard for hospitals to achieve these codes of ethics unless it refers to different specializations, such as law, management and religious sciences. It is necessary to get exposed to external environment, like universities, and to design programs that handle the subject of ethics side by side with medical legislations.

Codes of ethics are important when rules and regulations fail. In other words, if the law is not fair, ethical legislations shall offer the needed justice. Ethical committees in hospitals are criticized for not offering different experiences and specializations. For example, the committees' head and members are mainly doctors! AHPS and nurses reject them. In fact, we cannot imagine that the clinical sector, particularly hospitals, do not have a clear agenda of ethical considerations. This is not harmonised with the authors indications such as Siebens (1998), Carter (2001), Gangon (1999) and Peterson (2004) who stated that described that ethical system means religious, linguistic, legal and more general beliefs which individual workers need to have honesty, trustworthiness, friendship and confidentiality as well as the highest levels of satisfaction and creating leaders or wise men. Certainly, this was considered in the literature as stated by Vera (2009) who said that the high communities and service organizations trying hard to cause their employees to be attributed to the behavioural principles, asking them not to stay away from it.

In same context, code of ethics that can be shared by all such as social, religious, cultural, academic, and economic groups .This is consistent also with what is stated by Storey and Buchanan (2008) that the governments in hospitals must be invested in so-called the “clinical governance” to have a comprehensive health service. Hence, we noticed that the western countries such as Britain have the so-called clinical governance, which assume responsibility for ethical, technical, social, administrative training and development courses. For this reason, the ethical aspects have become a serious responsibility that the clinical leaders undertake.

Referring to the Figure 3.1 in the third chapter, we find that the ethics has been included in many aspects such as clinical relations with colleagues, trust, law, religion, dignity, friendship, and confidentiality. The Jordanian hospitals don't invest these aspects correctly, because those responsible of ethical aspect are more concern of technical or clinical aspect. We also noticed the absence of diversity in religious and legal aspects at Jordanian hospitals, due to the lack of religious, legal, social committees working alongside with clinical committees. At present, the Jordanian curriculum does not include clinical ethics in university and college modules enough. To rectify this, Abu Moghli, (2006: a) has planned a postgraduate managerial course incorporating some of the cultural and ethical issues that face nurses in providing care for their patients. However, there are no guidelines for doctors and nurses regarding the adoption of this concept in spite of there being clinical committees. Furthermore, there are no written protocols or code of ethics available to Jordanian hospitals.

Figure 7.8 discusses the situation of clinical ethics in Jordanian hospitals and provides suggestions for development in this area in order to match international standards. The diagram takes into account both governmental and institutional recommendations in clinical ethics.

**Figure 7.8 Clinical Ethics and Recommendations**

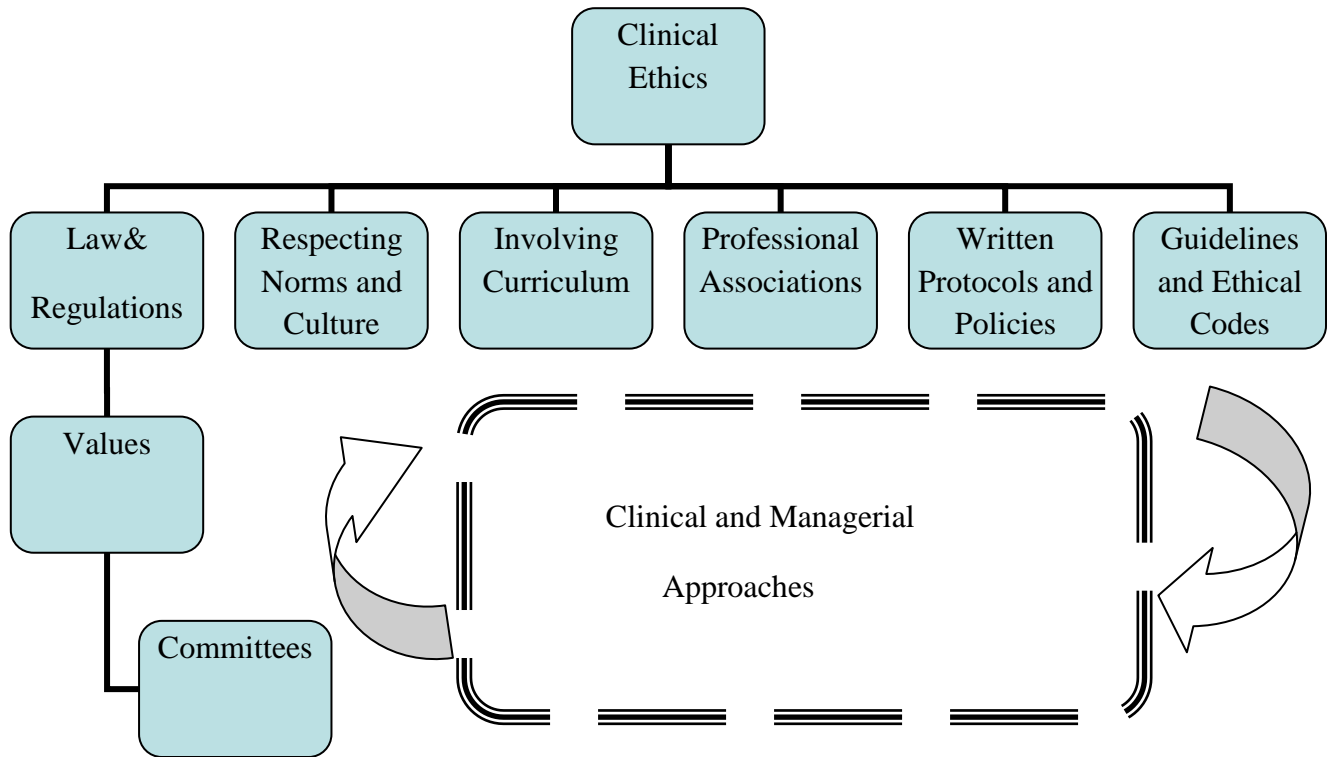


Figure 7.8 emphasises the importance of ethical guidelines and protocols to provide clinicians with useful values for both clinical and administrative affairs. Clinical ethics should provide clinicians' with a set of guidelines against which they can judge the appropriateness of their work in comparison to international norms. There is a need for this important element to be emphasised by university curriculum and clinical academics, as well as international commissions interested in standards and criteria. Furthermore, ethical committees should be constructed from clinical, social and religion to secure the practice of clinical criteria under a comprehensive umbrella. It is necessary for clinical ethics and ethical codes to be applied to minimise medical errors and

provide patients with high quality care and service. Ethics are also important for clinicians when dealing with each other as well as patients, visitors or relatives.

### **7.9 Discussion of Doctors as Leaders**

Doctors practice management in spite of the fact that they are not qualified enough to be managers. Jordanian government and MOH ask doctors to be managers, in addition to their original profession. Those doctors also think that the profession of medicine is extremely complex and difficult, and they practice management which as they believe is much easier. In fact, some doctors do have managerial qualifications and have taken some training courses in management; however, this does not mean to deprive those from AHPS and nurses who have MBA and PhD in health management from being managers. The dilemma is that there is no general manager of any Jordanian hospital, who is a nurse or AHPS

Unfortunately, medical decision makers see that these managers, who are doctors, should be assisted by individuals who should be doctors as well. This means that cultural, managerial and technical diversity is forgotten as long as managerial assistants have qualifications as the doctors. Those doctors admit that they do not have the accounting skills, needed in making balances, organizing, planning, strategies based on economy and general policy. However, they assign their colleague doctors as assistants, and sometimes they assign assistants for those assistants. It is noticeable in Jordanian health management that there is cooperation between general managers in Jordanian hospitals, who are most of the time doctors and managerial, accounting, maintenance, purchase, planning and human resources departments.

The literature showed that doctors are criticized for not being democratic when dealing with different medical and managerial units. Unfortunately, this contradicts with transformational



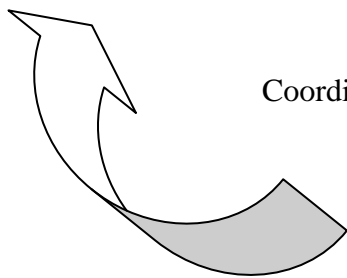
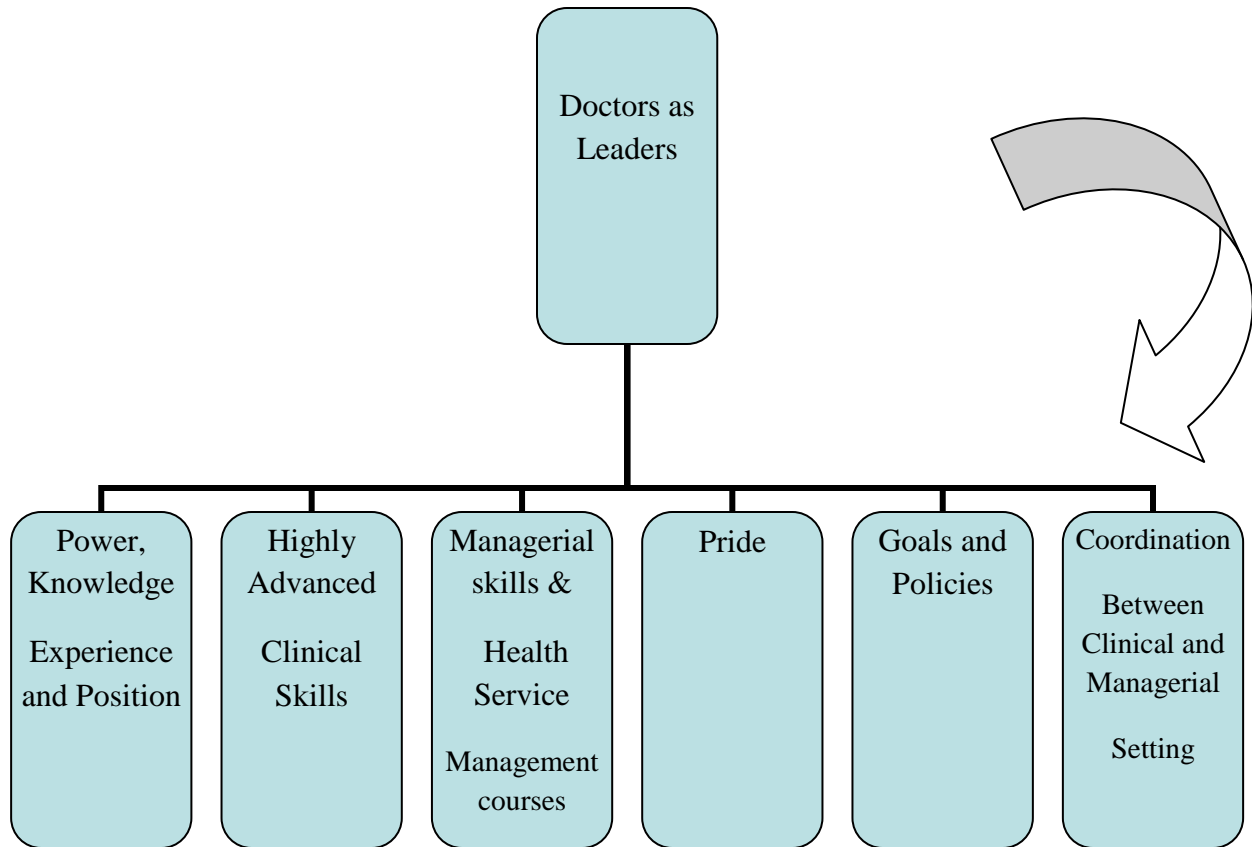
leadership that includes justice in authority distribution and democracy in leading the team. For instance, Loughman (2009) adds that open communication channels are extremely important for doctors, if they desire to make wise decisions mapping out policies, these things require the participation of other clinicians, such as nurses and AHPS. In this approach, Xirasgar (2008) strengthens this idea in saying that transformational leadership means a democratic doctor who bears big responsibilities as a responsible leader.

That's why tensions and conflict between them and different post structures are a raised due to centralization (Willcocks, 1998). This means that there is no difference between the Jordanian setting and the global ones towards doctor's management regarding the style of leadership and centralisation. Thus, Smith et al (2004) and Aluisse et al (1989) clarified that it's now necessary to include management skills in the medical curriculum

Jordanian hospitals' managers consider managerial supervisors, who are normally the general managers' assistants, might fill in the doctors' managerial gaps. This harmonize with what Vera (2009) declares that doctors and non-clinician administrative managers, who are aware of financial, human resources and planning issues, in addition to other managerial subjects, should cooperate with each other. If we examine figure 3.4 in chapter three, we can find that doctors are aware of clinical management or management as a concept but in a narrow and insufficient way. Their limited time does not give them the opportunity to be to be professional in management Doctors have big responsibilities towards their hospitals and the surrounding community however, there is weakness in their communication with the medical staff and the surrounding community, in addition to the fact that centralism is widely spread in medical service staff which led them to be nervous and worried. In fact, medical professional associations have a role in

taking care of doctors and qualifying them, but unfortunately its original role is supervising doctors technically.

**Figure 7.9 A Developed Model of Doctors as Leaders**



Coordination between Clinical and Management Departments

Figure 7.9 demonstrates that doctors have insufficient time to coordinate between both clinical and managerial responsibilities. Training in management and university modules on health service management are needed so that doctors are able to achieve hospital goals with the collaboration of others including nurses, AHPS and management staff. The most important thing that could be provided is training on HR, budgets, strategies and health planning, as well as some skills useful for coordination between clinical and managerial missions. This would enable doctors to make rational decisions, both clinical and managerial. It is also necessary to support doctors with adequate power to achieve the necessary hospital goals smoothly.

#### **7.10 Discussion of Nurses as Leaders**

While interviews conducted with clinicians indicate that the doctors' situation has made nurses upset and uncomfortable. For example, nurses see themselves less than doctors who have professional immunity.

Most suggestions from nurses for medical service are normally rejected, changed or amended because they do have minor levels of authority, unlike doctors. In fact, nurses' decisions are often the most realistic, because of the fact that they are the closest to hospitals' and patients' concerns and worries. The reasons behind the weakness in nursing management can be referred to the weakness of nursing associations' decisions; they do not constitute pressure over health system to facilitate nurses' work without being humiliated. They are normally opposed by higher managements preventing them to get high managerial positions.

Many people who were deans of nursing faculties in Jordanian universities and militaries doctors who worked at Al Hussein Medical City have tried hard to give managerial positions to nurses in

Jordanian hospitals. There are meetings and conferences sponsored by nursing associations in order to contact with American and European universities in order to give nurses more authorities and power, besides their rich knowledge and wide experiences.

The story of the British NHS shows some differences to that of Jordan, the RCN has been willing to improve the leadership skills of nurses. A high level of authority has been given to nurses to encourage them to reach the transformational style of leadership, because they believe that this may help them to improve morals and consultation sense as argued by Clarke (2000), Hancock (2005) and Burke (2004). The RCN recognises CL as a corner stone for the development of nursing and health care, creating nursing leadership and handling health care difficulties.

They are deprived of the right to be managers or even to have a role in medical decision making, in spite of their high qualifications. This contradicts with Storey and Bunchnan (2008), who says that nurses are high-spirited and responsible; they can solve their personal problems and the problems of community and patients. Also, this is contradicted with Macleod (2010), Lekan et al (2011), Utley et al (2011) and Cummingset al (2010) who emphasised that CL leadership is necessary for nurses to get job satisfaction and positive work environment within the concept of transformational leadership. They added that nurses have the highest level of demonstrating values for their essential role in supervising skills and establishing effective communication and delegating tasks. Accordingly, there is a big difference between the literature and the reality of nursing situation in Jordanian hospitals

Thus, they have to be treated in a gentle way. Park and Tim (2009) emphasised that the environment of nurses should be positively convenient besides their big social responsibility in Jordanian hospitals. Professional and legal authorities granted to nurses are just written theories that shall never turn into realities. For example, we do not expect nurses' matrons or units' heads

to change plans and programs in Jordanian hospitals. Storey and Buchanan (2008) who demands that nurses should have sufficient powers and authorities and good qualifying, because they are the most capable entity to manage their nursing units. It can be said that nursing in Jordan is very professional, but professional associations and universities fail to improve them and give them the needed authorities. Additionally, it's difficult to equalize them with doctors which affected the nursing profession and its future negatively.

When we examine figure 3.4 in chapter three, nursing situation in western countries is much better than Jordan, this might be due to the fact that nursing associations activities are stronger. Furthermore, universities modules are much better as it tries to connect theory with practice regarding management modules. In conclusion, figure 7.10 presents the preferable situation for nursing in Jordanian hospitals. This follows new trends in both domestic and international fields.

