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IMPLICATION OF THE CONSTRUCTION OF CLINICAL HYBRID ROLES ON SERVICE DELIVERY IN KENYAN PRIVATE HOSPITALS

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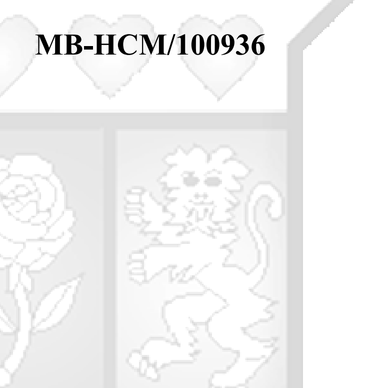
MB-HCM/100936



A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION IN HEALTHCARE MANAGEMENT AT STRATHMORE BUSINESS SCHOOL.

NOVEMBER 2021

DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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Michelle Nguu

Signature

Date…17th/November/2021……………………

Approval

The thesis of Michelle Mwendwa Nguu was reviewed and approved for examination by the following:

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Signature

Date…17th/November/2021

Dr.George Njenga

Executive Dean

Strathmore University Business School

Dr.Bernard Shibwabo

Director, Office Of Graduate Studies

DEDICATION

To my son, Kelani Kwe Kisia,

All the time I woke up to study or found you asleep as I came from a night shift and straight to Strathmore Business School, therefore, I love you and I do not intend to do it again.

ACKNOWLEDGEMENT

I would like to thank the Almighty God for providing the opportunity to participate in this course and for seeing me through it. He has been a constant source of strength and encouragement for me to press on.

To the faculty and staff at Strathmore Business School for walking with me through this journey. For all the lecturers who struggled to make me understand concepts and constantly giving me insights that are still applicable in my daily life.

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Lastly, to my family, thank you for your support and encouraging words. For all the time I have spent away trying to complete my studies, I owe you a lot and will forever be grateful because you had my back.

VT OMNES VNVM SINT

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LIST OF ABBREVIATIONS AND ACRONYMS

MLMs	Middle Level Managers
EBPs	Evidence Based Practices
UHC	Universal Health Coverage
PHD	Doctor of Philosophy

ABSTRACT

There is an increasing trend of clinicians and other healthcare workers taking on management roles in addition to their clinical roles; consequently, leading to the growth of hybrid clinical managers. This has been influenced by the change of policy around service delivery, increased need for accountability in terms of the quality of health services offered and patient outcomes. Evidence from several studies shows that the inclusion of doctors in strategic, financial and policy reforms agendas leads to better performance. Over the last decade there has been a growing interest in investigating how hybrids transition, navigate and manage the duality of their roles. This study used Identity theory to understand how clinical hybrids make sense of their identity as both clinicians and managers and how they navigate both roles whilst prioritizing better service delivery. Identity theory focuses on the construction processes of personal identity and social identity through the processes of fforming, repairing, maintaining, strengthening, or revising the constructions. Identity theory was useful in explaining the identity work doctors in this study undertook to manage tensions between their personal, social professional identities. The clinical hybrids in this study did not want to lose their identity as doctors and want to remain within their professional groups to maintain their legitimacy with their peers. To assess how doctors navigate their dual role, how they deal with their peers and what accountability mechanisms they put in place as managers to protect their clinical autonomy, this study used ethnography of private hospitals in Nairobi County. A total of ten doctor managers were conveniently sampled across different gender, specialties, and years of working experience. Data was collected using in depth interviews with the aid of an in-depth interview guide that made use of open-ended questions for in-depth inquiry. The interviews lasted 45-60mins and were audio recorded and later transcribed and thematically analyzed alongside hand-written notes taken during the interviews to complement the audio-recording. The study results revealed that to manage the uncertainty of their dual roles, clinical hybrids relied on evidence-based practices to ensure positive clinical outcomes. The study revealed that organizational support was key in helping hybrid clinicians manage their dual roles. When hybrid managers lacked organizational support and were left out of key strategy making decision, this usually led to negative impact on service delivery because they would be forced to meet the objectives of the organizations at the expense of offering quality care. However, the hybrids showed innovative top and downward strategies that helped them navigate their role and organizational conflicts by drawing on administrative l skills acquired as a prerequisite to the current roles. The hybrids recommended that organizations employing hybrid clinical managers institute well illustrated job descriptions and allocate percentage time to be spent on clinical and managerial roles to avoid dual role conflict. The study findings will be useful in informing context specific training that not only builds clinicians' management and leadership skills but also supports them through the transition period through e.g. mentorship activities, reflective sessions etc. that can support hybrids to support their daily work.. Additionally, the results can be used to inform the ministry of health and professional associations in development of clear job titles and positions for clinicians who are also managing organizations and in provision of the required recognition for such positions.

CHAPTER ONE

INTRODUCTION

This chapter provides an overview of who clinical hybrids are, defining what a hybrid is; what their roles are and how they emerged and the challenges they face in enacting their roles during routine service provision. The chapter then explores how their roles shape their identity; how their identity consequently influences their relationships with peers; the effect on their clinical autonomy, and effect on accountability to their organizational goals and purposes and to themselves at an individual level.

