Health care executives and 'their' patients

How do they keep in touch?

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Introduction

In their offices at the end of long and silent corridors, executives usually do not meet patients. Either they walk through their organisation in the same anonymous way as their patients or they are known as the 'executive' and kept at a distance because of their status. Questions arise: do we know something about the number and the type of contacts health care executives and patients actually have? How does the executive, in an environment of growing distance, stay in touch (to speak in marketing terms) with their ' product' and their 'clients'? Where do they meet?

This article explores the contact patterns between patients and health care executives. Firstly, the tools actually used by health care executives to become aware of the needs of their patients will be described. This is achieved using data from a questionnaire sent to 900 Dutch health care directors, working in different health care organisations, with a 46% response rate[1] and by analysing 12 interviews with Dutch health care executives from different backgrounds and different types of care institutes.

Secondly, to get a notion of how the contacts with clients influence health care executives in their behaviour and policies implemented, two executives of different Dutch institutes for health care were observed in their normal working roles.

Thirdly, the most intimate contact with the role of patient is to become a patient yourself. Do health care executives change their policy and vision once they have experienced the patients' role? To get an insight into the experiences and behaviour of executives on becoming patients, five interviews, published in 2004 in *ZorgVisie*, a Dutch magazine for health policy and management, were analysed.[2] Based on these findings, prudently, a few conclusions can be drawn.

Research context

This paper results from a long running project 'Caring for Management' that studies the work and behaviour of health care managers.* Much has been written about health care systems, governance questions, and organisational transitions. Health care managers, however, have been 'invisible'. This project will attempt to change that. It started in 2000 with a literature review[3] on the role, behaviour and competences of health care managers and was followed by an extensive survey in the same year.[1] These data provide the background for further qualitative exploration of real-life managerial work and behaviour in health care. The focus of the qualitative part of the research project is based on the analysis of current trends in Dutch health care, namely that:

- Health care institutes are scaling up by merging.
- More than 50% of the executives of health care institutes are now educated in economics and management. A 'managerial revolution' seems to have taken place.
- The structure of Dutch health care organisations has changed from functional based to process based divisions
- The management of health care institutes has changed. Due to the growing span of control of managers, and the

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increasing number of organisational layers we see a decrease in 'hands-on' management.

This analysis leads to the conclusion that the distance between the executives and primary processes is increasing.

Contact patterns

How often do executives actually meet their patients? The survey[1] shows that 66% of the total number of contacts of health care executives are internal contacts and 34% are external contacts, but only 6% of the internal contacts are contacts with patients and/or clients. At most 7% of the contacts of executives of institutions for people with intellectual disabilities take place within the institution; in respect of home care this represents only 4% of internal contacts.

In larger health care organisations, executives tend to have more managerial contacts and fewer contacts with professionals and patients/clients.[4] Contacts with clients are less than 4% of the total amount of contacts of the average health care executive. Based on these figures one could easily draw the conclusion that patients are not considered to be an important factor in the daily work of the executive. Is this conclusion correct? To check this, executives were asked how they keep in touch with primary processes and with their clients.

Twelve health care executives were interviewed about the phenomenon of an increasing distance between executives and the primary processes in their growing organisations. The executives considered growth to be an unavoidable social reality arising from technical developments, specialisation and an increase in part-time working.

These executives do indeed encounter some of 'their' clients at meetings of the patient council, or they meet a specific patient or his family following a complaint about care received. They also meet specific groups of clients at external consumer boards. A more abstract form of meeting the patient and identifying their needs is by investigating patient satisfaction. This method was not mentioned much. Some executives walk around to have informal chats with patients in the corridor or in the organisation's restaurant. The executive of an organisation providing care for older people for example, walks through the care unit or joins Sunday morning concerts. In organisations for people with intellectual disabilities, clients often bring coffee or simply walk in for a little chat. This used to be the same in psychiatric institutions but as these organisations became bigger, the office of the executive turned out to be too far away: "I had a room where patients dropped in…". Particularly in hospitals there seems to be little contact between executives and patients. Most patients stay in hospital for a short period and the patient population is diverse. Due to this, hospitals are crowded with people, like big shopping centres. Walking through the hospital, the executive is as anonymous as the patient.

Most executives do strive for contacts with primary processes; they try to make regular visits to the work floor. Although most of these executives consider making regular work visits important, they are aware that they in fact are not acting accordingly. Only one of the 12 executives built in monthly work visits as standard into his planning. During these visits, most executives are passively informed, although a few do partake themselves in the physical work of care giving.[5]

Some of the executives interviewed do not in fact visit the work floor at all. They rely on their former experience in the primary process, and believe monitoring and delegating contacts through the layers of their organisations should provide enough information. They may also simply feel uncomfortable disturbing the privacy of their patients and the autonomy of the professionals working on the ground.

Contacts in practice

Knowing how often executives and clients meet and knowing on which occasions they meet does not tell us if, and how, executives use this information as part of policy-making. Therefore, we need to have more inside (real life) information.

Two executives, a hospital director and an executive of a organisation for people with intellectual difficulties, were observed for five days. The days were chosen from the diaries of the two executives. We selected days with the most diverse meetings, a work visit or other moments of contact with clients, managers or professionals.

