SIMULATED INTERACTIVE MANAGEMENT SERIES

Article 5. Strategic decision making, motivation theory, and junior doctor interviews

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Feedback

Those of you who are avid readers of the internet section “St Jude’s diary” will have seen a situation developing regarding possible sexual harassment. However, many may have missed the last instalment where a staff nurse has made a formal complaint about sexual harassment by one of the staff grade doctors. Review the St Jude’s diary sections for articles 3 and 4 (emjonline/contents/SIMS3, SIMS4). Were there warning signs of this problem? Could this have been handled differently? A major in tray task this edition is to set out the management action of this complaint (emjonline/contents/SIMS5).

The psychotic patient was a significant problem. He did not want treatment but obviously needed help. He was restrained and then sedated and is now doing well under the care of the psychiatrists. What is the legal context for this action of treating patients against their will? We will examine this in a later time out. How would this differ in North America, Europe or Austalasia. E-mail responses welcome.

Candidates OP, SJ and CB were popular choices for short listing. For the other five there was less agreement. A tight person specification should make this process much easier and fairer. The person specification used for the shortlist is on the internet in the feedback section along with the shortlist.

The preparation for the independent review has taken a great deal of time and effort and had a definite effect on staff morale. For the first time all parties involved have met to establish the facts of the case. Statements have been given. The A&E staff involved have required a lot of support as they became very anxious about the process. Re-assurance and encouraging a fully open and honest approach have been helpful.

The independent review has reported and a copy of the report is given on the internet. Staff are relieved but it seems the matter is not going to rest here as the complainant is still not happy. It seems the case is going to the Ombudsman.

The problem with the ECG machine has been resolved. This was a key piece of equipment whose replacement was urgent and important. The “normal” procedures had failed so you went to see the medical director to discuss the issue. You took with you a draft letter to the medical director that stated the department could not safely see patients with chest pain and that the hospital’s ability to meet the standards for thrombolysis were seriously compromised. This direct approach to the medical director has resulted in a new ECG machine. One small battle over but does this show a worrying lack of general equipment in the department?

The memo regarding a request for information from the police contained an interesting typo (they had “found blood on a ~~widow~~, oops window”) (emjonline/contents/SIMS4). Finding a widow with blood all over her might well represent a “serious arrestable offence” where it might be justifiable to break patient confidentiality. Blood found on the window after a simple burglary is unlikely to meet the criteria. Guidelines concerning the release of information to the police were agreed by the British Association for A&E Medicine, the Association of Chief Police Officers and the Central Consultants and Specialist Committee of the British Medical Association.[1]

These rules apply to the UK. It would be interesting to hear how this problem might be tackled in other countries.

The request for an expert opinion in a case of personal injury is not NHS work but represents a variable workload for many A&E consultants. It is important that if you are undertaking this work then you should have the necessary training and expertise. There are a number of training courses designed specifically for this task. Dr York has been trained and is a member of one of the professional organisations of expert witnesses. The report is another in tray task in this edition, a task that of course will not be carried out to the detriment of NHS work.

Time out—people

MOTIVATIONAL THEORY AND THE A&E DEPARTMENT

Motivation of groups of individuals to reach agreed objectives is at the heart of management. The variety of theories that try and explain motivation shows how difficult it is to encapsulate basic, human drives. These theories all help to explain different aspects of motivation and are useful in considering the issue. They are summarised in table 1 and are

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Table 1 Summary of some of the many theories that help describe different aspects of motivation (derived from references 2, 3)

Author	*Theory*	*Brief description*
Schein		Basic description of views of human motivation
Mayo	Hawthorne Study	Original research that indicated that social factors were much more important in motivation than physical factors. Also showed that if you try to study a behaviour, that behaviour alters simply due to the study.
Maslow	Hierarchy of Needs	Motivation drivers vary from basic physiological to self fulfilment. As each level is satisfied the next becomes the main motivator.
McGregor	Theory X & Y	Theory X workers need supervision and driving. Theory Y workers are self driven.
Herzberg	Motivation-Hygiene	The motivation of a workforce depends on the balance between positive drivers (motivators) and negative influences (hygeine factors)
Likert		Description of management styles and organisational structure
McCelland	Acheivement motivation	Description of motivation in terms of need for Achievement, Power and Affiliation.
Vroom	Expectancy	Examines the components of motivation
Robbins	Equity	Examines the effect of the perception equity of rewards or position on motivation.
Ouchi	Theory Z	The Japanese approach of a high degree of management/worker integration.

well described in Cole.[2] They range from the "Jekyll and Hyde" view of Theory X and Theory Y (some workers need to be driven and constantly monitored while others are driven by internal desire to serve and to do a good job) to the very functional model of Herzhberg who examines the positive and negative drivers in any work situation (motivators and hygiene factors). This article will not re-iterate these theories but attempt to examine how they might be used to explain the behaviours of some of the key figures in St Jude's.