1.1 Background of the Study

'Hybrid' is a term used to describe managers with a professional background who are able to incorporate, translate and interpose the logics of both management and professionalism (Bresnen et al., 2019a). In health care, 'Hybrid' clinical managers are nurses, doctors or other health profession that play a role in the management of a healthcare institution while still performing their traditional roles of clinical management (Berghout et al., 2017a); Bresnen et al.,2019). The growth of the hybrid roles in healthcare has been as a result of the evolution of the healthcare industry which has seen more emphasis being put on efficient use of resources, improvement of service delivery and enhancing patient safety (Berghout et al., 2017a; (Bresnen et al., 2019b). According to literature, the development of the hybrid clinical role has been twofold; medical practitioners are the most powerful group in the healthcare industry and they industry and they also consume the most resources in the same industry. Therefore, to align their clinical objectives and help in the achievement of organisational goals, this role emerged (Correia & Denis, 2016a); Bresnen et al., 2019).The medical profession strives for neutrality and has over the year's resisted regulation by entities who are not part of the health industry in a bid to protect their clinical autonomy (Cruess & Cruess, 2005). Hybrid managers hence serve as a liaison between the organisational systems and the doctors because doctors have been shown to refuse top-down management by preferring to be led by their own (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014; Correia & Denis, 2016b). Medical professionals also have unchallenged economic powers as they are the sole suppliers of medical services and therefore influence demand (Berghout et al., 2017b). This is integral since healthcare resources

are scarce and there is a growing need for provision of quality service whilst using available resources effectively.

Studies have also shown that clinical autonomy has been one of the underlying factors that have led to doctors taking up managerial and administrative roles (Loh, 2015). This because doctors from a sociological perspective are motivated to seek and maintain influential positions as the medical profession been engaged in a struggle for control and self-governance against competitive forces(Spehar et al., 2012). Many other variables, such as organizational size, complexity, formalization, and centralization may also moderate the relationship between hybrid managers' commitment to healthcare innovation implementation and effectiveness. For example, hybrid middle managers' commitment may have a weak or non-existent influence on implementation effectiveness in small or highly centralized healthcare organizations. In these types of organizations, middle managers may have little autonomy, or their role may be indistinguishable from that of top managers (Birken et al., 2012).

Research into hybrid managers has shown different changes in how they interact with their peers. Hybrid managers bring their clinical knowledge to their managerial decision-making role and they are seen as a bridge between managers and their clinical peers (Braithwaite & Westbrook, 2005). However, this does not come without challenges because the hybrid managers do not want to lose their identity as doctors and still want the professional recognition (Spyridonidis et al., 2015a). Research has shown that hybrid managers sometimes spend more time 'fighting fires' than working on long term strategic issues required to improve effectiveness and efficiency of clinical service provision and deliver because not all of their peers respect or find legitimacy in their roles as managers (Kippist & Fitzgerald, 2010) Other research findings report opposite findings that doctors prefer to be managed by their fellow doctors because they regard them as one of their own (Daly et al., 2014). Research has also reported that hospitals that are led by hybrid managers perform better than in manager run hospitals (Goodall, 2011a).

Hybrid managers are accountable to different stakeholders. These stakeholders include the organization they work for, their patients, their peers among other external stakeholders (Cleary et al., 2013). The need for them to be accountable is because they are the biggest users of medical products and in a management capacity are in charge of

human resource (Correia, 2013).Hybrids have both formal and informal accountability. Accountability goes hand in hand with clinical autonomy because the hybrid clinical managers have to be efficient and effective in the use of medical resources to ensure good clinical outcomes(van de Riet et al., 2019). Hybrid managers need to be accountable on how they use the resources of the organization when giving care to patients and managing their colleagues. Conflicts comes in when they use their clinical autonomy to protect their clinical duties which could lead them to note meet the organizational objectives especially the financial objectives(Kippist et al., 2009). Hybrids also have informal accountability to their peers. When hybrids take up more managerial work, their peers are left to pick up more clinical work but since they report to the hybrid managers this often leads to conflict(Kippist et al., 2009).Research has shown that hybrid managers have both informal and formal accountability.(Berghout et al., 2017a). The way hybrids manage this tension has been found to affect strategic direction, management and outcomes in healthcare organisations and collaborative working with their own and other clinical professions(L Kippist et al., 2014)(Numerato et al., 2012).

Recently, improved healthcare performance and service delivery has been linked to more doctors taking up different management roles on top of their traditional clinical roles (Daly et al., 2014); Bresnen et al., 2019). Several studies (Byrkjeflot & Jespersen, 2014a);(Correia & Denis, 2016b); Daly et al., 2014) have been conducted to highlight the importance of hybrid managers in the healthcare industry. These studies have mainly been conducted in public hospitals(Nzinga et al., 2019b)(Correia & Denis, 2016)(Spehar et al., 2014) A study similar to this has been done here in Kenya and it also focused on public hospitals (Nzinga et al., 2019b).Both public and private hospital face similar issues in terms of efficient use of resource, scarcity of health resource and shortage of human resource(Spehar et al., 2012)(Sartirana, 2019) These studies done in public hospitals have shown an overall improvement in patient safety and quality, better policy implementation and adoption by peers and overall better financial performance of healthcare institutions led by clinical managers (Veronesi et al., 2013); Lega & Sartirana, 2016; Goodall, 2011). Since little research has been done on hybrid managers in private hospitals, I chose to do this study in private hospitals to study if the engagement of hybrid managers in management of the health facilities led to good

clinical outcomes and what overall impact, they had on service delivery by exploring the variables explored of peer relations, clinical autonomy, and accountability.