The first of the two observed health care executives leads one of Holland's largest hospitals with five sites and 2,500 employees. Being a mathematician he is not formally educated in the care sector but is well versed in its practice. Previously, he used to be the executive of an organisation for people with intellectual difficulties. During this

period of observation there was no contact with patients at all, although he accompanied his daughter to be treated in his own hospital and referred to this in one of the meetings with managers. He regularly mentions his wife, a nurse in another hospital, and uses her opinions and experiences. A lot of his daily contacts are with medical professionals and he sometimes visits wards.

In the organisation for people with intellectual disabilities, he had a lot more contact with clients and their families. Now, in this hospital, where he does not have a connection with the patient, his behaviour is driven by a more abstract notion of the patient. In meetings he always tries to imagine the experiences of patients and advocates their needs, using the slogan: 'patients first'. In his welcome speech to new employees he tells them to like their work and love their patients. To be in contact with primary processes the executive and his colleague, an economist, are strongly involved with quality improving projects of the organisation. Although this executive does not meet the patients in person, his vision of patients' needs and wants, is strongly personal.

Executive 2 leads an organisation for people with intellectual disabilities, scattered across 120 locations and employing 1,600 staff. Primarily educated in care giving and latterly in management, his professional and managerial career have all occurred in this specific sector and mainly in his current organisation. He is strongly committed to the ideology of 'community care', which means supporting disabled people to live a life as normal as possible. He writes about this and has a firm knowledge and notion of the evaluation of this kind of care all over the world. He is acquainted with and well known by his personnel, makes structural monthly visits to different parts of the organisation and wants to be in contact with the work-floor and patients to fine-tune his vision.

During the observation period, there were many contacts with clients as they work in the organisation's restaurant or while they deliver mail. On his monthly visit he talked with many of the clients and played chess with one of them. In a meeting with the client board, where professional attitudes were discussed, the executive used all his free time to chat with clients.

He seems to be very involved with clients but this 'ideological attitude' has another consequence. In this organisation employees complain that this executive gives too much attention to clients and too little attention to the professional dilemmas that the ideology of community care brings up.

Thus while both executives are involved with their patients their behaviour differs as their organisational contexts differ. Executive 1 uses the experience of his relatives to build an image of the experience of patients. He compares this image with the allocation of attention to the work of professionals. He tries to imagine how a patient will experience the care given in his hospital and he stimulates his employees to do the same.

Executive 2 has a lot of contact with clients and their families and has a firm vision of how care should be provided. However, he does not have as many contacts with professionals and this firm vision has negative as well a positive influence on professionals; a phenomenon which is also found in other empirical research.[6] In this situation the knowledge of clients seems to work out as a system of 'planning and control'.

Effects of experienced care

The final question in this paper is whether the experience of being hospitalised changes the contact patterns of executives, and whether 'mental maps' and policy are influenced. In 2004, the Dutch magazine *ZorgVisie* published five interviews with executives who experienced being a patient or a close relative of a patient.[2] The published texts of these interviews were analysed.

All of the executives had both good and bad experiences and their opinions vary from annoyance to admiration. The annoyances were mostly raised by periods of waiting and by insensitive attitudes of staff. The practice of keeping patients waiting for a long period, without informing them why things take such a long time, made the executives angry, especially when the desk officer in charge did not make any kind of contact. These health care executives experienced a strong feeling of dependency and the longing for confidence and attention.

They also noticed that some treatment decisions were not inspired by care but by economic or efficiency concerns. For example, the mother of one of the executives who was staying in an institutions for care after having a stroke was moved from a small dining table, where she had nice contacts despite her problems in talking, to a big table were she had no contact at all during dinner. These big tables were

deemed more efficient for serving dinner. The executives experienced that this kind of decision-making is hard to accept for patients, especially when things go wrong.

These self-experiences changed neither contact patterns, nor the number of contacts with patients, but they certainly changed the 'mental maps' of the executives, and they became aware of three main issues:

- Management, alone, is not providing better care
- Patients are not clients: dependency makes you lose your tongue
- The attitude of caregivers is very important

When these executives returned to their organisations, they changed their policy based on these insights. First, due to their insight that individuals need personal attention, they tried to improve care by making it more personal, for example, by appointing personal patient coaches but predominantly by devoting more time, money and attention to the training and assessment of attitudes of health professionals and other personnel. Another way of personalising care was to provide more and better information for patients. Second, executives who experienced the patient role directly, showed more respect for the work of professionals and had come to understand the importance of supporting their work.

Conclusion

Bridging the distance between executives and patients seems to be not a matter of quantity but a matter of quality. Executives who experienced care themselves, did not increase their contacts with patients but changed their 'mental maps'[7] and their policy. If health care executives are more responsive to patient perspectives, they are more willing to change into more empathic organisations.[8] Hopefully, executives will stay healthy but they can improve their imagination of being a patient. Their image of the patient perspective can be strengthened by sharing the real experiences of the clients of their organisations.

It also became clear that it is important for executives to pay attention to the dilemmas that health care professionals confront in their daily work. When we typify management as the process of allocating attention[9] we see that health care executives have to allocate their attention to at least two perspectives, the perspective of the patients and the perspective of the professionals. Patient experiences and professional dilemmas can give input to the imagination of the patient and professional perspectives. They will lead to the involvement of the health care executives and to management behaviour which consists of supportive leadership and personalised care. If we underwrite the assumption that leaders influence employees' attitudes then this behaviour and policy will lead to more empathic health care organisations.

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