**Figure 7.10 The Nursing Leadership as a Developed Model.**



Figure, 7.10, provides a developed model for nursing leadership that depends on the involvement of governmental, academic and professional institutions. A more specific curriculum is needed to support nurses with the fundamentals of management besides their clinical responsibilities. Also, the empowerment of nurses by top management and government is necessary in order to enable them to become decision makers like doctors. There is a need for, professional associations and international commissions to create training courses and CPD departments, to strengthen their

managerial and clinical abilities. The nursing situation in Jordan needs to take a lead from the international experience and western countries in particular, (see the NHS and the RCN) as these countries often have experienced the same history of difficulties before gaining their new systems of empowerment and autonomy.

### **7.11 Discussion of AHPS as Leaders**

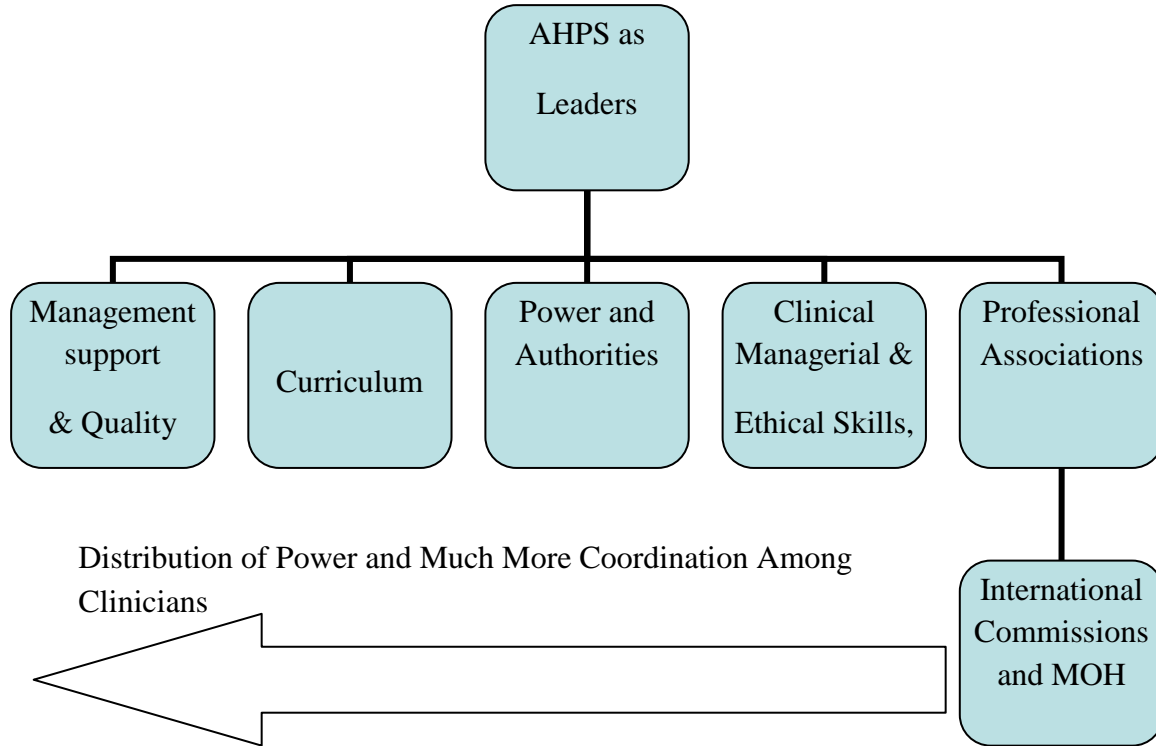
AHPS managers declared that they are highly experienced and bear big responsibilities. However, they do not have their rights in management; moreover, their supervisors are normally doctors not AHPS. The health service starts from pharmacists, radiographers, medical engineers and laboratory staff; without them it would be impossible for doctors to diagnose patients' cases. AHPS are also the most clinicians whose duties are highly connected to managerial, accounting and strategic aspects. They are very aware of international health standards, in addition to ethical aspects but they are not able to be managers or leaders. These factors made them, like the mentioned nurses, lose their self-confidence and lose trust in their managements

In addition, these differences in points of view between them and doctors have made them isolated more and more each time they see how superior doctors are. They often feel they are just the doctors' servants whose duties are just about fulfilling the doctors' commands. In other words, they consider themselves the lung that enables other clinicians to breathe. Jordanian hospitals managements disregard managerial diversity, as most doctors' assistants are doctors not nurses or AHPS.

The literature discussed the situation as the same in Jordan and there is no big difference between Jordan and the global ones regarding the situation of AHPS. Fiedler and Chemers (1984), Scholten and Grinten (1998) and Willcocks (1998) have examined the right of AHPS to have managerial and leadership responsibilities that are currently being ignored in health service management. Thus, Glover and Hughes, (2000) declared that health service should be demonstrated by qualified health technicians rather than true medical technocrats capable of managing all aspects of the health care profession to enable individual practitioners to develop knowledge and competence in complex clinical situations (Cutcliffe et al, 2001).

The next figure, 7.11, suggests the importance of AHPS being provided with management abilities. As stated in regard to doctors' and nurses' situations. AHPS could be given greater professional power and greater experience of management through their university and college curriculum. Furthermore, government and top management in hospitals can pay serious attention to providing professional training in both management and clinical aspects. Thus, AHPS are able to perform management alongside doctors and nurses on hospital boards. More support is needed from international clinical associations in terms of training and criteria for quality.



**Figure 7.11 AHPS and CL as a Developed Model**

### 7.12 The Discussion of Comparison among Clinicians in Performing CL

According to participant's feedback, doctors were responsible for implementing hospital strategy. This because they are the most powerful body who can implement their orders and policy on the others according strong support from decision makers in the MOH. There was good participation from AHPS in delegation and tackling centralization and also thought linking cultural and clinical concepts was important to CL. It seems that they are keeping updated with the international guidelines regarding clinical investigation and criteria may role their job description than others unfortunately, nurses showed the lowest response towards working with the concept of autonomy and applying rights and justice. This is because still have the big challenge to be involved in management and always opposed by doctors making them doing according to doctors order. So,

this is one of the most obstacles in this research .Basically, it's regular to see that nurses have a higher level of interest in cultural diversity than others ,because they are the most employees keeping in touch with patients, visitors, their colleagues from other clinical positions . Moreover, their experiences regarding professional and social approaches derived from seminars and conferences either local or international.

AHPS demonstrated that they believed to work ethically and faithfully respecting laws, regulations and legislations more than others. This is again due to their written commitment embodied in policies and procedures. We can say that their criteria of their job are mostly explained more than others in health care setting and .That's why quality was discussed seriously by AHPS who declared that quality, as a comprehensive management system. The ethical considerations are adopted by doctors more than others. It seem that doctors are mostly responsible to establish ethical committees and they are always the investigators of any faults regarding patients and professional mistakes deriving from other employees

In spite of the clinical and administrative qualifications of many hospital employees, CL may face obstacles in its efforts to increase the practice of health service management in a suitable manner in the future. The next section discusses what some of these obstacles may be in an attempt to reveal the reasons behind the potential success or failure of CL.

### **7.13 Obstacles in Implementing CL in Jordanian Hospitals**

The obstacles alluded to in the fourth objective of the introductory chapter have been gathered from clinicians who have supervisory missions in the Jordanian hospital system in the strategic

apex. They have been encouraged to express their real thoughts as many of them have attempted to correct some of their incorrect management behaviour.

### **7.13.1 Obstacles Related to Doctors**

It is noticeable from the clinicians' points of view that others such as nurses and AHPS are not satisfied with the doctors' performance. This is due to loss of managerial delegation, weakness of communication with other clinical staff members and their restricted time that does not enable them to accomplish managerial dealings quickly and effectively. Furthermore, doctor managers do not have enough knowledge about strategic and accounting issues, in addition to managing individuals in Jordanian hospitals. In other words, they are assigned as doctors due to the old culture spread at MOH and Arabic culture, regardless of whether they have managerial qualifications or not

### **7.13.2 Obstacles Related to Nurses**

Nurses face obstacles which may contribute negatively to Jordanian CL, primarily they suffer some frustration related to power and authority being unfairly given to doctors. For this reason, nurses feel that they are still followers. Many of the nurses interviewed suggested that the administration module for nurses is being taught in an incorrect manner meaning that they are not being given enough knowledge of their rights and duties.

### **7.13.3 Obstacles Related to AHPS**

The qualitative data has shown that there is not enough representation of AHPS in top management and decision-making. Unfortunately, this is because present hospital culture believes

that doctors should be managers. It may be that medical and administrative managers can work together to create a balance, however, when doctors are involved in management this is likely to create a bias towards doctors. Doctors also find it difficult to take orders from non-medical staff such as AHPS and nurses.

#### **7.13.4 Obstacles Related to Culture**

A common culture in Jordanian hospitals is criticized because it lacks Institutionalism. For example, individuals from clinicians make decisions and strategies alone without looking at medical industry in a comprehensive manner and no involving all departments .Additionally, the non-health institutions are not also involved as different experiences that might help in developing Jordanian hospitals. For example, it would be great if our hospitals benefit from banks, universities, companies, corporations, factories and other entities in order to popularize diversity and globalization.

#### **7.13.5 Obstacles Related to Communication**

Communication closeness in health organizations and medical institutions is due to inconsistency in medical industry environment. The channels are not clear among clinicians and different clinical departments. Also, the unfair distribution of power makes some disturbed manner between doctors and others due to centralism and the superiority of doctors in particular

#### **7.13.6 Obstacles Related to Hospital Policy, Management and Leadership**

Most directors of private hospitals are also the owners. Furthermore, there is a big gap between top management and those on the lower levels due to hospital culture and the superiority of

managers and decision makers. For example, the executive office might not fulfil the demands of staff demands; there is a lack of justice and an illogical distribution of roles. There is also very little stability in management. Every new manager comes with his own approach, making it difficult for clear criteria or protocols to measure the effectiveness of CL. For example, some managers are supported and empowered from the top management in the MOH while some are not supported and have very limited resources. Centralisation is also an obstacle; and meant that decision makers often have no idea of what is going on in the real clinical environment. Finally, some managers are biased and discriminate between those on top and lower professional levels.

#### **7.13.7 Obstacles Related to Ethics**

Jordanian hospitals still lack guidelines regarding ethics and written criteria in judging the correctness of medical procedures and managerial issues as well as social and religious aspects. This causes closeness in regard to the international culture; the world is nowadays considered to be small due to globalization.

#### **7.13.8 Obstacles Related to Quality**

It is not sufficient to highlight the importance of equipments and clinical issues more than policies and management .So, Jordanian hospitals have no comprehensiveness in quality considerations in both culturally and managerially aspects.

After the general review regarding CL in Jordanian hospitals, the next section will discuss the research questions and objectives in an attempt to confirm that all factors have been discussed and most gaps have been filled.

#### **7.14 Testing research questions and objectives**

*Question Number One:* It becomes clear, when answering this question; this authority could be categorized to positional rank, especially when it comes to doctors. Knowledge power is restricted to doctors; although nurses and (AHPS) have high academic degrees .The common culture in Jordanian hospitals might be a reflection to higher decision makers' opinions, who are doctors. It is also clear that legislative authority, governed by the medical or health law in Jordan, is affected by professional ranks which are headed by doctors.

*Question Number Two:* Through analyzing the qualitative data, it becomes clear to the researcher that the cultural diversity and the combination of clinicians' cultural elements are considered to be sort of weak. This is due to the fact that clinicians are always busy with technical issues such as diagnosing illnesses, surgeries, prescribing medications, rather than drawing up a cultural system.

*Question Number Three:* CL specialized medical team believes in diversity, regardless of the professional rank and power of the perfect team that is qualified to work at hospitals. We find in Jordan, when analyzing research terms, that doctors are the most skilful personnel when it comes to technical knowledge. Furthermore, nurses and AHPS are sometimes highly qualified in their

technical and managerial specializations. Weakness of training and shortage of resources have made those nurses and AHPS highly depend on doctors' managements although they are capable of managing hospitals effectively. Once again, this contradicts with the unfair authority distribution culture among clinicians, which makes them lose their self-confidence

*Question Number Four:* Communications in Jordanian hospitals are considered to be weak, because of formalism and centralism that govern different medical departments. The relationships among doctors are strictly professional and social at the same time, this fact makes this profession stronger than any other medical profession such as nursing and AHPS. On the other hand, the technical and social relationships among doctors and nurses or AHPS are weak and do not reach the desired level of open communication channels. In general, it is hard to separate social relationships from technical ones, so both formal and informal ones are needed in CL.

*Question Number Five: Question Number Five:* Quality in Jordanian hospitals lacks comprehensiveness due to centralism which is controlled by higher management, formed of doctors. Furthermore, codes of ethics are a part of the quality of managerial and technical processes. In reality, these codes do not exist and this shall affect the quality of the provided medical service. The adopted quality in Jordanian hospitals goals were not to improve the managerial and medical services together but were aimed at obtaining international certificates such as the ISO

*Question Number Six:* The codes of ethics which actually exist in Jordanian hospitals as it emerges from customs, traditions and religion. Unfortunately, they are not written in specialized

records; such as checklists, manuals or guidelines. It couldn't be referred when necessary as to settle conflicts and investigate technical or managerial issues that were not mentioned in the civil law or medical laws. According to analyzed data, Jordanian hospitals could not merge ethical, technical and social culture, this weakens ethical codes, because these codes should be comprehensive and should provide answers to any problems result from the medical work in Jordanian hospitals.

*Question Number Seven:* When we actually answer this question, it comes to our mind that the non-democratic and dominating sense make us pessimisms about doctors' capability of leadership in Jordanian hospitals .This is because of closed channels of communications with clinicians' member team (nurses and AHPS). As well as the lack of time for these clinicians to fulfil their managerial, technical and clinical roles, this fact hinders them from resuming responsibility in sufficient way. It is well-known that clinicians, even they are high technician people, but they are unqualified to lead the clinical system in Jordanian hospitals according to their direct express and acknowledgment. Unfortunately, the MOH has the full awareness of such matter, as it is strongly supported those doctors through giving them technical, administrative, financial and economic responsibilities. Also, it seems that doctors lack confidence along with the medical team of nurses and AHPS; this is due to the absence of delegation concept in the technical and managerial authorities which reduces the managerial responsibilities of nurses and AHPS. Referring to the leadership theories; we find that doctors' leadership in Jordanian hospital is closer to the old and classical theories such as trait and style. They are adopting both technical and managerial characteristic based on giving orders rather than taking into account personal, technical and social considerations for the one team.



*Question Number Eight:* When answering this question related to the nature of nurses leadership in Jordanian hospital, we find that it comes more close to the transformational style. Nursing leaders and managers believe in opening the communication channels with all health team members working in these hospitals by feeling a real sense of their colleagues concerns, and even lead them to encourage innovation. In other word, we find that managers of nurses who hold PhDs and MA degrees of medical management are often applied it in practice and merged theory into application in order to reach high concept of management apart from centralism. They also aspire to apply the concept of justice when distributing authority. In spite of that, they are always trying to retain the noble values that considered social and cultural aspects in hospitals along with technical and therapeutic matters. They adopt mutual trust and collaboration between them and their colleagues of nursing and other medical positions in all aspects of life (not only in term of technical).

*Question Number Nine:* The lack of self-confidence for AHPS caused the “non-responsibility” in some cases. Even though they hold high and prominent academic degrees, but they are considered as the second or third-class clinicians. Their opinions are rarely taken even they believe in open communication rules; have no functional distinctions that prevent them from personal-social communication, and they are more daring than other clinicians. For example, they are respecting the law of hospital and complying with the objectives of Jordanian hospitals; such objectives is often connected with concept of quality, ethics and behaviours should be followed in the health organizations. As we stated previously, AHPS are characterized by collaborative and transformational styles, because these style of leadership often adopt openness; either by communication, the character of leader, or preparing and rehabilitation team members theoretically, technically, socially and personally.

*Question Number Ten*

It can be revealed from the literature in the fourth chapter; the Jordan experience in clinical leadership that this concept has been taught in clinical faculties for both graduate and undergraduate studies through different modules. These modules concentrated on some several aspects such as communication, the behaviour of leaders and followers, code of ethics and standards of ethics and quality assurance in addition to managerial skills in health sector and hospitals in particular. Furthermore, clinical associations have a good role in supplying the health professionals with international standards and organising the health care work as well as providing the guidance of ethical codes .USID has also a significant role in diagnosing the real setting of both health professionals and the managerial story in Jordanian hospitals. This international commission was trying to match the international standards regarding health care service in most clinical and managerial approaches

*Research Objectives:* The main aim of this study has been showed that the cognitive authorities and positions power that doctors enjoyed has made them leaders and managers more than other nurses and AHPS. We concluded that the leadership style in general is almost out of transformational style to take the varying degrees between the trait theory and transactional.

