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Perspective

Turning attention to clinician engagement in Victoria

Christine Jorm[1,3] MBBS(Hons), MD, PhD, Honorary Associate Professor

Robyn Hudson[2] BSc(Psych), BAppSc(Phty), MBA, Director, Clinicians as Partners

Euan Wallace AM[2] MBChB, MD, Chief Executive

[1]The University of Sydney, Room 215, A27 Edward Ford Building, Sydney, NSW 2006, Australia.
[2]Safer Care Victoria, 50 Lonsdale Street, Melbourne, Vic. 3000, Australia. Email: robyn.hudson@dhhs.vic.gov.au; euan.wallace@dhhs.vic.gov.au
[3]Corresponding author. Email: christine.jorm@sydney.edu.au

Abstract. The engagement of clinicians with employing organisations and with the broader health system results in better safer care for patients. Concerns about the adequacy of clinician engagement in the state of Victoria led the Victorian Department of Health and Human Services to commission a scoping study. During this investigation more than 100 clinicians were spoken with and 1800 responded to surveys. The result was creation of a clear picture of what engagement and disengagement looked like at all levels – from the clinical microsystem to state health policy making. Multiple interventions are possible to enhance clinician engagement and thus the care of future patients. A framework was developed to guide future Victorian work with four elements: setting the agenda, informing, involving and empowering clinicians. Concepts of work or employee engagement that are used in other industries don't directly translate to healthcare and thus the definition of engagement chosen for use centred on involvement. This was designed to encourage system managers to ensure clinicians are full participants in design, planning and evaluation and in all decisions that affect them and their patients.

Additional keywords: leadership, organisational culture, quality, safety.

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We have all heard calls for more 'clinician leadership'. The well-intentioned motivation behind government investment in leadership training is to find ways to catalyse healthcare improvement. Empowered individuals can and do make a difference. So why not create more of them? Yet the evidence for the value of leadership programs in terms of long-term organisational outcomes or meaningfully improved patient outcomes is limited.[1–3]

One major problem is that only a small percentage of clinicians receive leadership training and opportunities. Yet the enthusiasm and effort every health professional brings to the workplace determines the outcomes we all seek: improved patient satisfaction, safer care delivered and greater support for organisational change. Analysis of the UK Health Foundation's program evaluations found clinician engagement one of the 10 challenges to improving quality of care.[4] We argue that instead of simply looking for leaders to train, the Australian health system should be focusing on enhancing engagement of all clinicians, at all levels.

Indeed, respondents to the recent review of Hospital Safety and Quality Assurance in Victoria[5] suggested there was a deficiency in clinician engagement. To explore this further, in essence to ask directly whether clinician engagement in public health services was lacking, the Victorian Department of Health and Human Services (DHHS) commissioned a scoping review on clinician engagement.[6] The DHHS took a whole-of-system view, with interest in engagement at the microsystem level of care delivery and also in the involvement of clinicians to create better state health policy. Research included review of the literature, followed by interviews and small group meetings with more than 100 clinicians and executives from the public and private hospital systems, community health services and the DHHS. Additionally, a total of 1800 people responded to surveys.

The literature review revealed that the academic study of work and employee engagement provides a behavioural perspective on employee motivation. Work engagement was originally defined as: 'a positive, fulfilling work-related state of mind that is characterised by vigour, dedication and absorption' (Schaufeli cited in Guest).[7] Desired behaviours performed by engaged employees are those that are discretionary or pro-social – that is outside their enforced job description (in health typically reflected in more hours worked than contracted).

There is a relationship between work engagement and job strain (burnout) – 'the job demands–resources model'.[8] Job demands are the physical, social, or organisational aspects of the job that require sustained effort. Job resources refer to those aspects of the job that may: (1) reduce job demands; (2) be functional for achieving work goals; or (3) stimulate personal growth, learning, and development (including autonomy and feedback). Too many demands and too few resources predict

burnout[9,10] and, importantly in a healthcare setting, result in employees working less safely.[10]

Most engagement literature is focused on business enterprises, where maximising shareholder value is the organisational aim. Indeed, the UK government supported development work on employee engagement as one strategy to re-energise depressed British industry.[11] In healthcare, patient satisfaction and patient safety have been considered surrogates for the productivity and profitability measures used in business. Where clinicians are measurably engaged, there is lower staff turnover and absenteeism, decreased infection rates, increased patient satisfaction and lower patient mortality.[12,13]

Yet, there are special issues in applying the general work engagement literature to clinicians. First, even when salaried employees, clinicians may still identify as independent professionals. Second, many clinicians work part-time and even full-time workers may have multiple workplaces and employers. This can be reflected in clinicians having stronger emotional allegiances to professional organisations than their employing institution.[14] Third, clinicians have professional responsibilities to patients and clients. Most of their work is client-facing and they perceive their duty is first to the client rather than the employer or the broader system. Clinicians can be dedicated to patient care regardless of the status of the employee–employer relationship.

