

Creation of an academic medical centre: Management and service delivery at the Canberra Clinical School

PAUL A GATENBY

Paul A Gatenby is Associate Dean of the Canberra Clinical School, Woden Valley Hospital, ACT.

ABSTRACT

The Canberra Clinical School is attached to Woden Valley Hospital, the principal hospital in the Australian Capital Territory. The clinical school arose out of a memorandum of understanding signed between the University of Sydney and the ACT Department of Health (as it then was) in March 1993. One of the aspirations of those who negotiated the memorandum of understanding was that the creation of the clinical school would lead to a cultural shift in attitudes towards change within the health care system. This paper looks at the management structure of Woden Valley Hospital and at what the development of a clinical school in Canberra can achieve, particularly in relation to hospital and health service management.

The Canberra Clinical School arose out of a memorandum of understanding signed between the University of Sydney and the ACT Department of Health (as it then was) in March 1993. This agreement was the culmination of many years of work to develop a clinical academic presence in the ACT. Plans for a complete medical school had been considered in the early 1970s, but Canberra essentially lost out to Newcastle (Fraenkel, Johnston & Kearney 1990). In the current climate of concern about excessive numbers of doctors, a clinical school in association with a pre-existing medical school was really the only way forward and, with advantages to both sides, agreement was reached (University of Sydney/Australian Capital Territory 1993).

There are clear benefits for the University of Sydney, but the thrust of this paper concerns the benefits for the ACT Department of Health and, more broadly, the community of Canberra and the region. Academic medical centres are characterised by a threefold responsibility: teaching, research and clinical service. The creation of the school will bring a number of benefits to the health system in Canberra, including the opportunity to recruit academic staff to plug gaps in clinical expertise that exist within the Canberra region. This has already occurred in areas such as clinical immunology and fetal medicine. The Canberra Clinical School will create an environment of scholarly activity in the health services – through both teaching and research. It is widely recognised that this enhances service delivery or at least provides a milieu in which the latter is more likely (Fraenkel, Johnston & Kearney 1990). Teaching, which the majority of medical practitioners in Canberra and the region will participate in, is correctly considered as helping maintain professional standards. The Canberra Clinical School will provide more ready access and more expertise for basic researchers (of whom there are many in Canberra) to collaborate with areas of academic clinical medicine; this too is likely to lead to direct benefits for the people of Canberra and the region (Fraenkel, Johnston & Kearney 1990). Strong emphasis will be placed on managerial skills and interests in quality assurance, outcome measures and health care reforms in recruiting senior staff to the Canberra Clinical School. The latter point leads into the main substance of this paper.

Before developing this theme further, it is necessary to clarify that the Canberra Clinical School will involve all public, and some private, health facilities in Canberra and the region. Indeed, the author shares some of the views espoused in 'The boundaryless hospital' (Braithwaite, Vining & Lazarus 1994), and also some of the criticisms (Larkins, Martin & Johnston 1995). The principal hospital, however, is Woden Valley Hospital, and it is the management of that institution on which the discussion will concentrate.

Woden Valley Hospital is reaching the end of a major redevelopment, following a decision to amalgamate the Royal Canberra Hospital with Woden Valley Hospital in 1992 after the Kearney report (1988). This development, one of the largest in the public health sector in recent years, has led to an excellently equipped 600-bed hospital with most of the facilities in place that are required for a teaching hospital. The hospital covers all major disciplines, including paediatrics and obstetrics, with the only current deficiency of note being open-heart surgery. It is likely that

this will develop over the next year or so, enhancing Woden Valley Hospital's position as both the principal hospital in Canberra and a major provider of health services to the surrounding region of New South Wales.

Woden Valley Hospital, however, has been left with a management structure that all but the most die-hard of supporters would regard as less than ideal. It also has a less than desirable cost structure when compared to similar organisations (Gillet & Solon 1995). One of the aspirations of those who negotiated the memorandum of understanding was that the creation of the clinical school would lead to a cultural shift in attitudes towards one favouring change within the health care system.

Indeed, the industrial scene in health in Canberra has been and continues to be fairly robust, creating a milieu in which management change may well be more difficult than in other jurisdictions. In general terms the pathway to reform will follow that seen elsewhere, with devolution of management control to clinical groupings, currently largely defined around 'classical divisions', and an expectation that the heads of these service management groupings will form the basis of a collegiate hospital management committee. An attempt was made to develop service management teams, aggregations of various clinical services that plausibly fitted together (O'Donnel 1993, pers. comm.), but this proposal was not accepted by staff and currently a hybrid between this and traditional divisional groupings exists. Within the current groupings, the individualistic structure of the senior medical staff and the extreme hierarchical structure of nursing have inevitably led to organisational difficulties. This clash of cultures is of course not unique to Woden Valley Hospital. There is an immediate need to tidy up what each division actually consists of and what divisional managers are responsible for, and to align these divisions with those that the Medical Staff Committee (another integral part of the way in which the hospital runs) recognises.