Most people entering medicine and nursing do so with some belief that they will be able to help people and that the force of Theory Y should be stronger in individuals than Theory X (they should be more internally driven by the desire to do a good job than need constant external monitoring). Indeed over the past 50 years the NHS has depended on individuals putting much more into the job than their contract. However, such commitment needs some reward. In the past this was given in terms of respect and positive feedback from patients. However, as medicine becomes ever more pressured, time available for the less technical areas of patient care reduces the "quality time" that permitted such human interactions in the past. While the doctors and nurses are still regarded with respect by many members of the population there have been increasing attacks on the professions by the media and at times by politicians and managers. Some of the speeches of high ranking politicians in the current UK government have not been models of how to motivate people. Let us examine the current behaviours of some of the staff of St Jude's.

Mr London has obviously given many years of hard service to the department. He achieved a lot, obviously worked very hard and was initially driven to succeed by the positive motivators of respect and recognition for running a good unit and of turning around a failing department. However over the years the "hygiene factors" (Herzberg's theory the factors that lead to dissatisfaction) have started to build up. Hertzberg points out that it takes a lot more motivators to achieve balance if there are negative factors around. He is now bearing a number of scars, complaints, battles lost with management over badly needed increases in resource, battles with colleagues over support for the department and criticism when things go wrong. Also the negative effects on family life, of being called even when off duty, the feeling that now someone is always looking over your shoulder and one mistake is not allowable are taking their toll. Even the Equity Theory is becoming important. He has always known the earning potential of some other colleagues is much greater but he made a definite career choice despite this disparity. It still chafes to see the young plastic surgeon in his very expensive sports car but it hurt even more to see a younger colleague in A&E get a merit award. He feels that he has given a lot and received no thanks. He has become cynical and embittered. However, he still cares about patients, especially children and will still respond with skill when the chips are down although he finds it increasingly difficult to tolerate the increasing demands of routine work. How do we change this situation, and more importantly how do we stop it happening in ourselves and in colleagues?

Dr York is starting out with enthusiasm and zeal. She has the same drive to make things better that Mr London had in his early days. She is also, perhaps, very aware of her illness and is keen to show that this does not have an impact. The negative factors of the job have not had time to accumulate and balance the motivators of the new role.

Dr Wales sees medicine very much as a job to earn a reasonable living. He will do this to a reasonable standard but is unlikely to put much extra effort into his post. He is likely to have a stronger influence of the Theory X mentality. He will not tolerate many negative factors and he may be likely to "soldier" (to do the bare minimum to prevent any disciplinary action).

Sister Oak has a strong adherence to tradition and professionalism. She has a large amount of experience and has seen a number of fashions come and go. Her motivation is possibly directed at keeping the unit running as smoothly as possible, perhaps overemphasising the need to process patients quickly. In terms of McClelland's Achievement/Motivation theory her need for Affiliation (n-Aff) might be a stronger motivator than the need for Achievement (n-Ach). Loyalty to a department is commendable but it can sometimes stand in the way of progress.

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Table 2 Option appraisal process for reduction of waiting time. The long list after option generation, the short list after option refinement, and the choice of options after option appraisal

Option long list	*Option short list*	*Preferred option*
More junior doctors	Nurse practitioner service	Nurse practitioner service
More nurses	Improving triage	*And* more support staff.
Nurse practitioner service	Primary care sessions	*And* redesign patient flows
Improving triage	More support staff	
NHS Direct software	Redesign patient flows	
Public education		
Primary care sessions		
More support staff.		
Divert to primary care.		
Re-design patient flows		

Sister Ash is highly ambitious. While she has a high level of care for patients she also wants to see her profession advance and to increase her own skills and potential. She is willing to work hard and to "go the extra mile" as long as this involves challenge and innovation. Routine repetitive work she will do well but will not put in any extra effort.

It is not constructive merely to use motivation theory to perform amateur psychoanalysis. The key is to use this analysis to improve performance. Analyse the motivation of some of the staff in your unit. What are the main motivators for SHOs, nurses, reception staff? How might you use some of the motivation theories to identify issues that motivate staff and those that cause disenchantment? How would you approach some of the motivation problems in St Jude's? In this area there are probably no "right answers" but some feedback discussion will be given in the next article.