The first objective represented by the extent of clinicians' application to the concepts of clinical leadership (CL) in Jordanian hospitals .It seems that cognitive and technical reality of professions are not necessarily qualify them to lead Jordanian hospitals or giving them an important positions. Even they have administrative qualifications along with technical training; this is due to the un-fair authorities' distribution between clinicians and other. We found when we talked about the second objective that the common authority among clinicians is position or rank

authority, despite development of experiences and knowledge, and this exist among all clinician. Also, the discussion of the third objective revealed that there is a difference between clinicians' behaviours as managers, who adopt centralism when they make orders. Unlike, nurses and AHPs prefer the openness in communication among them in order to strengthen their personal and technical relationship. Hence, nurses and AHPS are characterized by transformational style more than doctors who have the sense of leading role in technical and managerial process (trait theory).

### **7.15 Summary and a New Model**

Jordanian clinicians have not involved within the transformational concept, because curriculum is insufficient to construct the concepts of quality, ethics and communication. In general, clinical leaders are characterized as being within trait theory as they seek to meet their personal needs, positions rather than concerning of hospitals goals and surrounding community. The clinical culture in Jordanian hospitals doesn't seriously take into account the relations with communities and organizations around the hospital to acquire new expertise. For example, the culture sense and diversity in terms of individuals' experience, process, goals and visions is not clearly seen. There is a sense of optimism for clinicians' rehabilitation at Jordanian hospitals in regards of technical setting, as there is mutual arrangement among the faculties of management, medicine and clinical in general, which make clinicians to work within teamwork concept.

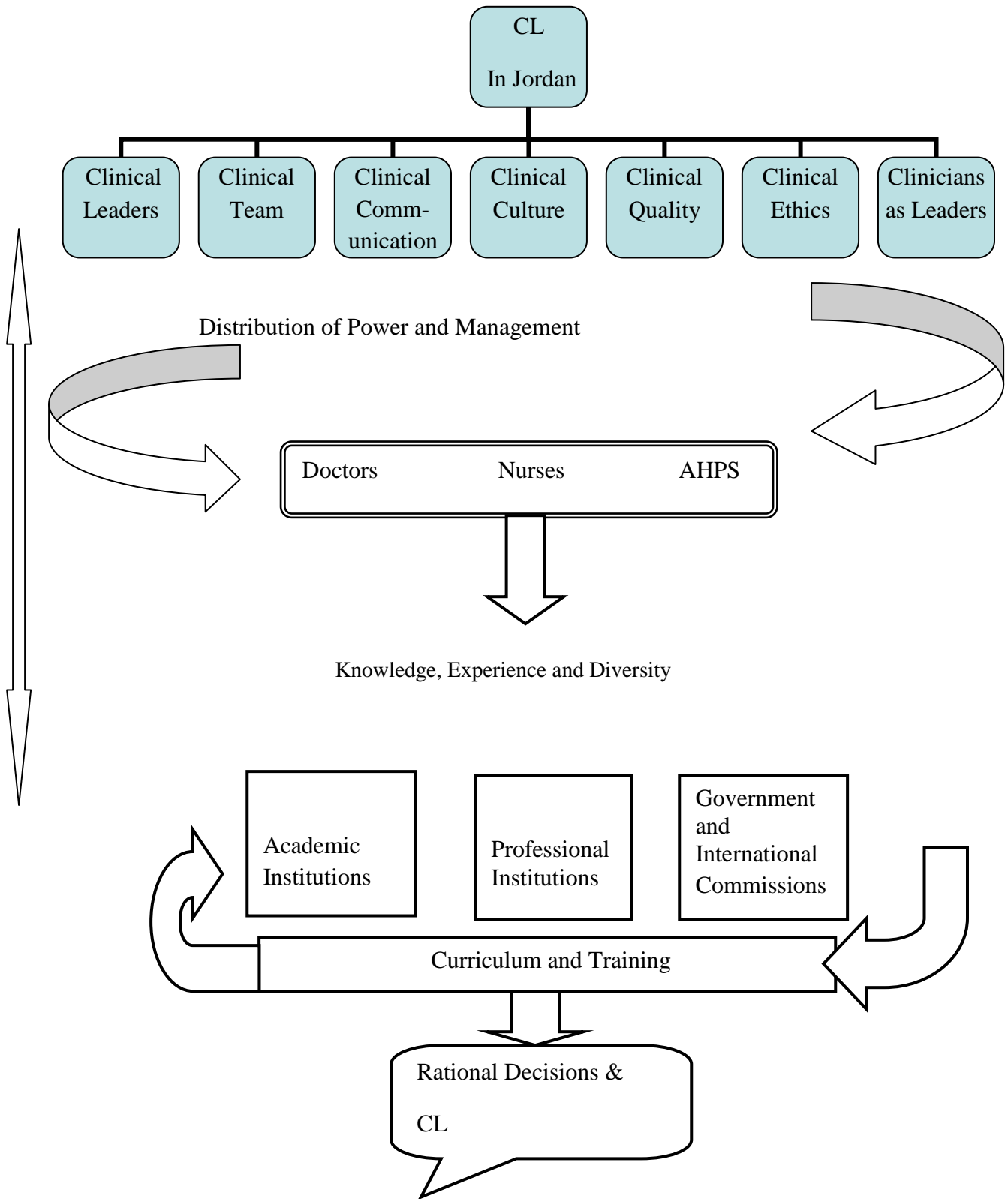
The clinical communication concept in Jordanian hospitals can be characterized as being governmental and bureaucratic at the same time by focusing on both formal and written settings. On the other hand, both quality and ethics concepts are not competitor, namely they didn't constitute key significant in Jordanian hospitals, because such hospitals didn't set guidelines, rules, and concepts. For example, they lack for an obvious diversity at medical and clinical committees but most of them are doctors who work for the benefit of hospitals, taking into

account that they are decision-makers. Accordingly, CL in Jordanian hospitals has been contributed to make doctors as leaders who are not high qualified, non-democratic and isolated from nurses and AHPS. They do have the minimal level towards characteristic of diversity concept among their clinical teamwork. On the other hand, clinical leaders of nurses are excluded from having enough powers although they are technically and managerially qualified. At the same time, their colleagues of AHPS lack confidence, because they are forgotten by senior management, universities, curriculum and syndicates. They try to extend their role through focusing on quality and ethical considerations which make them to be among the transformational leadership such as nurses.

The obstacles in Jordanian hospitals could be revealed by weak delegation and lack of understanding among clinical teamwork. Doctors and other health care team contributed to the occurrence of what so-called centralism in decision-making, close communication channels, and losing sight of the cultural concept. Furthermore, lack of training is noticeably affected not to create quality and ethics within an international concept.

As a result, figure 8.12 reveals that CL in Jordanian hospitals could be developed if there was a fair distribution of power amongst clinical members from doctors, to nurses and AHPS. This could be practiced by tackling any differences among hierarchical levels and ignoring the impetus towards centralisation and bureaucracy. For example, ascending communication should be strongly encouraged in order to gain the valuable participation of lower levels in clinical decision making, qualifying them to be leaders one day, not to angle CL to be for top managers only. Furthermore, securing diversity of knowledge and experience, as real and important resources of power should be collaborated with academic, professional and international institutions. That means that CL should be the mutual responsibility of all clinicians according to their different capabilities.

Figure 7.12 New Model of CL According to Jordanian Demand



Also, clinical associations should encourage their followers by enhancing them with both technical management-training courses. In this vein government embodied in MOH is also required to build strong relationship and partnership with international and private sector commissions, to develop clinical quality as a comprehensive concept, and to create a new culture of ethical considerations along with a code of ethics which can be applied. In particular, universities and academic institutions should supply clinical students with highly advanced courses in health service management such as postgraduate studies by building real partnerships with Jordanian hospitals in an attempt to strengthen the exchange of information and create more links between theory and practice.

The next chapter will discuss the conclusions, recommendations and implications and how this research will contribute something valuable to academic research in both managerial and clinical settings.

## **Chapter Eight**

### **Conclusions and Implications**

#### **8.1 Introduction**

This chapter aims to assess the results of qualitative instrument and reveal the main findings and their implications for the research questions and objectives, regarding CL in Jordanian hospitals. This chapter consists of eighteen sections: sections 8.2 to 8.11 discuss the findings and implications of existing factors of CL in Jordanian hospitals. Section 8.12 discusses the obstacles to successful CL and section 8.13 outlines the research contribution that this thesis constitutes. Research limitations and directions for further research are discussed in sections 8.14 and 8.15, respectively. Suggestions and recommendations for the future development of CL in Jordanian hospitals are explained and discussed in section 8.16. Finally, summary and conclusion are presented in the last section, 8.17.

#### **8.2 Findings and Implications of CL concept**

CL in Jordanian hospitals is considered to be new in Jordan. Moreover, administrative authorities are restricted to doctors who are normally the hospitals' general managers. Therefore, it is not possible to involve nurses and AHPS in administrative positions and clinical decision, and this leads the management to lose diversity.

In fact, the government departments represented by MOH and other relevant organizations such as professional unions and clinical faculties have not been able to provide a clear concept of CL. This is because the absence of real coordination between these bodies and hospitals. Thus, the concept of classical management has been widely known in Jordanian hospital more than the leadership concept that was discussed earlier in this thesis.

International agencies, such as USAID, have tried to disseminate the concept of health services management, but it was difficult due to some obstacles regarding knowledge and experience. For example, the culture in Jordanian hospitals is a complicated process needs to have some tangible changes regarding power and legislations as well as professional behaviours.

### **8.3 Findings and Implications of Clinical Leaders**

Clinical staff is highly qualified with regards to the clinical settings, which earned them a high international reputation. Clinicians in Jordanian hospitals lack administrative qualifications, despite their high level of academic achievement. Most of the agenda and objectives concern medical and clinical rehabilitation, rather than administrative qualifications. Despite the apparent activity of international agencies, MOH and clinical faculties have no real high-impact on clinical staff advancements or administrative settings. Accordingly, great conflicts between doctors and other clinicians in Jordanian hospitals due to bureaucratic and centralism approaches as well as the old culture granting more power to doctors and denying this to staff working at other levels.



However, it seems difficult to apply the transformational style in Jordanian hospitals due to the bad distribution of power and authority among clinicians and doctors in particular. It was also noted that individual considerations are simply presented in Jordanian hospitals, as there is a minimal level of considerable interests for individuals. For example, most clinicians come to hospitals to perform their clinical duties with no respect to their knowledge and experiences, this makes intellectual stimulation almost impossible. This leads to frustration of their ambition and enthusiasm ignoring the concept of inspirational motivation.

#### **8.4 Findings and Implications of Clinical Team**

Clinicians have not succeeded in the common values between clinical team members, which would establish a culture of teamwork. Although the MOH is striving to rehabilitate the clinical team who have considerable knowledge but it has not been able to accurately acquire them the spirit of shared responsibility. This is due to fear of responsibility. Accordingly; they are far away somewhat from the transformational style that believes in a culture of team spirit, fair distribution of authorities, delegation, and individual considerations to the teamwork. Therefore, the transactional style is the dominant concept in Jordanian hospitals because it is closer to adopting the concept of reward and punishment and giving orders.

Unfortunately, the output from Jordanian universities does not fit with Jordanian hospitals' requirements from the administrative setting. Jordanian universities only

focused on the clinical rehabilitation more than the administrative, social, behavioural and psychological setting. This is contrary to western hospitals, which often combine academic and applied sciences. One of the positive concepts practiced by the Jordanian hospitals is that seniors at the different medical departments, have full responsibilities in the training of fresh employees from juniors, and this is indicative of the spirit of uniform teamwork who believes that followers may one day become leaders.

### **8.5 Findings and Implications of Clinical Culture**

Jordanian hospitals failed to create a system of professional ethics and public morals that govern the clinical and managerial work of the clinical team. Health systems in Jordanian hospitals could not get rid of authority misdistribution, forgetting that these are the main principles that form culture of the health work.

The respect of regulations, laws, traditions and customs of the surrounding communities is not of a great importance to clinicians; their concerns are stressed upon clinical issues rather than cultural ones. Thus, doctors, the managers of governmental hospitals control the hospital's culture; they are biased for their authorities, disregarding other cultural factors. Jordanian hospitals lack cultural diversity in language, race, religion and colour, this weakens the provided medical services. Jordanian hospitals dedicated its effort to keep up with globalization and international criteria as for managerial and clinical performance.

Codes of ethics do not exist as a precise and clear agenda in reality; however, they do exist in theoretical settings and managerial courses taught to clinicians, along with quality

requirements. Clinicians highly respect each other, because of their respect to the society's values that are based on religious and national tolerance. This respect does not generate from the effective laws and regulations or hospitals' codes of ethics.

Leadership in Jordan seems to be responsible and follower, order and execution, manager and employee, supervision and punishment. In fact, CL in Jordan tries to eliminate randomness and works hard to adopt leadership that believes in everyone should assume the responsibility of achieving the hospitals' visions and goals .

### **8.6 Findings and Implications of Clinical Communication**

Communication channels in Jordan are sort of acceptable; because technical and personal settings among clinicians merge together. Clinicians prefer personal communication as it reinforces their technical relationships, in a way that written communication does not. In fact, informal communications are not less important than the formal ones; both of them help in achieving goals. Clinicians state that formal communications are not enough to perform technical and managerial tasks.

Clinicians prefer open communications, according to the interviews conducted with them. They would like to build a clinical team that assume responsibility and eliminate any vagueness or ambiguity concerning medical and technical information. For example, there is still randomness in Jordanian hospitals with regard to uniting the medical information net concerning doctors, nurses, pharmacists, departments' issues, X-ray

radiography, labs results. Jordanian hospitals are criticized for the increased bureaucracy, creating managerial differences among different professional levels. For instance, doctors are still isolated technically and socially from other nurses and AHPS. On the other hand, nurses and AHPS have open communications with all managerial levels as they have wide and strong relationships that enable them to obtain medical information easily and smoothly.

In general, Jordan is like any other country in the world; it needs education and training in clinical communication as long as centralism and bureaucracy spread over medical industry in the world.

### **8.7 Findings and Implications of Clinical Quality**

Jordanian hospitals are severely criticized for incomprehensive quality. Clinical quality is important and should include managerial, ethical, social and cultural approaches. Unfortunately, Jordanian universities fail to teach management modules with stressing upon comprehensive quality in clinical settings at bachelor, master and PhD approaches.

As a result, USAID in cooperation with MOH have worked hard but disregard comprehensive quality and centralize its attention on the standards and basics of clinical tasks. On the other hand, clinical associations in Jordan showed their interest in connecting medical services employees with the concept of quality but under the laws, regulations, and instruction that govern the association and the clinical professions'

procedures and policies. Quality is criticized severely because Jordanian hospitals apply quality concepts in order to achieve international standards. In general, private hospitals in Jordan adhere to quality standards in the clinical and managerial settings for commercial goals. Moreover, clinicians sometimes adhere to quality standards because they fear laws and punishments and there is no special agenda or a checklist concerned with quality standards. But in reality quality needs establishments that patronize culture besides academic, professional, and social settings.

### **8.8 Findings and Implications of Clinical Ethics**

The absence of the ethics concept as a system is noticed in Jordanian hospitals because law and regulations are still the most influential. Unfortunately, the failure of universities and medical schools to mention the ethical settings in the modules being taught to clinician. They mostly focus in technical settings rather than moral or social ones.

It has become clear in this research that functional, technical and managerial differences among clinicians are due to the loss of ethical setting. In fact, there is no comprehensive standard for the functional ethics in Jordanian hospitals, including the economic, behavioural, administrative, clinical and psychological settings. The reason for this is also due to obvious evasion by MOH decision makers. They are so keen on the distribution of authorities among themselves rather than being concerned with the distribution of responsibilities such as ethical considerations, which are often stronger than the force of law. However, there are serious and commendable attempts by Jordanian hospitals to

institute ethical committees embodied in written ethical system to be complied with laws and regulations. It was also noticed that AHPS are more attached to the scientific demands than others in terms of accurate diagnosis, coupled with the quality and ethics. Generally, the concept of ethics exists in Jordanian hospitals but not as a professional sense, because it does not exist in written agendas

### **8.9 Findings and Implications of Doctors as Leaders**

It was difficult for doctors to carry out two types of responsibilities at the same time. Unfortunately, the medical decision-makers in MOH that assigning doctors as managers will cause to lose them as surgeons and practitioners. At the same time, it is difficult for MOH to recognize that non-medical individuals to become managers in the hospitals. In Jordanian universities, we find that there are very few modules, not exceed two or three, in which doctors can gain administrative awareness and skills required to lead the teamwork in hospital. Hence, USAID efforts to qualify doctors in administrative issues were also insufficient. Also, it is noticed that professional syndicates do not provide efforts for doctors' rehabilitation in the administrative settings, as to be limited to some routines such as retirement and the charging of fees.

It can be concluded that doctors refuse to assign assistants from nurses and AHPS because that would give them more powers, and this is what doctors try to avoid. In spite of this, we find that these assistants hold high academic qualifications such as master and PhD degrees, such qualifications are related to the management of medical services for

example. Unfortunately, these assistants are excluded from crucial decisions because they threaten the existence of doctors as managers and decision makers. We cannot deny that doctors have a lot of knowledge, culture and awareness to the needs of hospital and community more than other. This does not mean to make them managers as such positions influence the strategy and plans of Jordanian hospital. In fact, we find that doctors have separated themselves socially from other nurses and AHPS because of the weakness in social relations and communication.