The Medical Staff Committee is recognisable from models discussed by Duckett et al. (1981) and is currently made up of elected heads of divisions, largely on traditional professional lines, with a diagnostic division embracing pathology and imaging services now recognised as two entities by the Hospital Management Committee, and two separate divisions of obstetrics and gynaecology and paediatrics now combined on the Hospital Management Committee into Women's and Child Health. There is also on the Medical Staff Committee a representative of 'a division of community medicine' to represent general practitioners who have hospital appointments. This group is not represented separately on the Hospital

Management Committee and has no relationship to an active ACT Division of General Practice, nor to the Community Division of the Department of Health and Community Care.

Divisions involved in clinical care generally have a nursing and a medical manager, and this situation is likely to persist in the medium term. The incumbents have generally adopted a complementary rather than adversarial role, although disputes involving visiting medical officers and a recent operational efficiency review carried out by Booz•Allan and Hamilton have and will put strains on the working relationship.

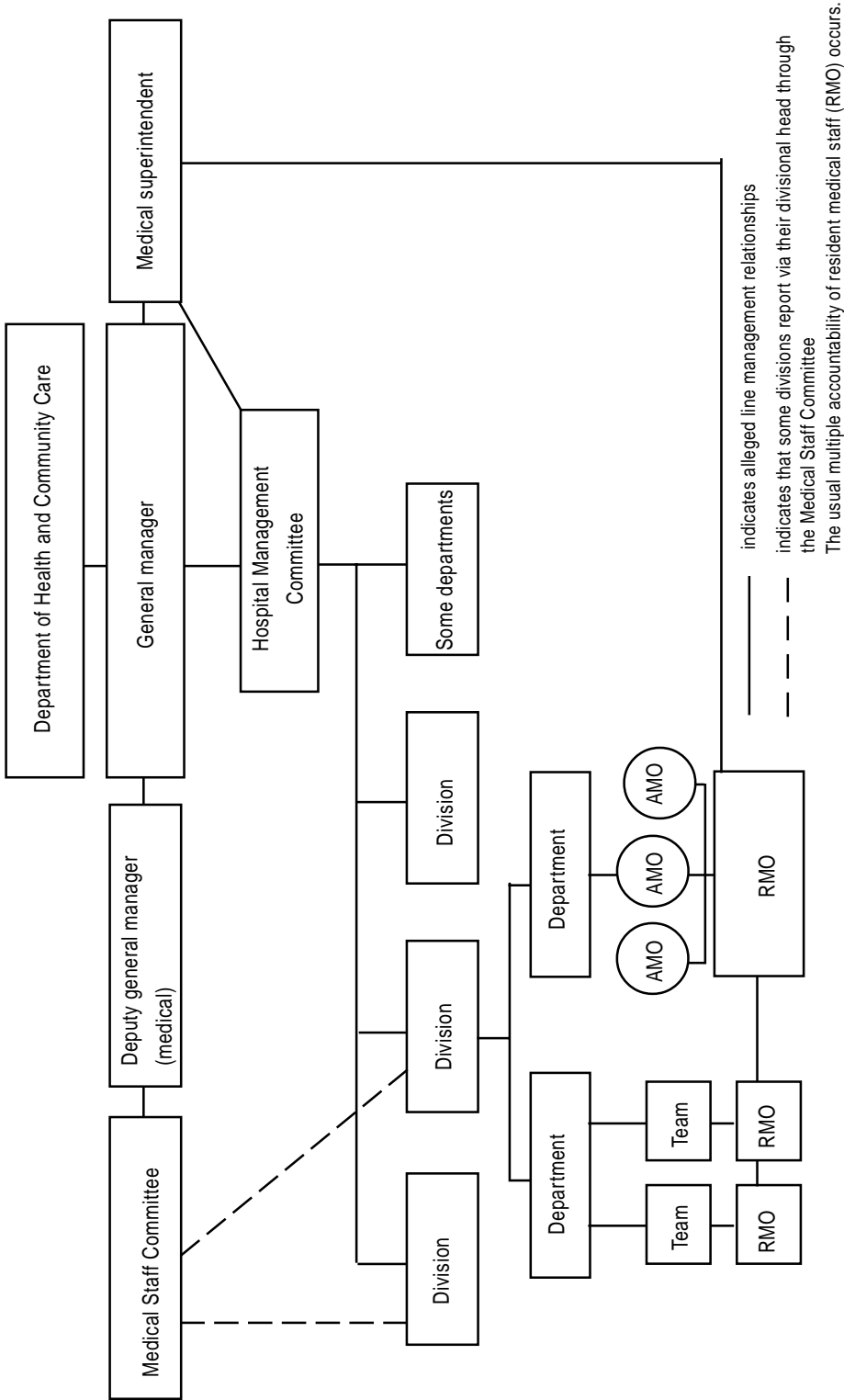
Figure 1 shows a model of the hospital's current structure from the medical point of view. The model is developed from those described by Duckett et al. (1981).