Time out—strategy

DECISION MAKING

Life is full of choices and when you are considering long term projects that are going to require a large amount of time, effort and resource then it is crucial that the correct path is followed at the outset. The process of moving an organisation from the present reality to the future vision is complex but aided by some simple management techniques. The first step is to make the right decision and plan overall strategy, *strategic decision making*.[4] The second is to analyse the changes involved and get key people to "sign up to" the plan. The third phase is implementation or detailed *"project planning"*.

These techniques have already been used in examining the waiting time problem and we will use this to examine the process more closely.

Define the problem and/or objectives—This is the key step. What are the objectives for improving waiting time? New government targets in the NHS plan give very concrete objectives.[5] Are these also the views of the local purchasers of the service?

Generate options—This is the "creative" phase where lateral thinking is paramount. This stage should be *inclusive* and all ideas should be put down no matter how impractical. The solutions for waiting time problems will vary but table 2 shows some of the ideas at this stage.

Assess/test options—The first stage is to refine the option list by examining the "long list" and removing those that are not practical or feasible. Be careful at this stage not to discard an option because it is radical but some sifting will have to take place. The second phase is to examine options in greater detail to look at the details of cost, implementation and risks. The third phase may be to test some options, usually in a theoretical model but this may entail some "market research" and sounding out key stakeholders.

Option appraisal—This first step is to define the *criteria* against which the option will be judged. Common criteria include cost, acceptability to staff and other stakeholders, risk of not achieving objectives (*risk analysis*). Often these criteria are given different weights to emphasise the key criteria. The other key part of this process is stakeholder involvement. There is no point in deciding on an option that a key stakeholder will not support. For example, if the chief executive vetos your chosen option all your work will be wasted.

Choose option—This is the crunch time when a decision has to be made. By this time often there is a clear leading option but at times the choice can be difficult. This is where leadership and decision making skills come to the fore. Despite all the process it will often be judgement that counts. However, it may be possible to merge some options to provide a package that combines the strengths of two or more of the options and often reduces the risks.

Process review—Critique the process. What went well, what could have been done better? Has it taken too much effort? What lessons might we learn for the future? Those who carried out the decision management exercise in SIMS article 3, review how to conduct the exercise. Do you follow all the steps? What shortcuts did you take? Would this work in reality?

Those experienced in real strategic decisions will recognise that this approach is not always needed. However, if the problem is difficult, or if it is hard to motivate staff to change then option generation and appraisal is a good way of setting out the consequences of no change. Involvement of staff is again key to making the next steps of implementing change happen.

In tray

INFORMATION

- The internet section contains the statements from staff involved in the allegations of sexual harassment.
- Reply to the Ombudsman's office regarding the complaint.
- Notes from interview with personal injury claimant.
- NHS plan (www/doh.gov.uk.nhsplan)
- Letter from ophthalmologist
- A junior doctor has come to the department with an infection on the back of his hand. During the examination you note bruises on the arm and antecubital fossa. On direct questioning he confirms that he has been under a lot of stress recently and has been

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injecting street heroin. He pleads with you not to break his right to confidentiality as a patient and promises that he will seek help, take a week's sick leave and stop injecting

TASKS

- What action is needed over the allegation of sexual harassment? What are the policies and procedures for possible disciplinary action?
- Review your own department's equipment "wish list". Write a case of need for the first two items.
- Draft a report following your interview with the personal injury claimant, is there other information missing?
- Outline your actions in the case of the junior doctor with the drug problem.
- Consider the case of the psychotic patient. When can you treat patients against their will? Examine the legal position. Do you have a "game plan" to manage these rare but critical events?
- Prepare for the interview for the junior doctors.

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Conflicts of interest: JW is an editor of the EMJ but this series was conceived and approved before he took up post.

Web info (emjonline.com/contents/SIMS5)

Staff statements
Notes from personal injury patient
Letter from ophthalmologist
Report of independent review
Further letter from Mrs Green
Diary
NHS Plan

Disclaimer

The characters and incidents in this series are mostly fictional and any resemblance to persons or departments is coincidental. Some situations are based on real problems but in no case have names or details been used that might identify a department or person.

1 Central Consultants and Specialists Committee. *Police requests for information from medical practitioners in hospital accident and emergency departments. Guidance for consultants or other doctors in charge of accident and emergency departments.* London: British Medical Association, 1991.
2 Cole GA. Human relations and social and psychological theories. In: *Management theory and practice*. 5th ed. London: Letts Educational, 1996.
3 The Open University. *Managing health services. Book 6. Motivating your team.* Milton Keynes: The Open University, 1990.
4 Cole GA. Decision making in organisations. In: *Management theory and practice*. 5th ed. London: Letts Educational, 1996.
5 The NHS Plan. *A plan for investment. A plan for reform.* London: HMSO, 2000.

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