The private healthcare system in Kenya has rapidly grown over the last decade, and this has seen the incorporation of hybrid clinical managers in different hospital departments. Various studies have been conducted in public healthcare facilities in high income countries and also in Kenya examining the different roles played by hybrid health care managers (Bresnen et al., 2019; Nzinga et al. 2017.).These studies have focused on the challenges encountered by hybrid clinical managers (Nzinga et al., 2017.) in terms of lack of capacity training, lack of institutional support, career and professional identities and difficulties in role management (Bresnen et al., 2019; Denis & Van Gestel, 2016; Loh, 2015). This evidence from these studies has shown the importance of hybrid clinical managers in managing health care business and the challenges they face in performing their dual roles.

Hybrid clinical managers have the added advantage of having clinical knowledge which goes hand in hand with improving the quality of care given (Daly et al., 2014). They profess good political will and influence due to the stature of the medical profession as a revered profession and this helps in change management and implementation and lobbying (Bresnen et al., 2019a). Most of these studies (Cruess & Cruess, 2005);Denis & Van Gestel, 2016) that have shown a positive link between improved hospital performance with clinicians in management have mostly been done in high income countries with few studies focusing on the impact of the hybrid manager in low to middle income countries (Doolin, 2002).

In attempt to understand the nature of hybridity, prior research has classified hybrid clinical managers into several typologies (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). The ‘incidental’ hybrids who take up a management position with the basic instinct is to protect the profession from managerialism as usually their primary interest is not using managerialism as a mechanism for service improvement (McGivern et al. 2015). The ‘willing’ hybrids on the other hand are more proactive, develops authentic hybrid professional entities and knowledge and are more interested in improving service delivery, patient safety and care using their managerial role (Mcgivern et al. 2015).The ‘ambivalent’ hybrids fluctuate between the incidental and willing typology depending on the prevailing context and will sometime takes up

management role-but other times will distance themselves from the role (Nzinga et al., 2019b).

The challenges hybrid clinical managers face while performing their dual roles is well documented (Loh, 2015). The lack of proper management competencies and training has been one of the greatest challenges experienced by the hybrid clinical managers (Mcgivern, et al, 2015; Limb, 2015). Effectively managing the dual roles is also another challenge characterized by the difficulties hybrids face in choosing between spending more of their time in their clinical role or their management positions. Identity crisis is also a challenge experienced by hybrid clinical managers (Loh, 2015). Many faces the dilemma of the possibility of the loss of the traditional identity as clinicians and or caregivers as they pursue a career in management (Bresnen et al., 2019; Loh, 2015) versus the strategizing for efficiency as managers. Hybrid clinical managers find themselves in management roles that lack institutional guidance or well-defined job descriptions consequently leaving them to make decisions based on primarily what is important to them as clinicians (Mcgivern et al., 2015). Studies have shown that hybrid managers often lack support from the senior management in terms of involvement in decision making, budgetary discussions and during the enhancement of key hospital policies (Loh, 2015)

However,, research from Low Middle Income Countries on of clinical hybrids' perceptions of implication of their roles on the overall performance and the quality of services in private healthcare settings remains poorly understood. This study aims to understand the impact of hybrid clinical manager on service delivery while exploring how the variables discussed affects a hybrid manager on how they enact their roles and whether the impact they have on service delivery is negative or positive.

1.2 Problem Statement

Doctors now, more than ever are actively taking up management positions in hospitals and other healthcare organisations (Veronesi et al., 2013). Studies have shown that healthcare institutions that involve hybrid clinical managers in strategic and management decision making perform better (Taylor, Clay-Williams, Hogden, Braithwaite, & Groene, 2015 ;) (Goodall, 2011; Loh, 2015). This better performance is linked to their ability to navigate the different professions and act as a link between the senior management and frontline healthcare workers. The duality of their roles is not

without challenges as evidenced by different studies (Denis & Van Gestel, 2016; Limb, 2015). The challenges range from lack of training in leadership and management, professional identity crisis, difficulty in balancing their dual roles and lack of institutional or organisational support (Denis & Van Gestel, 2016; Limb, 2015; Loh, 2015). Training of doctors in leadership, financial and human resource management is one of the ways that hybrids are equipping themselves to enact their dual roles and navigate the challenges they face (Sammut & Ngoye, 2019).

With more doctors taking up courses in health management and consequently embracing hybridity at the workplace, it is objectively important to see how they maintain or deal with vocational autonomy, professional culture and how they navigate relationships with their colleagues (Loh, 2015). The impact of their role on service delivery and accountability as they navigate the two fore mentioned facets and work within the policies of the organisational structure is important (Loh, 2015; Louise Kippist & Fitzgerald, 2009b). The scope of the study included a sample of medical doctors with professional training in healthcare management drawn from a private hospital in Nairobi County.

1.3 Study Objectives

1.3.1 General Objective

To examine the implication of the constructs of clinical hybrid roles on service delivery in Kenyan Private Hospitals.