As a result, it seems that doctors' personality in the management and leadership is dominated by the concept of bureaucracy and centralism. They are almost closer to the trait theory and more concerned of information, physical and personal matters rather than the effect by common goals and visions.

### **8.10 Findings and Implications of Nurses as Leaders**

In spite of their high rehabilitation, nurses don't prove their success as administrators because of doctors' power. Unfortunately, nursing faculties and applied sciences don't make them leaders and administrators responsible for decision-making. They are still supervisors being far from strategies

It has become clear thorough this study analysis that Jordanian nurses have lost their confidence of themselves; because they do not have sufficient powers. However, international organizations such as USAID have sought to consider this issue by

confirming the need of CPD units responsible for galvanizing nurses with administrative skills and critical settings such as professional ethics, diversity of experiences and culture.

Nurses are more aware of CL because of the sensitive modules and academic disciplines which is taught at their universities and training institutions and international conferences held in international and Jordanian universities in order to discuss CL topics and management of hospitals. Also, the professional syndicates concerned of nurse in several issues such as technical, but seem very weak when it comes to administrative support and leadership.

As a result, the identity of nurses in Jordanian hospitals is considered democratic and effective within the concept of nursing and relationship with others from doctors and AHPS. This leads to open channels of communication and strengthen the formal and informal setting to become merged in achieving the goals of the hospital simplicity and easily. Therefore, the transformational leadership is the closest concept to the nursing management, because of the ethical considerations and open communication in addition to several things such as attention to the quality concept, achievement of common goals and visions within the clear framework adopted in calm clinical situation.



### **8.11 Findings and Implications of AHPS as Leaders**

AHPS are deprived somehow from their rights, in spite of their importance in primary diagnose. It is noticeable that their authorities are less than the doctors' and nurses' due to the fact that Jordanian universities and professional associations failed to prepare and qualify these entities to be leaders and managers. AHPS showed some transformational sense thorough open communication and respecting their colleagues' expertise and knowledge .This makes them closer to transformational leadership that believes in motivating individuals and valuing their efforts. Unfortunately, their relationships with doctors are not subjective, but a relation based on fear from punishment and professional rank, as it is in nurses' case.

AHPS feel that they are just employees and technicians like any other non-clinicians. They do have great importance in achieving quality standards that hasten hospitals accreditation. In other words, these AHPS feel as if they were passive individuals, whom the other doctors seek to have their promotions and the high positions they deserve to be seizing. Also, their associations are managerially weak as well; these associations do not support them in having authorities, but restricted to arranging the profession issues,

### **8.12 Findings and Implications of CL Obstacles**

Doctors are the biggest obstacle to achieve the concept of CL in Jordanian hospitals by holding the whole power and ignoring the real sense of delegation .Also, communication

channels with other departments and among colleagues are weak; this causes considerable gaps in hospital management. Thus, there are some problems in the transition of administrative and medical information when providing medical services to patients due to the centralism.

Regarding the clinical culture in Jordanian hospitals, these hospitals did not reach the creation of cultural system to take into account the habits, traditions, religion; language and cultural diversity. In addition, there is no real partnership between the private sector and local community represented by universities, worship institutions and professional syndicates to strike a cultural balance between Jordanian hospitals and Jordanian society. Furthermore, the absence of written guidelines is highly problematic, especially the ethical considerations, which lead to make law and instructions are the only reference. As well as the absence of ethical bodies and committees in the full sense of the word, that aimed to link clinical procedures and administrative policies. Such committees are only designed to restrict medical errors and play a role of police. Also, the quality considerations are often not for the quality development in technical and administrative but in order to obtain international quality certificates.

Indeed, the dominant styles in these hospitals are transactional and trait theory, because doctors are proud of their knowledge regardless other colleagues' experiences such as nurses and AHPS as well as non-clinicians. Unfortunately, Jordanian MOH has a noticed mistake by giving doctors critical positions such as managers who have insufficient administrative qualifications.

## **8.13 Contribution of Research to Knowledge**

### **8.13.1 Academic Contribution**

The leadership concepts and theories such as transformational have been existed in clinical sector. These concepts are the team work concepts, culture, communication channels, quality and ethics to be practiced by clinicians in different power and position to provide adequate health service. This study is rare; it could merge leadership concepts for clinicians to perform roles they were not used to do before besides their original roles embodied in health care.

As a result, this study presented a new mass of knowledge by considering that quality and codes of ethics are additional and important headings to shape CL. Furthermore, the diversity of clinical team members may give the real sense of leadership to be considered as the uniform of such critical sector which provides health for all. Also, the study has indicated that the fairness of power distribution may reveal the effectiveness of team work by creating the comprehensiveness of work culture

### **8.13.2 Managerial Contributions**

The study proved that there are additional authorities that enrich work progress in organizations, other than the authority of position, law and work. The one teamwork share these authorities and all experiences are considered as a concrete mass. These things can make sound decisions based on the culture of diversity.

### **8.13.3 Clinical Contributions**

This study introduces the management needs at Jordanian hospitals by creating responsible clinicians in both clinical and administrative missions such as doctors, nurses and AHPS. In reality, this study considered the concepts of ethics and quality as real elements that contribute to health service industry. Jordanian hospitals cannot reach the level of health services in western countries unless the culture of the Jordanian hospitals is respected and doing away from some pathogenic behaviours such as personal interests, corruption and favouritism.

### **8.14 Limitations**

The main limitation in this study is the severe shortage of Jordanian academic setting such as publications and dissertations. The researcher faced another limit; the insufficiency of policies, agendas, monthly-quarterly and annually reports discussed the reality of Jordanian hospitals, which necessitated him getting help from the international agencies such as USAID, as well as the records of MOH .

Actually, when we conduct this study in critical places such as hospitals, some thought that there was an investigation by the researcher in order to know the clinical efficiency rather than administrative one. Some of clinicians felt some fears and anxiety when they conducted the interviews, as they thought that these explanations and analysis of such study will reach their managers. Also, this study did not include non-clinicians point of

view such as manager–assistant, accountants, workers in personnel affairs, maintenance, transportation, engineering, security and other.

### **8.15 Directions for Further Research**

Future researchers might wish to cover some of the issues that I was not able to include. Therefore, more studies are required such as the effectiveness of doctors in managing hospitals and clinical sectors. More research is required to make effective comparisons between clinicians and non-clinicians and the effectiveness of management and CL. Nursing leadership as a separate topic should also be investigated due to the large number of nurses in the clinical body. The role of professional and academic institutions should also be investigated to explore to what extent their participation is needed to create successful CL. Finally, a comparative study should be made that examines the differences between CL and the effectiveness of the health service management in developing countries and highly developed ones.

### **8.16 Recommendations and Suggestions**

After having the analysis of data and obstacles in this study, some more suggestions are required to put out protocols and guidelines for laws, regulations, legislation and job titles for clinicians and administrators. These guidelines and protocols may include quality and ethical behaviours for procedures and policies in technical, administrative, and social approaches.

It is noticeable that powers and authorities is limited to doctors and senior management, Therefore, nurses and AHPS have the rights to practice powers in clinical atmosphere. This requires some tangible efforts between Jordanian hospitals, MOH, clinical faculties, and clinical unions'. Hence, clinical faculties and health professions in order to create the sense of CL. Also, the experience of western countries is recommended to be used and adopted in Jordanian hospitals to fill some administrative gaps such as clinical governance. In addition, the concept of communication skills is almost weak between clinicians themselves and managements; therefore mutual efforts are required from clinical and managerial as well as educational institutions to fill such important element

Moreover, doctors need to be trained and rehabilitated to carry out the administrative affairs of hospital through the appointment of administrative assistants of nurses and AHPS to ensure the distribution of power and diversity and the creation the teamwork concept .Finally, the cultural system in Jordanian hospitals should absorb the community culture by respecting laws and regulations as well as norms, language and religion that are good reasons for health care development.

### **8.17 Summary and Conclusion**

CL concept in Jordanian hospitals is considered new because there is a lack of powers distribution due to centralism and bureaucracy. The concept of clinical communication is almost acceptable because of the balance between the formal and informal setting. Nevertheless, both concepts of quality and ethics are not at the required level by the clear

default to the scientific institutes and clinical unions. Doctors showed non-democratic sense due to the real support from MOH making them to behave in trait theory. However, nurses and AHPS behave in transformational.

The study recommended that the managerially and technical rehabilitation for all clinicians is very important, by linking behaviours, processes, protocols, and guidelines together in an attempt to have the real concept of CL

## **References**

- Abbot, A. (1988), "The System of Professions", the University of Chicago Press, USA
- Abdelhalim, A. and Adwan, Y. (1997), "Factors Associated with the Patient Satisfaction for Services Provided by Hospitals in Jordan", *Al-Yarmouk Researchers* 13 (1), Irbid – Jordan
- Abu-Gharbieh, P. and Suliman, W. A. (1996), "The Role of the Baccalaureate-Prepared Nurses in Jordan: Perspective of Head Nurses, Physicians and Nurses Educators", *Dirasat, Medical and Biological Science*, Vol. 23, No. 1, University of Jordan.
- Abu-Moghli, F. (2006: a), "Clinical Master Programme, Specialised Nursing: Ethics and Roles", Course Syllabus, Faculty of Nursing, University of Jordan, Amman - Jordan.
- Abu-Moghli, F. (2006: b), "Management and Leadership", Course Syllabus, Faculty of Rehabilitation Sciences, University of Jordan, Amman- Jordan
- Abu-Moghli, F. and Zu'mot, A. (2006: a), "Nursing Management and Leadership Module", Faculty of Nursing, The University of Jordan, Amman – Jordan
- Akhlaghi, F. and Mahony, L. (1997), "Service Integration and Multi - Skilling in Facilities Lanagement within the National Service Facilities", Vol. 15, No. 3, pp. 66-71
- Al Qutob, R. (2006), "Health Service Management", Course Syllabus, Faculty of Medicine, University of Jordan, Amman – Jordan
- Al-Ajeel, M. (1998), "Levels of Job Stress among Staff Nurses: Comparative Study Between Ministry of Health Hospitals and Private Sector Hospitals", Thesis, University of Jordan, Amman - Jordan
- Al-Gazi, A. (1995), "Job Satisfaction among Nurses and Physicians in Hospitals and Health Centres", Jordan University for Science and Technology Thesis, Irbid - Jordan
- Allen, D. (1995), "Doctors in Management or the Revenge of the Conquered: The Role Of Management Development For Doctors", *Journal Of Management In Medicine*, Vol. 9, No. 4, pp. 44-50.
- Al-Maryat, A. (2000), "Management by Objectives", Ministry of Health, Health Directorate of Al-Tafila, Jordan
- Al-Shalabi, F. (1999), "Level of Medical Services Provided in Jordanian Government Hospitals: An Evaluation Study from Physicians Perspective", Master Thesis, Al-Yarmouk University Irbid – Jordan, Amman –Jordan.



- Aluise, J., Schmidt, C., Bland, C. and McArtor, R. (1989), "Administrative Skills for Academy Physicians", *Journal of Health Education Training*, Vol. 4, No.1, pp. 7-13.
- Alwan, A. (2005) "*Health in Jordan*", WHO, Amman- Jordan
- Anderson, H. C. (1994), "Teamwork Brings TQM to Healthcare", *Managing Service quality*, Vol. 4, No.1, pp. 35-38
- Andersson, A., Vimarlund, V. and Timpka, T. (2002), "Management Demands on Information and Communication Technology in Process Oriented-Health Organization", *Journal of Management in Medicine*, Vol. 16, No. 2, pp. 159-169.
- Armandi, B., Oppediasano, J. and Sherman, H. (2003), "Leadership Theory and Practice: a Case in Point", *Management Decision Journal*, Vol. 41, No. 10, pp. 1076-1088.
- Ayoko, O.B and Callan, V.J, (2010), "Teams' Reactions to Conflict and Teams' Task and Social Outcomes: the Moderating Role of Transformational and Emotional Leadership", *European Management Journal*, Vol.28, No.3, pp 220-235.
- Babbie, E. (1998), "The Practice of Social Research", Wadsworth Publishing Company, USA
- Bailey, R. (2008), "Design of Comparative Experiments", Cambridge University Press.
- Bamford, D and Griffin, M (2008) A Case Study into Operational Team -Working within a UK Hospital, *International Journal of Operations and Production Management*, Vol. 28, No.3, PP.144-3577
- Banjerji, P. and Krishnan, V. (2000), "Ethical Preferences of Transformational Leaders: An Empirical Investigation, *Leadership and Organization Development Journal*", Vol. 21, No. 8, pp. 45-413.
- Banks, D. A., Ghannoum, R., Sayaideh, A. S. K., Shafei, A. R. S. H. and Brosk, H. (2000), "Implementing Hospital Autonomy in: Changing MOH Operating Procedures, Partnership for Health Reform", USAID, Amman – Jordan.
- Bass, B. M. (1960), "*Leadership, psychology and organizational behaviour*", Harper and Brothers, New York, USA
- Bass, B. M. (1985), "*Leadership and Leadership Beyond Expectation*", Free Press, New York, USA
- Bass, B. M. and Avolio, B. J. (1994), "*Improving Organizational Effectiveness through Transformational Leadership*", Sage, Thousand Oaks, CA
- Bedeian, A. G. (1986), "*Management*", CBS College Publishing, USA.
- Bedeian, A. G. (1986), "*Management*", Dryden Press, USA

- Bell, L (2007) "Training Managers Constructing their Identities in English Health and Care Agencies", *Equal Opportunities International Journal*, Vol.26, No.4, PP.287-304.
- Bergman, D. Fransson-Sellgren, S. Wahlstrom, R. and Sandahl, C., (2009), "Healthcare Leadership Impact of Short-Term Intensive and Long-Term Intensive Training Programmes", *Leadership in Health Services*, Vol. 22, No. 2, pp. 161-175.
- Bryman, A and Bell, E (2003) "*Business research Method*", Oxford University Press, New York, USA.
- Bem, C. (2001), "Moral Sensibility and Ethics", No. 173, pp. 20-24.
- Bennis, W. and Nanus, B. (1985), "*Leaders*", Harper and Row Publications, New York, USA
- Bettinger, C. (1989), "Use Co-operate Culture to High Performance", *The Journal of Business Strategy*, Vol.23, No.2, pp.84-113
- Bezzina, M. B., Fischer, L. B., Harden, L., Perkin, K., Walkar, D., (2001).
- Block, L.A.M and Manning, L. (2007), "A Systematic Approach to Developing Frontline Leaders in Health Care", *Leadership in Health Services*, Vol.20, No.2, pp.85-96
- Boldon,R. (2011) " Distributed Leadership in organizations: A Review of Theory and Research", *International Journal of Management Review*", Vol.13, No.3, pp 251-269.
- Bolton, S. C. (2003), "Multiple roles? Nurses as Managers in the NHS", *the International Journal*, Vol. 16, No. 2, pp. 122-130.
- Bono,J., Hooper, A.C and Yoon,D.J (2011) "Impact of Rater Personality on Transformational and Transactional Leadership Rating", *The Leadership Quarterly*, Vol.23, No.1, pp 132-145.
- Bradley, E. H., Holmboe, E. S., Mattera, J. A., Roumanis, S. A., Radford, M. J., and Krumholz, H. M. (2003), "The Roles of Senior Management in Quality Improvement Efforts: What Are the Key Components?", *Journal of Health Care Management*, Vol. 48, Issue 1, pp. 15-21.
- Brazier, D. K. (2005), "Influence of Contextual Factors On Health-care Leadership", *Leadership and Organization Development Journal*, Vol. 26, No. 2, pp, 128-140
- Brooks, I. (1997), "Leadership of a Cultural Change Process", *Health Manpower Management*, Vol. 23, No. 4, pp. 113-119.