It is sometimes suggested that there is an ethical imperative to clinician engagement that is not necessarily present in other employment situations. It has been proposed that: 'everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it'.[15] However, one of those two jobs is well defined and staff have been highly trained to undertake the work. The quest for clinician engagement and leadership may sometimes be seen as an expectation that they take responsibility for change with minimal organisational support and do this extra work without compensation.[16] This can be a heavy burden for an already busy clinician.

The DHHS investigation (field visits, interviews and survey responses) revealed pockets of excellence and identified problems. Responses revealed an appetite, perhaps even a hunger, for richer, more consistent engagement.[6] A clear picture was developed of what disengagement and engagement look like at multiple system levels (Table 1).

The solutions proposed for Victoria in the clinician engagement scoping report fall under four headings (Table 2).

Victoria will seek to apply the framework described and to measure impact. We do want clinicians to flourish at work. This should be measured by staff satisfaction surveys or dedicated engagement instruments. It must be regularly reported at the board level. High involvement work practices, such as power and information sharing, training and reward for good performance can improve engagement.[7,17]

However, creating a positive work environment is not enough; engagement needs to be harnessed in the form of active participation in the structures that define the nature of clinical work and the patient's journey. For instance, if a worker enjoys coming to work, but refuses to attend unit meetings or read organisational communications, there is a problem. Healthcare is

Table 1. The results of clinician disengagement and engagement in the health system

A disengaged state	An engaged state
In policy development	
Clinicians: find the channels for providing advice to government inaccessible or exclusionary; consider consultation tokenistic, for rubber stamping policy, not improving it; feel policy makers do not understand the real problems and priorities in the system; find the department's policies make little sense (or do not reach them).	Clinicians: feel their opinions and expertise are considered, and their participation is valued; can identify and access relevant department staff who will respond to them; recognise policies are rooted in shared priorities and cognisant of practice realities.
Department staff: feel unsure about the quality of the advice they receive; are unable to reach out for expertise; may be unsuccessful implementing reforms.	Department staff: receive advice that is expert, evidence based and representative; know their advisory processes are credible and respected by the health system; have relationships with a broad range of clinicians and understand their perspectives; engineer reforms that are understood, owned and widely implemented.
In the leadership of health services	
CEOs and the department have antagonistic relationships. CEOs protect their work and are reluctant to learn from peers.	CEOs and the department have supportive relationships. CEOs share their work and help other institutions to improve care.
In the work of clinical networks	
Relatively few clinicians pursue individual clinical interests. The network struggles to obtain data. The network has little overall influence on the health care sector.	Many clinicians are involved. Diverse membership enables a creative approach to difficult healthcare problems. The networks are able to improve practice.
In the leadership of clinical units	
Managers feel they are battling alone. Clinicians are hostile to management requests.	Teams tackle problems and improve care. Implementation of required changes are a shared responsibility.
In the delivery of care	
Clinicians: avoid participating in workplace activities they do not have to; are unaware of health service or statewide policy directives; are often absent and away sick due to depression and burnout.	Clinicians: routinely go the 'extra mile'; initiate and support quality improvement; create a learning environment by sharing knowledge with all members of the team; know about and follow important health service and statewide policies.

Table 2. Framework for improving clinician engagement

Solutions	Examples
SET THE AGENDA. Develop objectives, expectations and good measures	Improve data collection on clinician engagement; set minimum responsibilities for health service boards
INFORM. Provide information and data to support engagement	Provide patient outcomes data to staff to motivate engagement; make guidelines and the results of improvement projects readily available
INVOLVE. Improve structures, processes and support for consultation and debate	Clarify the role of statewide networks; up-skill department staff; encourage more public debate about policy
EMPOWER. Invest in skills, capabilities and opportunities to lead change	Increase the availability of training in quality improvement; identify and address barriers to engagement caused by workplace and system inefficiencies

so complex that safer quality care cannot be achieved without clinicians' attention to the broader system, beyond the patient that is sitting in front of them.