The management structure of Woden Valley Hospital is unique in that there is currently no board and that, as stated above, the divisions recognised by the Hospital Management Committee are not identical to those that underpin the Medical Staff Committee. In addition, the heads of divisions are elected representatives who do not fill the role of divisional managers (medical). The interplay between the heads of divisions and divisional managers (medical) varies from division to division; clarifying the way in which the elected divisional representatives will have input into the Hospital Management Committee via their managers is a critical issue in the organisation's development.

I have attempted to highlight issues that are relatively peculiar to Woden Valley Hospital's development and the maturation of its management structure. All the usual problems of balance of power between doctors and nurses, full-time staff and visiting staff, where to put allied health and the like exist, but will be regarded as peripheral to the ideas developed here. In truth, they cannot always be separated, a point returned to below. Against this forbidding background, what can the development of a clinical school in Canberra achieve, particularly in relation to hospital (or, in broader terms, health service) management? Such opportunities can be usefully regarded at a number of levels.

Most senior academic positions, but not all, by nature of the skills required, will be recruited from outside Canberra, largely from health services that will have had two decades of modern health management reform. At the very least, the incoming senior academic staff will have 'seen it all before'. They will be able to contribute, in a general sense, to the clinicians' level of trust in the intrusion of management devolution into their daily practices, as well as to a healthy scepticism of the downside to

Figure 1: Organisational chart of medical staff for Woden Valley Hospital



this process. In addition, academic staff should by their very nature bring open enquiring minds, prepared to change and 'give ideas a go'. This in fact should apply to all levels of new appointments and enhance the flexibility of the medical work force.

Indeed, in a recent key issues paper (Baulderstone 1995) it was stated that part of medical students' education should be to understand the clinical pathways of patient care. Ideally they should learn about this by exposure to such practice in their clinical attachments. As the scene is not yet set for this approach, the faculty will have to tackle this at a more formal educational level. The faculty could imbue its students with modern management practices to provide an understanding of the controls in Australian health care. Having stated that, the issue of how much time to devote to the practice of health service management in an already crowded curriculum is contentious. Our intent is to adopt the same policy as we do for the rest of the course – that is, prepare our graduates for lifelong learning as, in the area of health service management, like the vast majority of medicine, the only certainty will be change.

The development of the Canberra Clinical School ought to contribute more than a mere change in ambience or plan for future flexibility of the medical work force. The author agrees with views espoused by Miles and colleagues (1993) that academic health centres have 'a duty to accept broad responsibility for the health of their communities' and should be directly involved in the process of health care reform. A case can be thus made for a direct and strong involvement by the senior faculty in the management structures of the hospital. In the early years of development (for example, the first five years) of the Canberra Clinical School this could be achieved by each professor conjointly holding the position of divisional manager (medical) in the appropriate discipline unless there are compelling particular reasons to the contrary. In this way they can contribute effectively to both the divisional management and, through a restructured Hospital Management Committee, the management of the hospital itself.

Examples of areas where this is already in place are Women's and Child Health (Professor of Obstetrics and Gynaecology) and Pathology (Professor of Pathology). The key issue is that executive and financial control will allow the manager/professor to fast-track the development of the divisional unit towards a service in which teaching and research are integral parts of the service and, at the same time through the Hospital Management Committee, contribute to the corporate management.

With this philosophy in mind, strong emphasis has been placed on managerial skills in the selection of professors. Indeed, such skills in recent years have been sought in the university in general, and the old adage, 'those who can, do, those who can't, teach', no longer ought to have any role in university staff selection, particularly in a clinical school where very clearly academic staff have contributions to make to both the university and the health service.