1.3.2 Specific Objectives

i. To examine how hybrid clinical managers, transition and navigate their clinical and managerial roles during routine service delivery.
ii. To characterize the influence of hybrids-peer relationships on routine service delivery processes.
iii. To explore the impact of accountability mechanisms used by clinical hybrids to influence service delivery.

1.4 Research Questions

i. How do hybrid clinical managers balance their dual roles of clinical practice and managerial duties during service delivery?

ii. What is the nature of hybrid clinical managers peer relationships within the health institutions?

iii. What are the different accountability mechanisms employed by hybrid clinical managers and influence on service delivery?

1.5 The Scope of Study

The study was conducted in private health facilities in Nairobi County, Kenya. The primary focus was to establish the impact on service delivery in these facilities managed by hybrid managers This study focused on hybrid clinical managers who have training in healthcare management and leadership. The impact on service delivery was measured on impact such as clinical outcomes, patients' satisfactory rates, and efficient and effective use of resources and financial performance of these facilities. It analyzed how hybridity influences peer relations, clinical autonomy, service delivery, and accountability of the hybrids to both external and internal stakeholders.

1.6 Significance of the Study

Several studies have highlighted the value of having doctors in management positions (Day & Leggat, 2015; Spehar, Frich, & Kjekshus, 2014). Doctors have also taken up management course at different levels of education to better equip themselves with the much-needed skills when enacting their managerial (Sammut & Ngoye, 2019). Hybridity in healthcare industry has seen several education institutions in the country come up with various courses on healthcare leadership, hospital management that target clinicians who are in management positions or clinicians that seek to take up more managerial and administrative work (Sammut & Ngoye, 2019). This has led to a new career path for some medical doctors, away from the traditional career choice of taking up speciality training in clinical medicine. These new career paths include medical doctors going into healthcare administration in health facilities, clinicians who have studied business management to a PhD level are now the main lectures training doctors on healthcare management and administration.

The study will help strengthen the curriculum used to train doctors on health management and leadership. It will highlight a new career path for doctors who wish to pursue management in the health sector by influencing the relevant licencing bodies to recognise hybrid managers as medical specialization and give them legitimacy among

their peers, something that is contributed to the Identity Theory. It will also help healthcare organizations who engage doctors in management to come up with clear job descriptions that allow the hybrid managers to balance their clinical and administrative roles well. This will create a favourable working environment.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter provides an extensive review of the literature on clinical hybridity including existing theories, models on the topic, and relates the concept of clinical hybridity to available empirical evidence that support or dispute the theories. Moreover, the chapter reviews the key messages from existing literature including the gaps that the proposed study seeks to fill. The chapter also outlines the proposed study conceptual framework and the proposed independent variables in the study, showing how they interact to explain the operationalization of the hybridity concept. To enhance clarity, the chapter is divided into theoretical overview, empirical review, research gaps, literature review, conceptual framework, and variable definition.

2.1 Theoretical foundation

As research in the area of professional hybridity continues to grow over the last few years, hybridity has becomes associates with questions of ‘subjectivity’ and ‘identity’ (Kraidy 2005). The public administration literature utilizes the institutional logics approach to explain how hybridity emerges. Institutional logics developed within the wider field of institutional theory as a way of explaining the interactions between normative societal structures, organizational forms, and individual behaviour.

On the other hand, management theory contends that hybridity is rooted in identity work which involves construction, transitioning, disruption contradicting and reciliation of both personal and social identities to make sense of self Identity theory has been useful in supporting this understanding (Mcgivern et al., 2015).

2.1.1. Institutional Logics Theory

According to Freidland and Alford “society has a central logic – a set of material practices and symbolic constructions – which constitutes its organizing principles, and which is available to organizations and individuals to elaborate. … These institutional logics are symbolically grounded, organizationally structured, politically defended, and technically and materially constrained, and hence have specific historical limits”(Friedland and Alford 1991, pp. 248–49).

The institutional logics perspective is a core meta-theoretical approach in organization studies (Greenwood et al., 2008) for the analysis of individual cognition and organizational behavior within the context of wider belief systems (Thornton & Ocasio, 1999; Lounsbury, 2007). This perspective has developed in North America and in Europe in reaction to prior approaches to institutional analysis in economics, political science, and sociology that have focused on partial aspects of how institutions influence individual cognition and organizational behavior; for example, historical, rational choice, and sociological views emphasizing diffusion and isomorphism of organizational forms and practices (Friedland & Alford, 1991). With the bridging of research findings in cognitive psychology and cultural sociology, scholars realize that there is much less pressure for consistency than most people thought, and that there are multiple cognitive orientations to action and structure (DiMaggio, 1997).