Hence the definition proposed for use in Victoria, based on definitions in use in Queensland, is focused on involvement:

> *Clinician engagement is about the methods, extent and effectiveness of clinician involvement in the design, planning, decision making and evaluation of activities which impact the Victorian healthcare system*.[6]

Clinicians should be full participants in design, planning and evaluation and in all decisions that concern them and their patients. For clinicians, such involvement may be a prescribed part of their paid role with protected time allowed, or discretionary. For managers ensuring that such involvement occurs is not discretionary, it is central to proper performance of their paid role. The provision of opportunities to engage and the number of clinician participants being engaged form management metrics for engagement.

We believe that it is time to pay attention to the engagement of all clinicians. Development of meaningful engagement between the clinician, the employing organisation and the system will create an enhanced opportunity to improve the quality and safety of the health system for patients, their families and their carers. After all, next to the patient themselves it is the clinician who is best placed to identify needs and opportunities for healthcare improvements.

Competing interests

The authors have no conflict of interest.

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References

1 Martin GP, Learmonth M. A critical account of the rise and spread of 'leadership': the case of UK healthcare. *Soc Sci Med* 2012; 74(3): 281–8. doi:10.1016/j.socscimed.2010.12.002

2 Jorm C, Parker M. Medical leadership is the new black: or is it? *Aust Health Rev* 2015; 39(2): 217–9. doi:10.1071/AH14013

3 McDonald R.. Leadership and leadership development in healthcare settings – a simplistic solution to complex problems? *Int J Health Policy Manag* 2014; 3(5): 227–9. doi:10.15171/ijhpm.2014.101

4 Dixon-Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. *BMJ Qual Saf* 2012; 21(10): 876–84. doi:10.1136/bmjqs-2011-000760

5 Department of Health and Human Services (DHHS). Targeting zero. Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria. Melbourne: DHHS; 2016.

6 Jorm C. Clinical engagement – scoping paper. Melbourne: Victorian Department of Health and Human Services; 2017. Available at: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/clinical-engagement-scoping-paper [verified 3 March 2017].

7 Guest D. Employee engagement: a sceptical analysis. *Journal of Organizational Effectiveness: People and Performance.* 2014; 1(2): 141–-56. doi:10.1108/JOEPP-04-2014-0017

8 Bailey C, Madden A, Alfes K, Fletcher L. The meaning, antecedents and outcomes of employee engagement: A narrative synthesis. *Int J Manag Rev* 2017; 19(1): 31–53. doi:10.1111/ijmr.12077

9 Purcell J. Disengaging from engagement. *Hum Resour Manage J* 2014; 24(3): 241–54. doi:10.1111/1748-8583.12046

10 Nahrgang JD, Morgeson FP, Hofmann DA. Safety at work: a meta-analytic investigation of the link between job demands, job resources, burnout, engagement, and safety outcomes. *J Appl Psychol* 2011; 96(1): 71–94. doi:10.1037/a0021484

11 MacLeod D, Clarke N. Engaging for success: enhancing performance through employee engagement: a report to governmen. London: Department for Business, Innovation and Skills; 2009.

12 West M, Dawson J. Employee engagement and NHS performance. London: The King's Fund; 2012.

13 Dromey J. Meeting the challenge: successful employee engagement in the NHS. London: IPA. 2014. Available at: http://www.ipa-involve.com/resources/publications/meeting-the-challenge/ [verified 24 October 2017]

14 Jorm C. Reconstructing medical practice – engagement, professionalism and critical relationships in health care. Hampshire: Ashgate; 2012.

15 Batalden P, Davidoff F. What is "quality improvement" and how can it transform healthcare? *Qual Saf Health Care* 2007; 16(1): 2–3. doi:10.1136/qshc.2006.022046

16 Bonias D, Leggat SG, Bartram T. Encouraging participation in health system reform: is clinical engagement a useful concept for policy and management? *Aust Health Rev* 2012; 36(4): 378–83. doi:10.1071/AH11095

17 Rana S. High-involvement work practices and employee engagement. *Hum Resour Dev Int* 2015; 18(3): 308–16. doi:10.1080/13678868.2014.1003698