There are, however, drawbacks to this plan that must be acknowledged. Distracting a senior academic from 'professing' their discipline can potentially be detrimental to intellectual growth and development. Time spent administering is time taken from teaching and, more particularly, research. To my mind it is in the early years a price worth paying as the establishment of a firm divisional base and influence in the decisions of the Hospital Management Committee is ultimately going to produce a stronger foundation for an academic medical centre than would otherwise occur. In addition, experience has shown that clinical managers are not always the most popular of individuals, particularly in times of fiscal restraint (basically currently and forever). Hostility to a particular manager may reflect on the clinical school. This will have to be worn. To not 'roll up the sleeves' and get involved in management, including resource allocation, could be seen as ivory-towered isolationism. This would deprive the organisation of much-needed expertise and runs the even greater risk that the organisation will grow and develop without cognisance of the clinical school's needs. Indeed, there are forces abroad that seek to reduce the intellectual content and medical contribution to medical school activities (Bondurant 1995). As has been pointed out by others, it is essential to attempt to maintain academic objectivity. This can be difficult and indeed experience shows that neutrality is hard to maintain as there is progression from defining problems to developing options and finally implementing policy decisions (Miles et al. 1993).

To participate optimally in the reform process requires that the academic units have adequate infrastructure to do so while protecting their disciplines, legitimate teaching, service and research requirements (Miles et al. 1993). The ACT Department of Health and Community Care is the principal source of financial support for the Canberra Clinical School and, as such, must recognise the need for such infrastructure. Generally it does.

To my mind the most important of these drawbacks is the first. The role of any senior academic in hospital management must be continuously evaluated; preferably the professorial staff in this role should be replaced

by a cadre of home-grown (or appointed) clinician managers over a period of about five years. Although everybody would wish for a golden age of stability instead of the endless crisis management, it is unlikely that a steady state will ever be achieved in the current climate of health service management in western countries (Schwartz & Mendelson 1991). The relationship at that stage between an academic head of division and a divisional manager would need to be clarified, but this can be seen as a mere extension of what needs to be done to sort out the relationships between elected divisional representatives and the current divisional managers.

The current divisional make-up of Woden Valley Hospital, for all its irregularities, lends itself well in a structural sense to this proposal. It is possible that the institution may move towards different managerial units – although with the failure of a recent attempt fresh in everybody's mind, such a development is not imminent. However, if such changes occurred there is no particular reason why the roles proposed here could not in the main be followed.

Whatever the path chosen, it is important that both the administration of the health services, in particular the hospital, and the clinicians involved in service delivery and student teaching see this as a useful proposal. There is no doubt that health care reform is under way, even in the ACT. Clinicians involved in a leadership role in teaching, research and service delivery should assume the same in administration. It is to be hoped that after the first decade, in 2004, a generally positive view of the development of an academic medical centre will be able to be written, as was possible for the Austin Hospital in Melbourne (Price 1984).

References

- Baulderstone P 1995, 'Paths to improving quality', AHA Key Issues Paper, No 4, pp 1–4.
- Bondurant S 1995, 'Health care reform continues themes for academic medicine', *Acad Med*, 70, pp 93–7.
- Braithwaite J, Vining RF & Lazarus L 1994, 'The boundaryless hospital', *Aust NZ J Med*, 24, pp 565–71.

- Duckett SJ, Scarf CG, Schneide AM & Weaver CJ 1981, *The organisation of medical staff in Australian hospitals*, Longman Cheshire Pty Ltd, Sydney.
- Fraenkel GJ, Johnston CI & Kearney BJ 1990, Research at the Royal Canberra and Woden Valley Hospitals and the potential for a University Hospital, February, p 16.
- Gillet S & Solon R 1995, *Hospital utilisation and costs study 1989–1990*, Volume 1, AIHW Health Services Series, Australian Government Publishing Service, Canberra.
- Kearney BJ 1988, Independent review of the ACT Health Services, November.
- Larkins RG, Martin TJ & Johnston CI 1995, 'The boundaryless hospital – a commentary', *Aust NZ J Med*, 25, pp 169–70.
- Miles SH, Lurie N, Fisher ES & Haugen D 1993, 'Academic health centres and health care reform', *Acad Med*, 68, pp 648–53.
- Price I 1984, 'The Austin experience 1973–1983', *Australian Health Review*, 7, pp 154–61.
- Schwartz WB & Mendelson DN 1991, 'Hospital cost containment in the 1980s. Hard lessons learned and prospects for the 1990s', *N Engl J Med*, 324, pp 1037–42.
- University of Sydney/Australian Capital Territory 1993, Memorandum of Understanding: To establish a Canberra Clinical School.