Institutional logics approach offers firm theoretical base for explaining hybridity, and also locating the actor's dimension in this dimension. Contests between logics are played out at an organizational level through the politics of form and structure, and at an individual level in the politics of identity. The way hybrid organizations are located in a field of conflicting institutional logics e.g. hospitals taking on a entrepreneurial/business sense frames its actors and activities, with particular material resources, for example financial allocations and regulations which subsequently influences the hospitals activities and performance (Minkoff 2002; Pache and Santos 2013). Thus, actors, (in the case of hospitals, the health workers) identities are supplied by the prevailing logics of their institution and so there may emerge a 'blocked hybrid' due to the difficulties individuals have in accommodating the competing logics of ensuring public well-being and efficient use of resources. However, there is also a likelihood that assimilation might occur as actors seek to sustain their core practices and identity by trading off surface compliance with intruding logics for legitimacy with their peers (Zilber 2002). In the later cases, health professionals might assimilate their hybrid roles by trading off entrepreneurial expectations to ensure acceptance by peers. Finally, blended hybrids are possible as an adaptive responsive to rapid transitions into new roles or organizational identities as the incumbents draw on different aspects of plural institutional logics and innovating to ensure continued service delivery

2.1.2 Identity Theory

Professions such as medicine, law, and accounting (distinct from occupations like management) are closed collegial, self-regulating expert occupations. Professional autonomy is legitimated by professionals' claims of socially valuable 'indeterminate' expertise, which only professionals can understand or regulate. 'Professional' is an exclusive identity, developed through qualifications, training, and socialization, creating social identity boundaries and enhanced careers (Mcgivern et al., 2015a).

Identity theory focuses on personal and social identify. Personal identity focuses on questions of 'who am I'? While social identity or collective identity focus on question of 'who we are'? (Mcgivern et al., 2015a). Identity is because of the groups a person belongs to e.g., professional groups, social classes etc. Identity construction requires 'identity work', defined as 'forming, repairing, maintaining, strengthening, or revising the constructions that are productive of a sense of coherence and distinctiveness (Sveningsson & Alvesson, 2003). Identity work is important because it is required to manage tensions between professional social tensions and personal tensions experienced by hybrids during role transitions and during the performance of their dual role (Mcgivern et al., 2015c). Institutions and identities are fundamentally interrelated. Identity work is a form of institutional work because 'identities describe the relationship between an actor and the field in which that actor operates. Institutions provide the raw materials for identity construction and identities function as institutional logics, affecting how identities are performed and how people interpret institutions. The health institutions in the study affect how the hybrid deal with accountability, how they protect their clinical autonomy and consequently how they relate with their peer (Mcgivern et al., 2015a).

Identity theory is key as one of the major challenges experienced by hybrid managers is the fear of the loss of their identity. Clinical autonomy is central to a doctors' professionalism and the need to safeguard it or work around it while performing their dual role is integral (Spyridonidis et al., 2015b). Identity processes drawn from identity theory can be used a framework to understand how doctors taking up hybrid roles accommodate the changes on their professional autonomy and the new managerial expectations (Spyridonidis et al., 2015b). Studies done on professional identity on doctors taking up managerial role have shown that doctors enhance their clinical

identity rather than replace it because it gives them legitimacy and belonging with their peers (Montgometry, 2001).

This study made use of identity theory to conceptualize and frame the phenomena of clinical hybridity as it provides underlying mechanisms that explain the processes of identity transitions (making sense of identity), identity contradictions and violations (challenges of existing identities) and identity reconciliation (repairing and validation of identities with peers) (McGivern 2019). These stepwise process of hybrid construction offer more nuanced understanding of how clinical hybrids make sense of who they are and how this understanding influences their day-to-day tole in service provision

2.2. Empirical review

There has been extensive research into hybrid clinical managers from how they transition into their subsequent roles and the challenges faced in the performance of their dual roles (Kippist & Fitzgerald, 2009b). However most of these studies have been done in high income countries with few being conducted in low-middle income countries (Denis & Van Gestel, 2016b)(Denis & Van Gestel, 2016b). Furthermore, these studies have not highlighted the impact of hybridization on accountability, its effect on peer relations and clinical autonomy.

A service is an act or performance one party can offer to another that is essentially intangible and does not result in ownership of anything (Kotler & Keller, 2016). Clinical services offered in health facilities differ from each other. They include curative, preventive, rehabilitative and palliative. Hybrid managers are meant to ensure that these services offered give the best outcomes. Healthcare outcomes improvement can't happen without effective outcomes measurement. Given the healthcare industry's administrative and regulatory complexities, and the fact that healthcare measures and reports on hundreds of outcomes there is much-needed clarity by reviewing clinical outcomes such as patient experience, timeliness of care, effective use of resources, mortality, readmissions and safety of care (Velentgas et al., 2013).

Studies done in high income countries that shown that hospital that are managed by hybrid managers perform better (Ham et al., 2008). A study done at the National Health Service in the UK showed that engaging doctors in leadership helped with the acceptance of new strategies and implementation of action plans. This is because the

directives were coming from fellow doctors who they respected and took them as their peers.(Ham et al., 2008). By virtue of their power and position doctors can block or confound the efforts of managers or non-clinical administrators to impose change via top-down mechanisms. Hence , by engaging doctors with change processes, improvements in performance have been achieved (Clay-Williams et al., 2017a).

Doctors prefer to be led by doctors(Loh, 2015) and there are articles in favour of medical leadership citing doctors' strengths in addressing patient outcomes, quality and safety issues and decision-making and point to their ability to use their clinical knowledge together with managerial knowledge when making or implementing strategic plans (Clay-Williams et al., 2017b). Further studies have also shown that hospitals with doctors in management perform better (Stoller et al., 2016). Healthcare has become extraordinarily complex — the balances of quality against cost, and of technology against humanity, are placing ever-increasing demands on doctors. These challenges require extraordinary leaders. Doctors were once viewed as ill-prepared for leadership roles because their selection and training led them to become "heroic lone healers." But this is changing. The emphasis on patient-centred care and efficiency in the delivery of clinical outcomes means that physicians are now being prepared for leadership.