- Brown, B.A., Harte, J. and Warnes, A.M. (2007) "Developing the Health Care Workforce: A Comparison of Two Work- Based Learning Models", *Education and Learning Journal*, Vol.49, No.3, PP.193-200.
- Bryman, A. (1986), *"Leadership and Organizations"*, Routledge and Kegan Paul PLC, USA
- Buchanan, D., Caldwell, R., Meyer, J., Storey, J. and Wainwright, C. (2007) "Leadership Transmission: A muddled Metaphor", *Journal of Health Organization and Management*", Vol.21, No.3, PP.246-258.
- Buchanan, D., Jordan, S., Preston, D. and Smith, A. (1997), "Doctor in the Process", *Journal of Management in Medicine*, Vol. 11, No. 3, pp. 132-156.
- Burke, R. J. (2004), "Implementation of Hospital Restructuring and Nursing Staff Perception of Hospital Functioning", *Journal of Health Organization and Management*, Vol. 18, No. 4, pp. 279-289.
- Camilleri, D. and O'callaghan M. (1998), "Comparing Public and Private Hospital Care Service Quality", *International Journal of Health Care Quality Assurance*, Vol. 11, No. 4, pp. 127-133.
- Capper, S. A., Ginter, B. M. and Swayne, L. E. (2002), *"Leadership Management"*, Sage Publications, California, USA
- Carmeli, A., Schaubroeck, J. and Tishler, A. (2011), "How CEO Empowering Leadership Shapes Top Management Team Processes: Implications for Firm Performance", *The Leadership Quarterly*, Vol.22, No.2, pp 399-411.
- Carter, M. and Klugman, C., (2001), "Cultural Engagement in Clinical Ethics", *Cambridge Quarterly in Health Care Ethics*, Vol. 10, No. 1, pp. 16-31.
- Caza, B.B, Tiedens, L. and Lee, F. (2011) "Power Becomes You: The Effects of Implicit Power on the Self", *Organizational Behavior and Human Decision Processes*, Vol.114, No.1, pp 15-24.
- Cho, J. and Dansereau (2010) "Are Transformational Leaders Fair? A Multi-Level Study of Transformational Leadership, Justice Perceptions, and Organizational Citizenship Behaviors", *the Leadership Quarterly*, Vol.21, No.3, pp 409-421.
- Chrispin, P. (1996), "Decisions, Decisions", *Journal of Management in Medicine*, Vol. 10, No. 6, pp. 42-49.
- Clark, J and Armit K (2008) "Attainment of Competency in Management and Leadership" , *Clinical Governance: An international Journal* Vol.13, No. 1, PP 1477-7274.

- Cohen, A. and Kol, Y. (2004) "Professionalism and Organizational Citizenship Behaviour", *Journal of Managerial Psychology*, Vol. 19, No. 4, pp. 386-405.
- Cole, M., Bedeian, A.G and Bruch, H. (2011) "Linking Leader Behavior and Leadership Consensus and Dispersion Models of Group Composition", *The Leadership Quarterly*, Vol. 22, No. 2, pp. 383-398.
- Conant, G. and Kleiner, B. H. (1998), "Human Resource Management in the Health Care Industry", *Health Manpower Management Journal*, Vol. 24, No. 3, pp. 114-118.
- Cooney, J. P, Landers, G. M. and William, J. M. (2002), "*Hospital Executive Leadership: a Critical Component for Improving Care at the End of Life*".
- Cooper, A.M and Palmer, A. (2000) "*Mentoring Preceptors and Clinical Supervision*", Blackwell Science, USA
- Cope, J., Kempster, S. and Parry, K. (2011), "Exploring Distributed Leadership in the Small Business Context", *International Journal of Management Review*", Vol. 13, No. 3, pp 270-285.
- Cranwell-Ward, J, Bacon, A. and Maakie, R (2002), "*Inspiring Leadership*", Thompson, London
- Creswell, J. W. (2003), "Research Design, Qualitative and Quantitative Approach", Sage Publications, UK
- Cummings, G.G, MacGregor, T., Davey, M., Lee, H., Wong, C.A., Lo, E., Muise, M. and Stafford, E. (2010) "Leadership Styles and Outcomes Patterns for the Nursing Workforce and Work Environment: A Systematic Review", *International Journal of Nursing Studies*, Vol. 47, No. 3, pp 363-385.
- Currie, G. and Lockett, A. (2011) "Distributing Leadership in Health and Social Care: Concertive, Conjoint or collective?", *International Journal of Management Review*", Vol. 13, No. 3, pp 286-300.
- Cutcliffe, J, R., Butterworth, T. and Proctor. (2001) "*Clinical Supervision*", Routledge, London
- Daft, R.L (1999) "*Organisational behaviour*", Harcourt, Inc, USA
- Damiani, A. S. M. (1998), "*Great Leadership*", CRC Press, USA
- Davies, C. L. and Walley, P. (2002), "Quality of Care: Replacing or Removing Ineffective Services", *International Journal of Health Quality Assurance*, Vol. 15, No. 1, pp. 124-129.

- DeChurch, L.A., Hiller, N.J., Murase, T., Doty, D. and Salas, E. (2010) "Leadership Across Levels: Levels of Leaders and Their Levels of Impact", *The Leadership Quarterly*, Vol.21, No.6, pp. 1069-1085.
- Department of Health (2000), *"The NHS Plan, A Plan for Investment, A Plan for Reform"*, DOH, London
- Department of Statistics (2004), "Jordan in Figures", Amman – Jordan
- Department of Statistics (2005), "Employment and Unemployment Survey", Amman – Jordan.
- Dexter, D and Prince, C (2007) Evaluating the Impact of Leadership Development, *Journal of European Industrial Training*, Vol.31, No.8, PP609-625
- Dierendonck, D. V., Leblanc, P. M. and Preukelen, W. V. (2002), "Supervisory Behaviour, Reciprocity and Subordinate Absenteeism", Vol. 23, No. 2, pp. 84-92.
- Durbin, A. J., (1988), *"Idiots Guide to Leadership"*, Alpha Books, New York, USA.
- Dussault, G. Codjia, L. Kantengwaga, K. and Tulenko, K., (2008), "Assessing the Capacity to Produce Health Personnel in Rwanda", *Leadership in Health Services*, Vol. 21, No. 4, pp. 290-306.
- Edwards, G. (2011) "Concepts of Community: A Framework for Contextualizing Distributed Leadership", *International Journal of Management Review*", Vol.13, No.3, pp 301-312.
- Emanuel, L. L. (2000), "Ethics and the Structures of Health Care", *Cambridge Quarterly Health Care Ethics*, Vol. 9, No. 2, pp. 151-166.
- Englmaier, F., Filipi, A. and Singh, R. (2010) "Incentives, Reputation and the Allocation of Authority", *Journal of Economic Behavior and Organization*, Vol.76, No.2, pp 413-427.
- Etzioni, A. (1962), *"Complex Organizations"*, Holt, Rinehart and Winston, Inc, USA
- Faculty of Nursing (2006), "Philosophy and Vision", The University of Jordan
- Fast, N.J., Sivanathan, N., Mayer, N.D and Galinsky, A.D, (2011) "Power and Overconfident Decision-Making", *Organizational Behavior and Human Decision Processes*. Vol.117, No.2, pp. 249–260.
- Fiedler, F (1967) *"A Theory of Leadership Effectiveness"*. John Wiley Press and Sons, Inc, Canada

- Fisher,R.J, Gregoire,Y., Murray,K.B, (2011) "The Limited Effects of Power on Satisfaction with Joint Consumption Decisions", *International Journal of Project Management*, Vol.21, No.3, pp. 277-289.
- Fitzsimons,D., James,K.T and Denyed,D. (2011) "Alternative Approaches for Studying Shared and Distributed Leadership", *International Journal of Management Review*", Vol.12, No.3, pp 313-328.
- Forbes, T., Hallier, J and Kally, L. (2004) *Doctors as Managers: Investors and Reluctant and A Dual Role*. *Health Service Management*, Vol. 17, pp. 167-176.
- Fox, M. D., McGeE, G. and Caplan, A. (1998), "Paradigms for Clinical Ethics Consultation Practice", *Cambridge Quarterly Health Care Ethics*, Vol. 7, No. 3, pp. 308-330.
- Freidson, E. (1986), *"Professional Powers"*, University of Chicago Press, USA.
- Gaughan, A. C. (2001), "Effective Leadership Behaviour: Leading the Third Way from a Primary Care Group Perspective", *Journal of Management in Medicine*, Vol. 15, No. 1, pp. 67-94.
- Gent, L., Parry, A. E. and Parry, M. E. (1998), "The High Cooperation Hospital Project Team", *Team Performance Management*, Vol. 4, No. 6, pp. 253-268.
- Gillespie, N. A. and Mann, L. (2004), "Transformational Leadership and Shared Values: The Building Blocks of Trust" *Journal of Managerial Psychology*, Vol. 19, No. 6, pp. 588-607.
- Glover, I. and Hughes (2000) *"Professions at Bay: Control and Encouragement of Ingenuity in Britain Management"*, Ash gate Publishing Ltd, England.
- Godiwalla, Y. H., Johnson, J. A. Godiwalla, S. Y. and Beta, H. C. (1997), "Managing Hospitals in Dynamic Environment", *International Journal of Health Care Quality Assurance*, Vol. 10, No. 5, pp. 202-207.
- Goodwin, N. (1998), "Leadership in the UK NHS: Where Are We Now?" *Journal of Management in Medicine*, Vol. 12, No. 1, pp. 21-32.
- Goodwin, N. (2000), "Leadership and the UK Health Service", *Health Policy*, No. 51, pp. 49-60.
- Gordon, G. (1985), "The Relationship of Corporate Culture in Industry Sector and Corporate Performance", Jousey-Bass, Oxford
- Greenberg, J. and Barcon, R. A. (2003), "Behaviour in Organization", Pearson Education INC, New Jersey, USA

- Grint, K. (1997), "Leadership, Oxford University Press, New York
- Guo, K. L. (2003), "An Assessment Tool for Developing Health Care Managerial Skills and Roles", *Journal of Health Care Management*, Vol. 48, Issue 6, pp. 367-375.
- Hakim, C. (1987), "Research Design", Unwin Hyman Ltd, London
- Hamric, A. B. (2001), "Ethics development for Clinical Faculty", *Nursing Outlook Journal*
- Hancock, H. (2005), "The Impact of Leading Empowered Organizations (LEO) On Leadership, Development in Nursing, Vol. 18, No. 3, pp. 179-192.
- Hansson, J (2000) "Quality in Health Care: Medical or Managerial", *Managing Service Quality Journal*, Vol. 10, No. 2, pp. 78-81.
- Harahsheh, Kharahsheh, Q. and Shudifat, R. (1998), "The Relationship between the Level of Motivation and the Nursing Care Performance", *Jordan Nursing Journal*, Jordan
- Harris, C., Cortvriend, P and Hyde, P. (2007) "Human Resource Management and Performance in Health Care Organizations", *Journal of Health Organization and Management*, Vol.21, No4/5, pp448-459
- Heiberg, I., Helljesen, G. S. and Kmlnes, J. (2002), "Plus: Leading for Change", *International Journal of Health Care Quality Assurance*, Vol. 15, No. 2, pp. 59-64.
- Hernandez,M., Eberly,M.B, Avolio,B.J and Johnson,M.D. (2011) "The Loci and Mechanisms of Leadership: Exploring a More Comprehensive View of Leadership Theory", *The Leadership Quarterly*, Vol.22, No.6, pp 1165-1185.
- Hewison, A. and Griffiths, M. (2004), "Leadership Development in Healthcare: A Word of Caution", *Journal of Health Organization and Management*, Vol. 18, No. 6, pp. 464-473.
- Holdway, K. and Kogan, H. (1997), *Health Care Management*, Kogan Page Ltd, London
- Hornby, P., Khogaly, A. and Alwan, A. (1998), "Human Resource Development: Report of WHO Assignment", Amman - Jordan
- Horner, M. (1997), "Leadership Theory: Past, Present and Future", *Team Performance Management*, Vol. 3, No. 4, pp. 270-287.
- Hur,Y., and Wilderom,C.P.M, (2011) "Transformational Leadership As A Mediator Between Emotional Intelligence and Team Outcomes", *The Leadership Quarterly*, Vol.22, No.4, pp 591-603.
- Hussey and Hussey (1997), "*Business Research*", Palgrave Macmillan, USA

- Jabnoun, N. and Rasasi, A. J. (2005) Transformational Leadership and Service Quality In UAE Hospitals, *Managing Service Quality Journal*, Vol. 15, No. 1, pp. 70-81
- Jackson, S. (1998), "Organizational Effectiveness within the National Health Service (NHS)", *International Journal of Health Quality Care Assurance*, Vol. 11, No. 7, pp. 216-221.
- Johnson, M. (1997) *"Nursing Power and Social Judgment Justice"*, Ash gate Publishing Ltd, England.
- Jones, M. and Higgs, J (1995), *"Clinical Reasoning in Health Care Professions"*, Butterworth- Heinemann, Oxford
- Jordan Nursing Council (2006:a), "Standards of Accrediting Courses", Amman –Jordan.
- Jordanian Nursing Council (2006,b), "Standards for Institutional Accreditation of Clinical Settings", Amman – Jordan
- Kalra, V., Abel, P., and Esmail, A., (2009), "Developing Leadership Interventions for Black and Minority Ethnic Staff- A case Study of the National Health Service (NHS) in the UK)", *Journal of Health Organization and Management*, Vol. 23, No. 1, pp. 103-118
- Kelloway, E. K., and Barling, J., (2000), "What We Have Learned About Developing Transformational Leaders", *Leadership and Organisation Development Journal*, Vol. 21, No. 7, pp. 355-362
- Kelly, S. E. (2002), "Bioethics and Rural Health: Theorizing Place, Space and Subjects", *Social Science and Medicine*, pp. 1-12
- Kokkinen, L., Konu, A and Viitanen, E. (2007) "Personnel Management in Finnish Social and Health Care, *Leadership in Health Services*, Vol.20, No.3, pp.184-194
- Konu,A and Viitanen, E(2008) Shared Leadership in Finnish Social and Health Care, *Leadership in Health Services Journal*,Vol.21,No.1,PP28-40
- Krishnan, V. R (2003), "Power and Moral Leadership: Role of Self Other Agreement", *Leadership and Organization Development Journal*, Vol. 24, No. 6, pp. 345-351.
- Kruijver, I. P. M., Kerkstra, A., Francke, A. L., Bensing, and J. M. and Wiel, H. (2000), "Evaluation of Communication Training Programmes in Nursing Care", *Patient Education and Counselling*, Vol. 39, pp. 129-145
- Kumar, R. (1996), "Research Methodology", Addison Wesley, Australia



- Kumpusalo, E., Virjo, I., Mattila, K. and Halila, H. (2003), "Managerial Skills of Principal Physicians Assessed By Their Colleagues", *Journal of Health Organization and Management*, Vol. 17, No. 6, pp. 457-462.
- Kunzle, B., Kolbe, M. and Grote, G. (2010) "Ensuring Patient Safety Through Effective Leadership Behavior: A Literature Review", *Safety Science*, Vol. 48, No. 1, pp 1-17.
- Lamb, M. C. and Cox, M. A. A. (1999), "Implementing Change in the National Health Service", *Journal of Management on Medicine*, Vol. 13, No. 5, pp. 288-297
- Landsberg, M. (2000), "The Tools of Leadership", Harper Collin Business, London
- Lee, B (2007) New Opportunities for Nurses and Other Health Care Professionals , *Journal of Health Organization and Management*, Vol. 20, No. 6, PP. 1477-7266.
- Leigh, J.A, Rutherford, J., Walid, J., Cappleman and Hynes, (2012), "Using the Patchwork Text Assessment As A Vehicle for Evaluating Students' Perceptions of Their Clinical Leadership Development", *Nurse Education in Practice*, Vol. 12, No. 1, pp 40-51.
- Lekan, D.A, Corazzini, K.N, Gillis, C.L and Bailey, D.E, (2011) "Clinical Leadership Development in Accelerated Baccalaureate Nursing Students: An Education Innovation", *Journal of Professional Nursing*, Vol. 27, No. 4, pp 202-214.
- Letour, B. (2004), "Managing Physician Resistance to Change", *Journal of Health Care Management*, Vol. 49, Issue 5, pp. 286-288
- Leurer, M.D, Donnelly, G. and Domm, E. (2007) "Nurse Retention Strategies: Advice from Experienced Registered Nurses", *Journal of Health Organization and Management*, Vol. 21, No. 3, pp. 307-319.
- Levay, C. (2010) "Charismatic Leadership in Resistance to Change", *The Leadership Quarterly*, Vol. 21, No. 1, pp 127-143.
- Liu, C. H., Yu, Z. U. and Tjosvo, D. (2002), "Production and People Values: Their Impact on Relationships and Leader Effectiveness in China", *Leadership and Organisation Development Journal*, Vol. 23, No. 3, pp. 134-144
- Lok, P and Crawford, J. (2001), "Antecedents of Organizational Commitment and the Mediating Role of Job Satisfaction", *Journal of Management Psychology*, Vol. 16, No. 8, pp. 594-613
- Loo, R. (1997), "The Future of Management Training in Canadian Healthcare Organization", *Journal of Management Development*, Vol. 16, No, 9, pp. 680-689

- Luna, T. et al (2000), "Health Worker Motivation Result of Two Studies at Al-Basheer Hospital", PHR, Partnership for Health Reform, November 2000, USAID, Amman – Jordan
- Mackenzie, S. (1995), "Surveying the Organizational Culture in an NHS Trust", *Journal of Management in Medicine*, Vol. 9, No. 6, pp. 69-77
- Macleod, L. (2010) "Nursing Leadership: Ten Compelling Reasons for Having a Nurse Leader on the Hospital Board", *Nurse Leader*, Vol.8, No.5, pp 44-27.
- Malek, M., Rasquinha, J. and Davey, P. (1993), *Managerial Issues in the Reformed NHS*, John Wiley and Sons Ltd, England
- Malek, M., Vacani, P., Davey, P. and Rasquinha, J. (1993), "Management Issues in the Reformed NHS", John Wiley, England
- Manjunath, U., Merti, B.A and Ramchandran, S. (2007), "Quality Management in a Health Care Organization: A Case of South Indian Hospital, the TQM Magazine, Vol.19, No.2, pp.129-139.
- Manning, T. and Robertson, B. (2002), "The Dynamic Leadership Development Beyond The Visionary Leader", *Industrial and Commercial Training Journal*, Vol. 34, No. 4, pp. 137-143.
- Manske, F.A (1990), "Secrets of Effective Leadership Education and Development", USA
- March, J. G. (1988), "Decisions and Organizations", Blackwell, Oxford
- Mark, A. (1994) *Medical Management*, *Health Manpower Management Journal*, Vol. 20, No. 1, pp. 18-20.
- Markens, B. J., and Spencer, J. S., (1998), "Leadership in Health Services", *International Journal of Health Care Quality Assurance*, Vol. 11, No. 1, pp. 1-4.
- McFadzean, F. and Mc Fadzean, E. (2005), *Riding the Emotional Roller-Coaster: A Framework for Improving Nursing Morale*, *Journal of Health Organization and Management Journal*, Vol.19, No.4, pp.318-339
- McAreavey, M. J., Alimo-Metacalfé, M. J. and Connelly, J. (2001), "How Do Directors of Public Health Perceive Leadership?" *Management in Medicine*, Vol. 15 No. 6, pp. 446-462.
- McPhail, A. and Jo, K. (2002), "The Nursing Profession, Personality Types and Leadership", *Leadership in Health Service Journal*, Vol. 15, No. 1, pp. 7-10.

- Menges, J.I, Walter, F., Vogel, B. and Beuch, H. (2011), "Transformational Leadership Climate: Performance Linkages, Mechanisms, and Boundary Conditions at the Organizational Level", *The Leadership Quarterly*, Vol.22, No.5, pp. 893-909.
- Merali, F. (2003), "NHS Managers' Views of Their Culture and Their Public Image: The Implications for NHS Reforms", *International Journal of Public Sector Management*, Vol. 16, No. 7, pp. 549-563
- Metcalf, J.A and Metcalf, B.A. (2007) "Development of Private Sector Version of the (Engaging) Transformational Leadership Questionnaire", *Leadership and Organization Development Journal*, Vol.28, No.2, pp.104-121
- Michael O. Court, D. and Petal, P., (2009), "Job Streets and Organizational Commitment among Mentoring Coordinators", *International Journal of Educational Management*, Vol. 23, No. 3, pp. 266-288
- Milburn et al (2000), "Health Care Motivation in Jordan", PHR, Partnership for Health Reform, December, USAID, Amman - Jordan
- Miles, S. F., and Mangold, E., (2002), "The Impact of Team Leader Performance on Team Member Satisfaction: The Subordinate's Perspective Team Performance Management", *International Journal*, Vol. 8, No. 5.6, pp. 113-121
- Miller, R. L. and Brewer, J. D. (2003), "A-Z of Social Research", Sage Publications, London
- Millward, L. J. (2005), *Clinical Leadership in Health Care: A Position Statement*. *Leadership in Health Service Journal*, Vol.18, No.2, pp.8-25
- Ministry of Health (2004), "Annual Report", Amman – Jordan
- Ministry of Health, MOH (2006), "Strategic Plan for Performance Improvement", Quality Directorate, Hashemite Kingdom of Jordan, Amman –Jordan
- Mourali, M and Nagpal, A. (2011) "The Powerful Select, the Powerless Reject: Power's Influence in Decision Strategies", *Journal of Business Research*, Vol.xxx. pp. xxx-xxx.
- Muasher, M. (2005), "*The National Draft Agenda*", UN, Amman -Jordan
- Mulec, K. (2005), *Positive Professional Leaders: Aspects to Consider in Leadership Development*, *Leadership and Organisation Development Journal*, Vol. 27, No. 1, pp. 66-81.
- Nachmias, C. F. and Nachmias, D. (1996), "Research Methods in the Social Sciences", St. Martins Press, UK

- Naylor, G. (1999), "Using the Business Excellence Model to Develop a Strategy for a Healthcare Organization", *International Journal of Health Care Quality Assurance*, Vol. 12, No. 2, pp. 37-44
- Nielsen, K. and Daniels, K. (2011) "Does Shared and Differentiated Transformational Leadership Predict Followers' Working Conditions and Well-being?", *The Leadership Quarterly*, pp. 1-15.
- Nusairat, F. (1998), "Patient Criteria of Hospital Services Choice in Private Sector of Jordan", Al Yarmouk University Researchers, Irbid – Jordan
- O'Connor (2004), "*Measuring Quality of Life in Health*", Elsevier Limited, UK.
- Ollila, S (2008) "Strategies Support for Managers by Management Supervision", *Leadership in Health Services*, Vol.21, No.1, and PP.16-27.
- Oni, O. O. A. (1995), "Who should lead in the NHS?", *Journal of Management in Medicine*, Vol. 9, No. 4, pp. 31-34
- Ovretveit, J. (1992), "*Health Service Quality*", University Press, Cambridge, UK
- Palfrey, C., Thomas, B. and Philip, C. (2006), "Health Service Management: What are the Ethical Dimensions", *International Journal of Public Sector Management*, Vol. 19, No.1, pp. 57-66
- Papadimos, T. J. and Machiavell, A. M. (2000), "Advice to the Hospital Chief Executive Officer"
- Park, J. and Kim, T., (2009), "Do Types of Organizational Culture Matter in Nurse Job Satisfaction and Turnover Intention?", *Leadership in Health Services*, Vol. 22, No. 1, pp. 20-38
- Peterson, D. (2004), "Perceived Leader Entirety and Ethical Intentions of Subordinates", *Leadership and Organization Development Journal*, Vol. 25, No. 1, pp. 7-23
- PHCI (2000:b), "Quarterly Report, April – June", USAID, Amman – Jordan
- PHCI (2002), "Supervisor's Perception of Their Role in Primary Health Care in Ministry of Health Care in Jordan", Amman – Jordan
- PHCI Baseline Report (2000:a), "Quality of Care in Primary Care Centres", USAID, Amman - Jordan
- PHCI, Primary Health Care Initiatives (2001), Annual Work Plan, Project Year Two, USAID, Amman – Jordan
- Preston, D. and Clarke, J. L. (2004), "The NHS Manager", *Journal of Management in Medicine*, Vol. 14, No. 2, p. 100-108.

- Preston, D., Clarke, J. L. (2000), "Theoretical Papers, the NHS, A View from the Bridge", *Journal of Management in Medicine*, Vol. 14, No. 2, pp. 100-108
- Punch, K. F. (2005), "*Introduction to Social Research*", Sage Publication, Ltd, London
- Rasdi, R., Ismail, M., Uli, J, and Noah, S., (2009), "Towards Developing a Theoretical Framework for Measuring Public Sector Managers' Career Success", *Journal of European Industrial Training*, Vol. 33, No. 3, pp. 232-254
- Riseborough, P. and Walter, M. (1988), "*Management in Health Care*", Butterworth and Co, London.
- Roberts, M. J. and Reich, M. R. (2002), "Ethical Analysis in Public Health", Vol. 359, pp. 1055-1059
- Robson, C. (1993), "*Real World Research*", Blackwell Publishers, Oxford, UK
- Robson, C. (2002), "*Real Word Research*", Blackwell Publishing, Oxford, UK
- Roland, M., Campbell, S. and Wikin, D., (2001), "Clinical Governance: A Convincing Strategy for Quality Improvement", *Journal of Management in Medicine*, Vol. 15, No. 3, pp. 188-201.
- Rucker,D., Galinsky,A. and Dubois,D. (2011) "Power and Consumer Behavior: How Power Shapes Who and What Consumer Value", *Journal of Consumer Psychology*, pp. 1-17.
- Rus,D., Knippenberg,D.V and Wisse,B. (2011) "Leader Power and Self- Behavior: the Moderating Role of Accountability", *The Leadership Quarterly*, Vol.23, No. 1, pp 13-26.
- Saif, A. M. (1996), "Authority Type and its Role in Hospital Organisational Relationships", University of Jordan Thesis, Amman – Jordan
- Salauroo, M. and Burnes, B. (1998), "The Impact of a Market System on the Public Sector: A Study of Organizational Change in the NHS", *International Journal of Public Sector Management*, Vol. 11, No. 6, pp. 451-467
- Schein, E. (1985), "How Culture Forms, Develops and Changes", Jossey -Bass, San Francisco, CA
- Schippers, M.C, Den Hartog, D.N,Koopman, P.L and Knippenberg, D.V (2008),"The Role of Transformational Leadership in Enhancing Team Flexibility", SAGE Publications,Vol.61, No.11,pp.1593-1616.
- Schneider, J. and Littrel, R. F. (2003), "Leadership Preferences of German and English Managers", *Journal of Management Development*, Vol. 22, No.2, pp. 130-148

- Scholten, G. R. M. and Grinten, T. E. D. V. (1998), "Between Physician and Manager: New Cooperation Model in Dutch Hospital", *Journal of Management in Medicine*, Vol. 12, No. 1, pp. 33-43
- Schultz, F. C. (2004), "Who should Lead the Health Care Organization MDs or MBAs?" *Journal of Health Care Management*, Vol. 49, Issue. 2, pp. 103-116
- Seifre, H., Economy, P. (2001), "*Leadership is Simple*", Henry Holt, New York, USA
- Seedhouse, D. (1988) "*the Heart of Health Care*", John Wiley and Sons, Ltd, England.
- Senior,C., Martin,R., Thomas,G., Topakas,A., West,M. and Yeats,R.M. (2011) "Development Stability and Leadership Effectiveness", *The Leadership Quarterly*, pp. 1-11.
- Senn,B, (2010), "Clinical Empowerment: Utilising Your Leadership Skills", *European Journal of Oncology Nursing*, Vol.14, pp 1-62.
- Shackleton, V. (1995), "*Business Leadership*", Live Fletcher, London
- Siebens, H. (1998), "Care for Quality", *Business Ethics*, Vol. 17, No. 3, pp. 150-161
- Silk, P. H. (1995), "Whose Job Is It Anyway? The Doctor/Nurse Debate", *Health Manpower Management*, Vol. 21, No. 1, pp. 5-7
- Simola,S.K, Barling,J. and Turner,N. (2010), "Transformational Leadership and Leader Moral Orientation: Contrasting an Ethic of Justice and an Ethic of Care", *The Leadership Quarterly*, Vol.21, No.1, pp 179-188.
- Smith, A. J. and Preston, D. (1996), "Communication between Professional Groups in an NHS Trust Hospital", *Journal of Management in Medicine*, Vol. 10, No. 2, pp. 31-39
- Smith, G. (2004), "*Leading the Professional*", Cogan page, London
- Smith, H. W. (1991), "*Strategies of Social Research*", Holt, Rinehart and Winston, INC, Florida, USA
- Smith, W. R., Wytttenbach, M. E., Austin, W. and Rangappa, S. (2004), "Hospitalist Programmes in Academic Medical Centres", *Clinical Governance: International Journal*, Vol. 9, No. 3, pp. 181-186
- Sones, M. and Granthan, S, (2009), "Communicating CRS via Pharmaceutical Company Web Sites Evaluating Message Frameworks for External and Internal Stakeholder", *Corporate Communications, an International Journal*, Vol. 14, No. 2, pp 144-157.

- Sorell, T. (1996), "Ethics and the NHS Reforms in the UK", *Business Ethics*, Vol. 5, No. 4, pp. 196-201
- Stewart, R. (1989), "*Leading in the NHS*", Macmillan Press Ltd, UK
- Stone, A. G., Russel, R. F. and Patterson, K. (2004), "Transformational Versus Servant Leadership: a Difference in Leader Focus", *Leadership and Organization Development Journal*, Vol. 25, No. 4, pp. 349-361
- Storey, J. and Buchanan, D, (2008), "Healthcare Governance and Organizational Barriers to Learning from Mistakes", *Journal of Health Organization and Management*, Vol. 22, No. 6, pp 642-651.
- Strauss, A. and Corbin, J. (1990), "*Basics of Qualitative Research*", Sage Publications, London
- Subasic,E., Reynolds,K.j, Turner,J.C, Veenstra,K.E and Haslam,S.A, (2011) " Leadership, Power and the Use of Surveillance: Implications of Shared Social Identity for Leaders' Capacity to Influence", *The Leadership Quarterly*, Vol.22, No.1, pp. 170-181.
- Suliman, W. A. and Abu-Garbieh, P. (1996), "Jordanian Nurses: Job Satisfaction and Anticipated Withdrawal from Practice", *Dirasat, Medical and Biological Science, University of Jordan*, Vol. 23, No. 2, pp. 78-87
- Suliman, W. A. and Abu-Moghli, F. (1999), "Leadership Styles of Nurse Administrator in Jordanian Hospital", *Dirasat, Medical and Biological Science, University of Jordan*, Vol. 26, No. 1, 2, Amman – Jordan
- Sullivan, H and Williams, P (2007). "Leadership for Collaboration. Paper Presented at the 14th International Conference on Multi-Organisational Partnership", *Alliance and Networks (MOPAN)*, 28-29 June, Leuven (Belgium).
- Sullivan, M. A. B. (1990), "*Nursing Leadership and Management*", Springhouse Corporation, USA
- Sydow,J., Lerch,F., Huxham,C. and Hibbert,P. (2011) "A Silent Cry of Leadership: Organizing for Leading (in) Clusters", *The Leadership Quarterly*, Vol.22, No.2, pp 328-343.
- Takala, T. (1999), "Business and Leadership Ethics Conference-Three Current Themes", *Leadership and Organization Development Journal*, Vol. 20, No. 7, pp. 360-364
- Tapeen, R. M. (2001), "*Nursing Leadership and Management*", Davis Company, USA

- Thacker, R. A. (1997), "Team Leader Style: Enhancing the Creativity of Employees in Teams", *Training for Quality*, Vol. 5, No. 4, pp. 146-149
- The Ministry of Information (1978), "Government in Jordan", Amman - Jordan
- Thompson, A. (1998), "Gender and Medical Ethics in the Arab World" *Bulletin and Medical Ethics*, No. 139, pp. 20-21
- Thorne, M. L. (1997), "Myth-Management in the NHS", *Journal of Management in Medicine*, Vol. 11, No. 3, pp. 168-180
- Thorpe,R., Gold,J. and Lawler,J. (2011) "Locating Distributed Leadership", *International Journal of Management Review*", Vol.13, No.3, pp 239-250.
- Tourish, D. and Hargie, O. (1996), "Communication in the NHS", *Journal of Management in Medicine*, Vol. 10, No. 5, pp. 38-54
- Townsend, P. and Gebhardt, i.e. (1997), "For Service to Work Right, Skilled Leaders Need Skills in Fellowship", *Managing Service Quality*, Vol. 7, No. 3, pp. 136-140
- Utley,R., Anderson,R. and Atwell,J. (2011) "Implementing Transformational Leadership in Long-Term Care", *Geriatric Nursing*, Vol.32, No.3, pp.212-217.
- Van Ginkel,W. and Van Knippenberg,D. (2011) "Group Leadership and Shared Task Representations in Decision Making Groups", *The Leadership Quarterly*, Vol.23, No.1, pp 94-106.
- Vera, A., and Hucke, D., (2009), "Managerial Orientation and Career Success of Physicians in Hospital, *Journal of Health Organization and Management*, Vol. 23, No. 1, pp. 70-84
- Vultee,P.J.V.,Axelsson,R and Arnetz, B(2007) The Impact of Organizational Settings on Physician Wellbeing, *International Journal of Health Care Quality Assurance* ,Vol.20,No.6,PP.505-515.
- USAID (2006), "Guidelines for Hospitals to Prepare to Meet Hospital Accreditation Standards", Second Draft, January, Amman- Jordan
- Walker,R., Cooke,M., Henderson,A. and Creedy,D.K, (2011) "Characteristics of Leadership That Influence Clinical Learning: A Narrative Review", *Nurse Education Today*, Vol.31, No.8, pp 743-756.
- Walker, R and Morgan, P. (1996), "Involving Doctors in Management", *Journal of Management in Medicine*, Vol. 10, No. 1, pp. 31-52



- Wallis,N.C, Yammarino,F.J and Feyerherm,A. (2011) "Individualized Leadership: A Qualitative Study of Senior Executive Leaders", *The Leadership Quarterly*, Vol.22, No.1, pp 182-206.
- Wang,H, Tsui,A.S and Xin,K.R, (2011), "CEO Leadership Behaviors, Organizational Performance, and Employees Attitudes", *The Leadership Quarterly*, Vol.22, No.1, pp. 92-105.
- White, T. (1993), "*Management for Clinicians*", Anthony White, UK
- Willcocks, S. (1998), "The Development of Clinical management at NHS Trust Hospital", *Journal of Management in Medicine*, Vol. 12, No. 3, pp. 168-177
- Willcocks, S. G. (1998), "Managerial Effectiveness in the NHS Hospital Trust", *International Journal of Public Sector*, Vol. 11, No. 3, pp. 130-138
- Wilson, C. R. M. (1987), "*Hospital Wide Quality Assessment*", W. B. Saunders Company, Canada Ltd, Canada
- Wilson, H. J., Callaghan, C. A. and Wright, P. L. (1996), "Observing Differences in Verbal Communication", *Journal of Management Psychology*, Vol. 11, No. 4, pp. 43-55
- Wright, P. (1986), "A Cultural Audit First Step in a Needs Analysis", *Journal of European Industrial Training*, Vol. 10, No. 1, pp. 24-34
- Wright,T.A and Quick,J.C. (2011) "The Role of Character in Ethical Leadership Research", *The Leadership Quarterly*, Vol.22, No.5, pp 975-978.
- Xirasagar, S., (2008) "Transformational, Transactional and Laissez-Faire Leadership among Physician Executives", *Journals of Health Organization and Management*, Vol. 22, No. 6, pp. 599-613.
- Yang,L. and Haung,C. (2011) "The Association among Project Manager's Leadership Style, Teamwork and Project Success", *International Journal of Project Management*, Vol.29, pp. 258-267.
- Yang,M.H, (2011) "Across-Authority Lightweight Ownership Transfer Protect", *Electronic Commerce Research and Application*, Vol.10, No.4, pp 375-383.
- Yudelowitz, J., Koch, R., Field, R. (2002), "*Smart Things to Know About Leadership*", Wiley Company, UK
- Yukl, C. A. (1981), "*Leadership in Organizations*", Prentice Hall International, NJ, USA
- Yukl, G. A. (1989), "*Leadership in Organizations*", 2<sup>nd</sup> Ed., Prentice-Hall Englewood Cliffs, NJ

Zhu,W., Avolio,B.J., Riggio,R.E and Sosik,J.J (2011) "The Effect of Authentic Transformational Leadership on Followers and Group Ethics", *The Leadership Quarterly*, Vol.22, No.5, pp 801-817.