A study done in Kenya in a public hospital highlighted as similar studies in similar settings have, that hybrid managers discovered during transition into their new roles they lacked administrative skills, financial and budgeting skills and other skills needed to effectively perform their managerial roles (Nzinga et al., 2019a). Another study done in public hospitals in Norway support these findings that doctors willing to transition to management are left to learn management on their own and during this time they experienced a high workload in terms in administrative roles (Spehar et al., 2012). This consequently led to their colleagues picking up their extra clinical roles which led to peer conflicts at work place and directly affecting the quality of clinical services offered (Spehar et al., 2012)(Kippist et al., 2009).

Another paper argues that organizational professional and hybrid clinical manager might have a negative impact on service delivery. This is in cases whereby a hybrid manager abandons their clinical work for administrative roles. This paper shows that the role of the hybrid clinician manager may not bring with it the organisational

effectiveness that the role was perceived to have. Hybrid clinician managers abandoning their managerial role for their clinical role may mean that some managerial work is not done. Increasing the workload of other clinical members of the health care organisation may not be optimal for the health care organisation (Kippist et al., 2009). Organisational professional conflict, as a result of hybridity and divergent managerial and clinical objectives, can cause conflict which affects other organisational members and this conflict may have implications for the efficiency of the health care organisation.

The aim of this research was to gather information to improve evidence on the important role of hybrids managers and help health institutions with decision making on how to engage with hybrid managers. There has been extensive research into hybrid clinical managers from how they transition into their subsequent roles and the challenges faced in the performance of their dual roles (Kippist & Fitzgerald, 2009b).

This literature review section will focus on the following areas to highlight the knowledge and theoretical contribution of this study

a. Overview of clinical hybrids
b. The transition processes of clinical hybrids
c. Challenges faced by hybrid clinical managers
d. Hybridization and Peer Relationships
e. Clinical autonomy of hybrids
f. Clinical hybrids interaction with accountability processes

2.2.1 Overview of clinical hybrids

'Hybrid managers' is a term used to describe individuals with a professional background who take on managerial roles, requiring them to move between different organizational groups (Croft, Currie, & Lockett, 2015; Bresnen et al., 2019). Hybrid clinical managers are healthcare professionals; doctors, nurses and other healthcare workers with both clinical and managerial responsibilities (Fulop, 2012a; Spyridonidis, Hendy, & Barlow, 2015; Mcgivern, et al, 2015. The recent increase in the inclusion of healthcare professionals in hospital management has been because of the linked improved performance both clinically and financially (Fulop, 2012b). Changes in organisational policies and the increasing need of professionals in most industries to

take up managerial roles over the years is one of the major factors attributed to the increase of hybridity (Bresnen et al., 2019b).

Past research on clinical hybrid managers has identified different types of clinical managers based on how they identify with their roles, how they get into those roles and the impact the role has on their professionalism (Mcgivern et al., 2015a); van de Riet, Berghout, Buljac-Samardžić, van Exel, & Hilders, 2019). A strategic leader, a social leader and an accepted leader are all terms that have been used to refer to hybrid clinical managers (van de Riet et al., 2019). The first view on the strategic leader describes them to be involved in hospital strategy and in the decision-making committees. The second view describes a social leader characterized by their communication and collaboration skills. The third and final view is the accepted leader; they are recognized by their peers and have specific job descriptions (van de Riet et al., 2019).

Hybrids have also been conceptualized into three other categories: the commercialized manager, the clinical manager and the neo-bureaucratic manager (Byrkjeflot & Jespersen, 2014b). The clinical managers is described as one who combines professional self-governance with management logic, while the commercialized manager, uses an enterprise logic with professional self-governance and finally the neo-bureaucratic manager who uses self-governance and neo-bureaucratic logic. Clinical hybrids have also been classified as 'incidental'/'reluctant' and 'willing' hybrid clinical managers (Fulop, 2012a). The 'incidental' manager is one who is asked to take up a management position with a basic instinct to protect their profession from managerialism with no interest is service improvement. The 'willing' hybrid manager on the other hand is more proactive, develops authentic hybrid professional entities and knowledge and is more interested in improving service delivery, patient safety and care (Nzinga, McGivern, & English, 2019).

Clinical directors are another form of hybrid clinical managers (Correia & Denis, 2016a); Loh, 2015; Llewellyn, 2001), often senior doctors heading clinical units, whereby they continue with their clinical practice on a part time basis while also having managerial functions (Loh, 2015; (Correia & Denis, 2016c). Clinical directors have also been described as medical leads in charge of a large group different clinical specialties (Lega, 2008; Lega & Sartirana, 2016).