Zikmund, W. G. (2003), "*Business Research Methods*", South Western, USA



## APPENDIX A

### ***Clinical Leadership in Jordanian Hospitals: The clinicians' perspective***

#### **Qualitative interview**

##### **Dear Participant**

This research is being undertaken as a part of Master degree requirements in the field of Health Service Management. The main aims of this research are listed as follows:

- 1- To identify the extent to which clinicians can perform their role of managing and leading the Jordanian hospitals according to their clinical background besides training, managerial experience and power.
- 2- To explore the obstacles of clinical leadership in Jordanian hospitals

Your cooperation as a manager or group leader is extremely appreciated to enable the researcher to diagnose the nature of your hospital leadership style and investigate the obstacles that may have negative affect on the hospital leadership. We would like to assure you that all collected data will be treated with **strict confidentiality** and only be used for scientific and academic purposes. Furthermore, your name will not be revealed or associated with your response nor will anyone outside the protect staff here at the University of Stirling be allowed to see your response. You are kindly requested to participate in this interview to be completed in 60 minutes time by expressing your own perspective in terms of clinical leadership at your hospital. The information you provide will contribute to an important study and may also be used to influence leadership concept of the Jordanian hospitals

We appreciate your willingness to help us in our research by completing all the statements provided and express your own perspective and experience as a manager or team leader. If you would like a copy of our completed study please feel free to indicate this on the last page of this questionnaire. We believe that you will find this questionnaire interesting and look forward to receiving your reply

**Thanks indeed for your kind cooperation.**

**Yours Sincerely**

**Dr. Tom Forbes**

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**Ala Obeidat**

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Before start

Introduce yourself as a researcher and the title of the study :  
Name (optional) and position/job title of participant

Date:  
Time beginning:  
Time ended:

**PART ONE: Leadership**

The following are the *definitions of Leadership* (each participant will be given a list of these definitions as mentioned in the literature review).

- A- *The range of skills to be acquired and practiced.*
- B- *Behaviour of an individual when he is directing the activities of a group towards a shared goal*
- C- *it is communications, appearance, recognition, encouragement and sharing, and it is the art of getting others to do something you want.*
- D- *it is the combination of strategy and character.*
- E- *It is the power and characteristics of a person to influence a group to achieve goals after systematic process starting with selecting the team, sharing ideas, inspiration, communication, motivation, empowerment and ending with power for subordinates.*

**Q1-1:**

**What do you understand from the term of leadership and how do you apply this on your hospital you are working in?**

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**Q1-2:**

**According to your experience as clinician, what are the factors may strengthen the concept of clinical leadership at your hospital?**

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**PART TWO: Leader**

The following are the *definitions of Leader* (each participant will be given a list of these definitions as mentioned in the literature review).

- *Persons who have authority and power (personal and positional). “positional power which derived from legitimate power, reward power, coercive power, and informational power, while the personal power means rational persuasion, referent power, expert power and charisma”.*
- *The person, who leads, should be extraordinary, boss, master, person in authority.*
- *Directive leader who informs subordinates what expected of them.*

- *Negotiating leader means friendly leader who shows concern and bargaining to achieve goals.*
- *Consulting leader who is doing consultation before decision-making.*
- *Delegating leader who authorizes sub-ordinates to do thing on behalf of him and sub-ordinates left free to make their own decision.*

**Q2-1:**

**Can you tell me about the types of authorities and sources of power do you have as clinical leader?**

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**Q2-2: would you please describe your leadership characteristics as clinical leader that may affect on your team members?**

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**PART THREE: Culture**

The following are the definitions of Culture (each participant will be given a list of these definitions as mentioned in the literature review).

- *“A pattern of basic assumptions than a given group has invented, discovered or developed in learning to cope with its problem of external adaptation and internal integration, and have worked enough to be considered valid”.*
- *“It is a common held beliefs, attitudes and values which give meaning to the organization for its members and provide them with roles for behaviour”.*

**Q3-1: How do you see that culture is an important factor at your hospital?**

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**Q3-2: suppose if we ignore the presence of culture at your hospital what will happen then?**

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**PART FOUR: Team**

The following are the *definitions of Team* (each participant will be given a list of these definitions as mentioned in the literature review).

- A multi-skilled people tend to be more interested in their jobs and vital to quality improvement and apply problem-solving techniques
- Team means the following: T: together, E: every One, A: achieve, M: more.
- Seeking self improvement, technically proficient, developing a sense of responsibility, setting examples of other and being team members but not yes men.

**Q4-1: what are the characteristics do you always prefer to be available in your clinical team members?**

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**Q4-2: to what extent knowledge and informational qualifications of your clinical team can play a significant role to take a wise decision? Please give more details.**

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**PART FIVE: Communication**

The following are the *definitions of Communication* (each participant will be given a list of these definitions as mentioned in the literature review).

- Process by which a person, group or organization (The sender) transmit some type of information (The message) to another person, group or organization (The receiver).
- Open communication climate means sharing types of information across functional and hierarchical levels.
- Communication could be upward, message from subordinates to supervisors or downward which means from supervisors to subordinates and bilateral between colleagues or departments in the same level which may build better relationship and more awareness about problem.

**Q5-1: what, from you experience and view as clinical leader, does the concept of clinical communication mean something important to your hospital?**

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**5-2: mostly, in hospitals the level of communication is ineffective, how can you illustrate that by real examples.**

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**PART SIX: Quality**

The following are the *definitions of Quality* (each participant will be given a list of these definitions as mentioned in the literature review).

*-It's a managerial process, qualification of staff, techniques, procedures, production, customer care and personnel.*

*-Quality of the British health service as a national framework of clear national standard of service and treatment and delivery of high quality of health services.*

**Q6-1: why do you think that the quality of health has a strong correlation with the effectiveness of clinical leadership?**

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**Q6-2: would you please tell me about the training courses and programmes held at your hospital talking about developing of health care quality?**

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**PART SEVEN: Ethics**

The following are the *definitions of Ethics* (each participant will be given a list of these definitions as mentioned in the literature review).

*-"Ethics is to behave in one-way rather than another"*

*-Ethics is a framework in which people should do as a set of principles for acting*

*-Ethical codes are a framework stressing dignity and respect for personhood; it is to behave according to values, beliefs, traditions, religion, culture, law and dignity.*

**Q7-1: do you think that ethics in clinical approach have to be a discipline in health care industry? If yes give reasons please.**

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**Q7-2: how can ethics improve the relationship between clinical leaders and their subordinates?**

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**PART EIGHT: Allied Health Professional as Managers**

The following are the *definitions of Clinical Managers* (each participant will be given a list of these definitions as mentioned in the literature review).

*-Persons who have moved into a management from clinical background and usually managing other professional staff.*

*- They are clinicians holding a responsibility to lead clinical and professional group except doctors and nurses, such as pharmacists, radiographers, laboratory technicians, quality control technicians and endoscopies to help doctors and nurses in their clinical duties.*

*-They are clinicians holding a responsibility to lead another professional group in the same department.*

**Q8-1: to which extent do you agree that allied health professionals have to be strongly involved in hospital management? Please give reasons.**

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**Q8-2: do you believe that clinical management and leadership have to be included in clinical curriculum for allied health professionals ? Please say why?**

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**PART NINE: Doctors as Managers**

The following are the *definitions of Doctors as Managers* (each participant will be given a list of these definitions as mentioned in the literature review).

*-They are physicians involved in health care management and having primary responsibilities to individual patient and wider community.*

*-They are normally consultants, registrars or senior doctors sharing in hospital administration in mutual way between clinical and managerial responsibilities.*

**Q9-1: to which extent do you agree that doctors have to be strongly involved in hospital management? Please give reasons.**

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**Q9-2: do you believe that clinical management and leadership have to be included in clinical curriculum for doctors? Please say why?**

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**PART TEN: Nurses as Managers**

The following are the *definitions of Nurses as Managers* (each participant will be given a list of these definitions as mentioned in the literature review).

- They are persons who authorized to become more involved in clinical management and leadership, developing creativity, innovation and problem solving.
- They are normally head nurses as senior staff nurses and ward managers or unit managers are performing nursing in both clinical and managerial aspects.

**Q10-1: to which extent do you agree that nurses have to be strongly involved in hospital management? Please give reasons.**

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**Q10-2: do you believe that clinical management and leadership have to be included in clinical curriculum for nurses? Please say why?**

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**PART ELEVEN**

**Would you please list the obstacles that negatively affect the clinical leadership at your hospital?**

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PART TWELVE

- Q1: Please indicate your gender: Male ( ) Female ( )
- Q2: Please specify in which department you work ( )
- Q3: Please specify your job title ( )
- Q4: Please specify how many team members you have as team leader or supervisor ( )
- Q5: Please specify how many years of working experience do you have in this hospital ( )

If you would like to have the results of this study, please supply out the following information

Name: .....
Address: .....

**Thank you very much for your help and cooperation.**



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## APPENDIX B

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10 May 2006

To whom it may concern

**RE Mr Ala Obeidat Registration Number 1222475**

The above named individual is currently registered for a PhD in the Department of Management & Organization at the University of Stirling. He is researching clinical leadership within healthcare settings. As part of his research he would like to request access to The University of Jordan Hospital for data collection purposes. Any data collected will be entirely confidential and the anonymity of all participants will be assured. The research will be subject to the University Of Stirling's ethical code of conduct, a copy of which can be provided if required.

Mr Obeidat will provide a research proposal outlining the aims and objectives of his research, proposed methodology and potential participants. Please feel free to contact me if you require further information.

Your help on this matter is much appreciated.

Yours sincerely

Dr Tom Forbes  
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## Appendix C

26 May 2006

To whom it may concern

### **RE Mr Ala Obeidat Registration Number 1222475**

The above named individual is currently registered for Master degree in the Department of Management & Organization at the University of Stirling. He is researching clinical leadership within healthcare settings. As part of his research he would like to request access to King Abdullah Hospital for data collection purposes. Any data collected will be entirely confidential and the anonymity of all participants will be assured. The research will be subject to the University Of Stirling's ethical code of conduct, a copy of which can be provided if required.

Mr Obeidat will provide a research proposal outlining the aims and objectives of his research, proposed methodology and potential participants. Please feel free to contact me if you require further information.

Your help on this matter is much appreciated.

Yours sincerely

Dr Tom Forbes  
Principal Supervisor

**Prof John Bowers**  
**Head of Department**



UNIVERSITY OF  
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## APPENDIX D

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e-mail: manorg@stir.ac.uk

10 May 2006

To whom it may concern

**RE Mr Ala Obeidat Registration Number 1222475**

The above named individual is currently registered for a PhD in the Department of Management & Organization at the University of Stirling. He is researching clinical leadership within healthcare settings. As part of his research he would like to request access to Princes Basma Hospital for data collection purposes. Any data collected will be entirely confidential and the anonymity of all participants will be assured. The research will be subject to the University Of Stirling's ethical code of conduct, a copy of which can be provided if required.

Mr Obeidat will provide a research proposal outlining the aims and objectives of his research, proposed methodology and potential participants. Please feel free to contact me if you require further information.

Your help on this matter is much appreciated.

Yours sincerely

Dr Tom Forbes  
Principal Supervisor

**Prof John Bowers**  
Head of Department



UNIVERSITY OF  
STIRLING

DEPARTMENT OF  
MANAGEMENT AND ORGANIZATION  
The Faculty of Management  
University of Stirling  
Stirling, FK9 4LA, Scotland

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## APPENDIX E

10 May 2006

To whom it may concern

**RE Mr Ala Obeidat Registration Number 1222475**

The above named individual is currently registered for a PhD in the Department of Management & Organization at the University of Stirling. He is researching clinical leadership within healthcare settings. As part of his research he would like to request access to Jordan Hospital for data collection purposes. Any data collected will be entirely confidential and the anonymity of all participants will be assured. The research will be subject to the University Of Stirling's ethical code of conduct, a copy of which can be provided if required.

Mr Obeidat will provide a research proposal outlining the aims and objectives of his research, proposed methodology and potential participants. Please feel free to contact me if you require further information.

Your help on this matter is much appreciated.

Yours sincerely

Dr Tom Forbes  
Principal Supervisor

**Prof John Bowers  
Head of Department**

Jordan University Hospital

مستشفى الجامعة الأردنية

Ref. JHU/113/1274

الرقم: 113/1274

Date: 20/6/2006

التاريخ: 20/6/2006

APPENDIX F

Dr. Tom Forbs  
Faculty of Management and Organization  
University of Stirling - United Kingdom

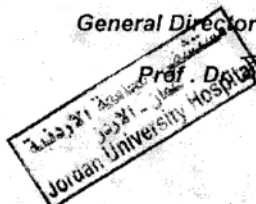
Dear Dr. Forbes ,,

Referring to your letter dated on 26<sup>th</sup> of May 2006 to providing a research access to Mr. Obeidat , PhD researcher at the University of Stirling . Mr. Obeidat is welcomed to conduct his research and collecting data ( Questionnaires and interviews ) within health service management concept .

Best regards .

General Director / Jordan University Hospital

Prof. Dr. Abdul Kareem Al-Qudah



RB/



General Director Office

مكتب المدير العام

ص ب (٦٣٠٠٠١) إربد (٢٢١١٠) الأردن

هاتف: ٧٢٠٠٦٠٠ (٢ - ٩٦٢) فاكس: ٧٠٩٥٧٧٧ (٢ - ٩٦٢)

Ref. ١٤١١/٢٤٧٦

الرقم

Date: ٦-٢٠٠٦

التاريخ

الموافق

## APPENDIX G

**Dr. Tom Forbes**  
Principle Supervisor  
University of Stirling  
Scotland

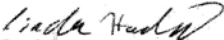
Dear Dr. Forbes,

Referring to your letter of May 26, 2006 in which you confirm that Mr. Ala Obeidat is currently registered for a PhD in the department of Management & Organization at the University of Stirling and researching clinical leadership within healthcare settings.

We would like to inform you that we allow Mr. Obeidat to collect data from the hospital using questionnaires and holding meetings with the hospital staff for the purpose mentioned above.

Hoping that you will provide us with the final results of the research.

Sincerely,

  
Prof. Mahmoud Al-Sheyab  
Acting CEO, KAUH  
Vice President, JUST





DATE : 07/06/2006

الرقم: له / ج / ٤٢١

## APPENDIX H

To:

Dr. Tom Forbes

University of Stirling

We are so pleased to invite your PhD Student Mr. Ala Obeidat conducting his empirical study entitled:  
(The Effectiveness of Leadership in Jordanian Hospitals).  
Mr Obeidat was given an authority to distribute the project questionnaires and doing his qualitative interviews with our seniors for academic purposes.

Regards.

Dr. Ziad Abandeh  
Princess Basma Hospital  
General Director.