2.2.2 Transition processes of clinical hybrids

Studies done to highlight the raise, adoption, and integration of clinicians into management and administrative roles have mainly been done in high income countries (Bresnen et al., 2019c) (Spyridonidis et al., 2015; Doolin, 2002). The studies have highlighted the historical context that led to the raise of hybrid clinical managers in countries such as the United Kingdom focusing on the National Hospital System (Louise Fitzgerald & Sturt, 1992; Bresnen et al., 2019; (Correia & Denis, 2016a); Fulop, 2012). These studies have focused on driving factors that have led doctors to transition into management and hence taking up dual roles. The factors identified include healthcare reforms geared to improving quality, patient safety, efficiency and effectiveness in the use of resources (Daly et al., 2014; (Correia & Denis, 2016d); Veronesi et al., 2013). Doctors in the past have constantly tried to resist managerial intrusion in their professions and there has been a preference for clinicians to accept orders or policies formulated by their peer (Correia & Denis, 2016a); Doolin, 2002).

A few studies have shown that health institutions that have clinicians as managers tend to perform better in terms of financial performance and overall improvement of quality of services offered (Daly et al., 2014). Effective clinical leadership has been linked to improved clinical outcomes, better adoption of healthcare policy reform, timely care delivery and overall improved system efficiency (Daly et al., 2014). Low morbidity and mortality rates and improved ratings on quality by service consumers have also been linked to the involvement of clinicians in management (Veronesi et al., 2013).

2.2.3 Challenges faced by Clinical hybrids

Several studies have highlighted the challenges faced by hybrid clinical managers on the performance of their dual roles (Loh, 2015; Limb, 2015;). One of the challenge faced by hybrid clinical managers is the balancing their dual roles (Kippist & Fitzgerald, 2009a), this means that when doctors abandon their clinical roles to do more administrative work, their colleagues are usually expected to pick up their work log breeding tension and conflict at the place of work (Loh, 2015; Chris Ham, Clark, Spurgeon, Dickinson, & Armit, 2011). Another challenge faced by hybrid clinical manages is the lack of recognition by the medical professional bodies as a speciality of medicine (Ham et al., 2011), which is further compounded by lack of professional training in management, lack of organisational support and an unwillingness to take up

professional training to enhance leadership skills (Chris Ham et al., 2011; Nzinga et al., 2019). This identity crisis as experienced by 'incidental' hybrids leads them to view their administrative roles as more of a 'side-line job' rather genuine interest in improving service delivery (Limb, 2015)

Hybrids also face the challenge of lack of recognition, either in terms of pay, kind or compensation (Chris Ham et al., 2011), major deterrent to clinicians to pursue management as a professional career (Chris Ham et al., 2011). Lack of organisational support, in terms of being involved in strategic and technical decision-making activities, making of budgets has also been shown to be a challenge experienced by hybrid clinical managers(Nzinga et al., 2019a).

Lack of adequate training in management and leadership is also a challenge e.g. 'incidental' hybrid find themselves in a management position without any prior training and consequently rely on their clinical experience to enact their new roles or use the support of the administrative managers they find in that particular role (Nzinga et al., 2019; Limb, 2015). Some tend to take up managerial or professional training as they enact their duties simultaneously and resort to asking for advice from their senior medical colleagues (Limb, 2015).

2.2.4 Hybridization and peer relations

Studies done in high income countries have shown the advantages and challenges of having hybrids in leadership positions (Loh, 2015; Veronesi et al., 2013; L. Fitzgerald, 1994). Peer relationships are relations with individuals working on the same level of the organisational hierarchy with no formal authority over each other (Holt-Lunstad et al., 2015). Hybrids have been known to take up leadership roles because their colleagues recognise their clinical expertise and skills (L Kippist, Fitzgerald, & Research Online, 2014). Studies have shown that clinicians prefer to receive orders or to be managed by their peers (Loh, 2015).The role of the hybrid clinical manager is to influence and implement organisational objectives and policies that aim at improving service delivery (Fulop & Day, 2010). For hybrids to lead their colleagues well, their peers need to perceive the hybrids as having professional knowledge about the organisation and competency in their clinical skills. This gives hybrids legitimacy and authority to hence offer leadership and direction to their peers (Swanwick & McKimm, 2011). Thus, there

is a need to understand how hybrid clinical managers relate with their peers at the workplace.

Past studies have shown that some clinicians perceive hybrid clinical managers as traitors who have neglected their traditional roles and taken on management roles (Kippist & Fitzgerald, 2009b).When hybrids abandon their clinical duties to take up more managerial roles, this leads to conflict with their peers who have to take on more clinical work formerly undertaken by the hybrids (Kippist & Fitzgerald, 2009a).

There is also a need to understand how the change from top-down leadership to bottom-up leadership has affected peer relations. This is important because one of key reasons behind the inclusion of clinicians into management is the perceived buy-in in engaging clinicians on change management issues and increasing their involvement in decision making (Ham et al., 2011);(Loh, 2015). Hybrid clinical managers also find themselves competing for positions, resources for their respective departments and attention with other hybrids in the organisations consequently leading to conflicts (Kippist et al., 2014). Thus, there is need to explore if the current hybrid managers have mentored or are interested in mentoring their peers into taking up management roles (Mcgivern et al., 2015b). It has been highlighted that the 'willing hybrids' find transition into a managerial role easier when they had mentors and senior colleagues helping them along the way (Nzinga et al., 2019a).

This study explores how hybridity affects peer relations in private hospitals and analyses how these relations influence acceptance of laws, policies, and regulations when hybrid managers implement these changes (Loh, 2015). The study also examined how the role of hybridity has resulted in any form of mentorship e.g. encouraging fellow peers to take management in healthcare as an alternate career path (Mcgivern et al., 2015b).