مستشفى الأردن  
JORDAN HOSPITAL



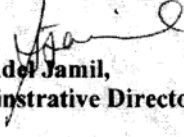
APPENDIX I

Date : 12.06.2006.

To : Dr. Tom Forbes  
University of Stirling – U.K.

We would like to inform you that your PhD candidate "Ala'a Obiedat" is fully authorized to access the hospital departments interms of clinical leadership and health service management approach.

Yours,

  
Dr. Adel Jamil,  
Adminstrative Director

المركز الطبي - عمان

شارع الملكة نور هاتف: ٥٦٠٨٠٨٠ - ٥٦٠٨٠٣٠ - فاكس: ٥٦٠٧٥٧٥ ص ب ٥٢٠٢٤٨ عمان - الأردن  
Queen Nour Street Tel. 5608080 - 5608030 - Fax. 5607575 P.O Box 520248 Amman - Jordan  
E-mail : jorhos@jordan-hospital.com

## APPENDIX J

التاريخ: 2006/5/30

معالي الدكتور وزير الصحة الأكرم

السلام عليكم ورحمة الله وبركاته

أرجو التكرم بتسهيل مهمني كباحث في مجال إدارة المستشفيات والخدمات الصحية لنيل درجة الدكتوراة من جامعة ستيرلنج / بريطانيا بهدف الإطلاع على مفهوم الإدارة الصحية لديكم ، وسيتم توزيع إستبانة على المشرفين الذين لديهم مهام إدارية وإشرافية في الأقسام العلاجية فقط كالأطباء والمرضى والصيادلة و المخبريين والمعالجين الفيزيائيين والعاملين في البحث الطبي كما سيتم إجراء مقابلات شخصية محدودة لا تتجاوز منتها عن 30 دقيقة وستتم الدراسة مستشفى البشير ومستشفى الأميرة بسمة من عينة مجتمع الدراسة. علما بأن نتائج هذا البحث ستعامل بالسرية التامة لأغراض البحث العلمي فقط.

وتفضلو بقبول فائق الإحترام

الباحث

علاء عبيدات

باحث دكتوراة في الإدارة الصحية

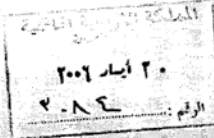
جامعة ستيرلنج بريطانيا

هاتف 0795047695

Email:obdt@hotmail.com

مرقفا طيه مائلي:

- 1- موجز الدراسة وأهدافها
- 2- رسالة للتوصية من الدكتور المشرف على الرسالة-جامعة ستيرلنج بريطانيا
- 3- إستبانة الدراسة
- 4- نموذج المقابلة الشخصية



ROYAL JORDANIAN  
MINISTRY OF HEALTH



وزارة الصحة

Ref.No. \_\_\_\_\_

Date \_\_\_\_\_

الرقم ٥٩٩ / ٢ / ٢٥ / ٨  
التاريخ ٢٠٠٦ / ٥ / ٢٥  
الموافق

## APPENDIX K

مدير مستشفى البشير  
مدير مستشفى الأميرة بسمة

تحية طيبة وبعد ،،،

أرجو تسهيل مهمة الطالب علاء عبيدات من جامعة سنتر لنج/بريطانيا  
والسماح له بتوزيع الاستبانة المرفقة على المعنيين لديكم وذلك لاستكمال  
متطلبات بحثه لمرحلة الدكتوراة .

واقبلوا وافر التحية ،،،

1 وزير الصحة

المهندس سعيد سميح دروزة

ساعد الأمين العام للشؤون الإدارية  
الصيدلاني اسماعيل السعدي

٥٤/٥٠

**Appendix L: Profile of Interviewees (N=38)**

University of Jordan Hospital		King Abdullah Hospital		Princess Basma Hospital		Jordan Hospital	
Position and Job Title	Years of experience	Position and Job Title	Years of experience	Position and Job Title	Years of experience	Position and Job Title	Years of experience
Director of nursing department (nurse)	30	Director of nursing (PhD nursing)	20	General director (consultant pediatrician)	35	Director of nursing (nurse)	25
Director of pharmacy (pharmacist)	12	Director of radiology (consultant radiologist)	5	Director on nursing (nurse)	26	Director of laboratory (laboratory technician)	20
Director of radiology (radiologist)	26	Director of laboratory (consultant laboratory)	22	Director of medicine (consultant internist)	25	Deputy director of nursing (nurse)	23
Director of laboratory (lab technician)	16	Director of pharmacy (pharmacist)	10	General director assistant for distractive affairs (GP)	30	Director of radiology (consultant radiologist)	14
Head of training and CPD department (nurse)	22	Director of surgery (consultant surgeon)	22	Director of laboratory (consultant laboratory)	22	Head of endoscopies (nurse)	15
Head of emergency (consultant internist)	9	General director assistant for medical affaires (consultant)	25	Director of nutrition department (nutritionist)	6	Head of orthopedic dept (consultant orthopedic)	33
Head of medical nursing department (nurse)	19	Nursing director assistant (nurse)	9	Director of medical records (nurse)	20		
Director of nutrition department (nutritionist)	30	Head of pediatric department (consultant pediatrician)	11	Head of training and CPD (nurse)	18		
Quality coordinator (nurse)	15	Head of anesthesia department (consultant anesthetist)	16	Head of medical engineering and maintenance (biomedical engineer)	10		
		Head of surgical nursing department (nurses)	20	Head of emergency dept (nurse)	17		
		Head of operation theater (nurse)	15	Head of medical committees (consultant internist)	24		
				Night manager (nurse)	20		
<b>Total</b>	9/38		11/38		12/38		6/38
Percent	24%		29%		31%		16%
Average of experience	20 years		14 years		21 years		22 years

## Appendix M Qualitative Interview

“Semi-Structured”

Time: From -  
To -

### القسم الأول:

1 1 ما هو تعريفك للقيادة بناءً على وجهة نظرك الشخصية كقائد او رئيس للمجموعة في المستشفى الذي تعمل فيه.

A	هي مجموعة مهارات مكتسبة لدى القائد يطبقها على اعضاء الفريق.
B	هو سلوك المدراء الشفهي والمكتوب في ادارة شؤون افراد الفريق لتحقيق اهداف المستشفى.
C	هو مدى التفاهم والاتصال الدائم بين المدراء و افراد الفريق وتشجيعهم لتنفيذ ما يطلبه المدراء.
D	هي المشاركة في رسم الاستراتيجيات.
E	هي مقدار السلطة لدى المدراء وتحفيز اعضاء الفريق على تحقيق الاهداف ضمن نظام محدد يبدأ من انتقاء وتعيين اعضاء الفريق المشارك وكذلك الاهتمام بقنوات الاتصال المفتوحة معهم "الشفهية والمكتوبة" وتحفيزهم بل ومنحهم السلطة لاتخاذ القرارات اللازمة.

2 1 أي من التعريفات السابقة تعطي جوهر القيادة وتعكس مفهومها الحقيقي في المستشفى الذي تعمل فيه؟ أعط أمثلة على ذلك ...


3 1 بناءً على وصف العمل ومساك الوظيفي وطبيعة عملك كمدير... كيف تعرف القيادة من وجهة نظرك الشخصية؟


4 1 هل لك أن تحدد بعض المعوقات في قيادة المستشفى الذي تعمل فيه ...


### القسم الثاني: القائد.

1 2 وهو الشخص الذي يملك المواهب الادارية غير العادية وهو الرئيس او السيد ذو السلطة القوية. بناءً على خبرتك في القيادة كيف تعرف القائد إذن؟


2 2 ما هي طبيعة السلطة التي تتمتع بها في المستشفى؟  
هل هي: السلطة الشخصية (المنطقية، الإقناع، المرجعية، او الخبرة)،  
أم هل هي: سلطة المركز (السلطة التي تأتي من قوة مركزك كمدير)؟

--

فما هو نوع السلطة لديك بناءً على ما قرأت؟

--

3 2 استناداً لخبرتك الشخصية في هذا المستشفى كيف ترى بأن سلطتك كمدير يمكن أن تؤثر في أداء فريقك؟


4 2 بناءً على أنواع السلطة الممنوحة لك كمدير، أي نوع تفضل من الأنواع التالية:

- A- سلطة الاقتناع.
  - B- السلطة المرجعية (كأن يرجع لك الآخرين دائماً في اتخاذ القرارات).
  - C- سلطة الخبرة.
  - D- سلطة التشريع والمنصب الذي منحك إياه المستشفى.
  - E- سلطة الثواب والعقاب.
  - F- سلطة الإكراه على عمل الأشياء.
  - G- سلطة المعرفة والعلوم.
- ... اختر واحدة ( )

5 2 أي من أنواع السلطة تحب دائماً ان تستبعدها عن عملك حددها؟  
أعط الأسباب ...


6 2 حدد أي نوع من القادة أنت ..

A- القائد المرشد...؟ السبب: ...
B- القائد المؤثر...؟ السبب: ...
C- القائد المستشار...؟ السبب: ...
D- القائد المفوض والمنتخب...؟ السبب: ...

### القسم الثالث: الثقافة.

هي مواقف القائد وأراؤه وتقديره لقيم المجتمع الذي يعيش فيه والتي تعطي المعنى الحقيقي للمستشفى الذي يعمل فيه وتحدد سلوك الأفراد فيه.

1 3 كيف ترى بأن هذا التعريف الخاص بالثقافة هو فعلاً يعكس ثقافة المستشفى الذي تعمل فيه؟


2 3 كيف تفسر لي معنى الثقافة في المستشفى الذي تعمل فيه إذن؟


**القسم الرابع: الفريق:**

هم أشخاص متعدّدوا المهارات يثيرون اهتمام قائدهم بهم دائماً ويسعون لتطوير النوعية والجودة وهم بارعون في حل المشاكل.

1 4 ما هي العوامل التي تساعد في تقوية اعضاء الفريق لديك؟


2 4 هل تعتقد بأن مؤهلات الفريق هو ما يحمله من معلومات وافكار؟؟  
وهل ذلك يلعب دوراً كبيراً في اتخاذ القرارات الحكيمة والصحيحة. أشرح ذلك.


**القسم الخامس: الاتصالات الشفوية والمكتوبة.**

وهي عملية نقل المعلومات بشكل شفهي او مكتوب بين الافراد العاملين بالمستشفى وبين مدرائهم والتي تحدد ان كانت رسمية (جمود) او غير رسمية (زمالة وتفاهم).

1 5 هل لك بأن تعرف ماذا تعني بالاتصالات بالنسبة لك كمدير؟


2 5 ما هو نوع الاتصال الذي تفضله مع اعضاء الفريق؟ هل هو الصاعد، النازل أم الجانبي؟  
أعط الاسباب ...


3 5 بناءً على الافتراضات السابقة. ماهية نوعية الاتصالات في المستشفى الذي تعمل فيه: هل رسمية ام غير رسمية؟




**القسم السادس: الجودة.**

هي مدى كفاءة الخدمات الطبية المقدمة للمريض في هذا المستشفى بأحدث الاسس والمعايير.  
لماذا تعتقد بأن الجودة في العمل الطبي لها علاقة بكفاءة القيادة الصحية؟

1 6


هل تعتقد بأن هنالك علاقة طبية بينك كمدير في الحقل الطبي والمدراء الآخرين في الادارات العليا في المستشفى (والادارة الاستراتيجية والمحاسبة وشؤون الموظفين وغيرهم)؟  
وضح ذلك ...

2 6


هل سبق وان التحقت بدورات تدريبية من أجل الارتقاء بالجودة سواء أكانت الجودة الطبية او الجودة الادارية في المستشفى؟

3 6


**القسم السابع: الاخلاقيات.**

وهي الاطار الذي يؤكد احترام وكرامة العاملين في المستشفى والتصرف بناءً على عادات وتقاليد المجتمع وثقافته ودينه والقوانين المرعية.

هل تعتقد بأن الاخلاقيات الادارية والطبية في المستشفى يجب أن تكون نظاما يحكم الخدمة الطبية المقدمة.

1 7


هل تعتقد بأن القانون غالباً ما يحل الصراعات والمشاكل التي تنشأ في المستشفيات خاصة المشاكل الطبية منها.  
وضح ذلك ...

2 7


هل أن الاخلاقيات تساعد على تحسين العلاقات بين المدراء والمرؤوسين؟

3 7


**القسم الثامن: القادة الطبيون ( Allied Health Professionals ).**

وهم الاطباء والمرضون والصيداللة والمخبريون وفنيوا الاشعة والكيمياء الحيوية والعاملون في البحث العلمي الطبي كعلم الامراض والمناعة والعدوى وغيرها، والذين لديهم مهارات اشرافية.  
هل توافق بأن هؤلاء القادة الطبيون يستطيعون تطبيق مبادئ القيادة والادارة بجانب عمله الاصلي كمعالجين؟ 1 8

2 8 ما هي طبيعة السلطة الممنوحة للقادة الطبيين حسب التعريف اعلاه؟  
هل هي المعلومات التي لديهم والخبرة،  
أم هل هي صفات الشخصية القيادية التي خلقت معهم اصلا؟

الرجاء تحديد ذلك.

**القسم التاسع: الاطباء كمدرء في المستشفى (Doctors).**

هم الاطباء الموكل لهم العمل الاداري والقيادي في المستشفى بالاضافة الى مسؤولياتهم كمعالجين للمرضى ومسؤولين عن صحة مجتمعاتهم.  
هل توافق بأن الأطباء يجب أن يكونوا معينين في الادارة الطبية؟ أعط أمثلة ... 1 9

2 9 الى أي مدى فعلا يمارس الاطباء مسؤولياتهم الادارية في ادارة المستشفى الذي تعمل فيه؟

3 9 هل تعتقد بأن مشاركة الاطباء في الادارة سيطور من جودة العمل الطبي؟

4 9 الى أي مدى يحتاج الاطباء الى دورات تدريبية تؤهلهم لأن يصبحوا مدرء في المستشفى؟

5 9 الى أي مدى توافق بأن الادارة للاطباء يجب ان تدرس في الجامعات جنباً الى جنب مع العلوم الطبية؟

6-9 ما هي السلطة التي يمتلكها الاطباء: هل هي سلطة المركز ام سلطة العلوم؟

**القسم العاشر: الممرضون المدراء.**

وهم الممرضون المفوضون بممارسة مهامهم الادارية جنباً الى جنباً مع مهامهم الطبية والتمريضية والذين يسعون الى تطوير الابداع لدى اعضاء فريقهم من الممرضين ويشاركونهم في عملية صنع القرار.  
هل توافق بأن الممرضين يجب أن يكون معينون في ادارة المستشفى الذي تعمل فيه؟ اعط الاسباب ... 1 10


الى أي مدى فعلاً يمارس الممرضون مسؤولياتهم الادارية في ادارة المستشفى الذي تعمل فيه؟ 2 10

--

هل تعتقد بأن مشاركة الممرضين في الادارة سيطور من جودة الخدمات الصحية في المستشفى؟ 3 10

--

الى أي مدى يحتاج الممرضون الى دورات تدريبية تؤهلهم لأن يصبحوا مدراء في المستشفى؟ 4 10

--

الى أي مدى توافق بأن الادارة للممرضين يجب ان تدرس في الجامعات والمعاهد الخاصة بالممرضين الى جانب دراسة التمريض؟ 5 10

--

6-10 ما هي السلطة التي يمتلكها الممرضون: هل هي سلطة المركز ام سلطة العلوم والمعرفة؟

--

**القسم الحادي عشر: مفهوم القيادة في المستشفى.**

هل تهتم بكامل ما يحصل لاعضاء فريقك على الجانب الفني او الشخصي؟ اعط أمثلة ... 1 11


هل تسمح بحدوث بعض الاخطاء بين اعضاء فريقك؟ وهل تصححها فعلاً. الرجاء إشرح ذلك ... 2 11


3 11 هل تهتم بالدورات التدريبية التي تساعد على تأهيل فريقك في العمل؟  
أعط مزيداً من التفاصيل ...


4 11 هل لك بأن تحدد الأسباب التي تعيق تطبيق مبادئ الادارة والقيادة في المستشفى؟


القسم الرابع عشر: المعلومات الشخصية.  
الرجاء كتابة المعلومات الشخصية وذلك لاغراض البحث العلمي فقط.

M1	الجنس:	ذكر <input type="checkbox"/>	أنثى <input type="checkbox"/>	
M2	اذكر اسم القسم الذي تعمل فيه ..			
M3	حدد وصفك او مسماك الوظيفي ..			
M4	اذكر عدد افراد فريقك الذي ترأسه ..			
M5	اذكر عدد سنوات خبرتك في هذا المستشفى ..			
	(أ) 1-4 سنوات	(ب) 5-9 سنوات	(ج) 10-14 سنة	(د) 15 سنة فأكثر

ملاحظة:

إذا أردت معرفة نتائج هذا البحث يرجى تعبئة النموذج أدناه:

الاسم:
العنوان:
البريد الإلكتروني:
هاتف أرضي:
هاتف خلوي:

مع الاحترام والتقدير،،،

الباحث

علاء عبيدات