2.2.5 Clinical autonomy of hybrids

Clinical autonomy is defined as the responsibility of the health practitioner to decide on the modality or clinical intervention that is best suited for the diagnosis they have made. Autonomy is major component of medical ethics and has been a symbol of power in the medical profession, status, and pride (Armstrong, 2002). Consequently, clinicians seek

to protect their clinical autonomy from management and prefer being answerable only to their peers.

It is therefore important to understand how hybrids navigate the facets of clinical autonomy, which include confidentiality, respect for patient autonomy, balancing between their individual autonomy and the bureaucratic accountability that is expected of them as managers (Entwistle, Carter, Cribb, & McCaffery, 2010; Gillett, 2008; Kukla, 2005;Harrison & Dowswell, 2002). Management uses measures such standard treatment guidelines to improve accountability, enhance efficient use of resources and lead to better patient outcomes (Timmermans, 2005). However, substantial research shows that in a bid to protect their individual autonomy, not all doctors follow standard treatment guidelines (Timmermans, 2005). How hybrids handle this dilemma is crucial, as they are expected to be the link between the organisations and doctors they manage (Mcgivern et al., 2015; Correia & Denis, 2016b). The ability of the hybrid to navigate these crucial principles of autonomy is important because their dual roles entail responsibilities towards their employers, their peers, the patients and the organisation and they are expected to do this ethically.

However, most clinicians who find themselves in the realm of hybridization fear loss of their professional autonomy since professional and managerial logics are traditionally considered to be conflicting (Berghout et al., 2017a; (Correia & Denis, 2016a). Due to the power and authority accorded to doctors as a result of their profession, hybrid managers have the power to decide if and when organisational directives that affect clinical practice will be implemented or not (Nugus et al., 2010). Furthermore, 'willing hybrids' strategically get into management roles as a way of protecting the speciality or clinical practice from outside influence (Spehar et al., 2012)

Most importantly, economic forces have changed patterns of clinical work both directly and indirectly. A hybrid clinical manager has the responsibility of leading the business aspect of the health organisation by ensuring cost containment and revenue generation while offering the best standard of care. Hybrid clinicians must achieve all this but also maintain clinical autonomy in matters such as upholding patient doctor confidentiality, use of evidence-based knowledge in administration of care and use of the patient centred approach.

This study sought to understand how hybrids navigate the organisational objectives of the healthcare business whilst still maintaining their clinical autonomy.

2.2.6 Clinical hybrids interaction with accountability processes

Accountability has emerged as a major issue in the healthcare industry. Accountability entails all the procedures and process by which an entity or an individual justifies and takes responsibility for their actions (Emanuel & Emanuel, 1996). Hybridization in the medical profession has been encouraged by the need to improve service delivery, enhance better patient outcomes and enhance the consumption of health resources effectively (Loh, 2015; Clark, 2006). Several scandals in high income countries in the medical field such as case of Dr Jane Barton at Gosport War Memorial Hospital, implicated in the premature deaths of over 450 patients through the over-administration of opiate drugs(Mannion et al., 2019) called for increased accountability to the general public and the patients (Mcgivern et al., 2015a). Furthermore, changes in healthcare industry in terms of patient autonomy, use of evidence-based medicine and efficient use of the limited health resources increased the need for more accountability to both external and internal stakeholders. (Daly et al., 2014; Correia & Denis, 2016b). The increase of medical legal litigation and expected better patient outcomes as well calls for more transparent reporting of results are among the major changes in health care system that encouraged hybridization (Sartirana, 2019; Spehar, Frich, & Kjekshus, 2012).

Mechanisms put in place to enhance accountability by hybrid clinical managers are many and diverse since they are accountable to both internal and external stakeholders (Cleary et al., 2013). These mechanisms include total waiting time, customer feedback, ensuring accreditation of the health facility, regular auditing of the organisation hiring competent and licenced personnel and provision of evidence based quality and appropriate treatment by use of standard treatment guidelines (Cleary et al., 2013). Studies done have also clearly highlighted the need of accountability among all the stakeholders involved in the healthcare system so as to offer quality services as illustrated by Brinkerhoff (Brinkerhoff & Bossert, 2014).

Management logics including cost containment, efficient use of resources and accountability are found to be conflicting with professionalism which is largely dependent on professional autonomy (Sartirana, 2019). Financial accountability by

hybrid managers is also crucial since they are tasked with managing the budgets of different business units (Byrkjeflot & Jespersen, 2014a). It is therefore prudent to understand how the nature of hybridization has influenced accountability in the health care system.

The study therefore analysed the different accountability mechanisms put in place by the hybrid managers aimed at improving service delivery and patient outcomes. Stakeholder engagements at different levels in the healthcare industry which have also been highlighted as an accountability measure that might provide an understanding of how the hybrid managers maintain accountability which is crucial in the efficient use of resources and effective service delivery.

2.3 Knowledge and research gap

Studies have shown that the training of clinicians which is mostly concentrated on gaining clinical skills rather than leadership skills as one of the factors that affect the perceived roles of hybrids (Stoller, 2009).The rigorous training that clinicians go through to gain scientific experience inoculates in them a value for autonomous decision making, making them more concerned about their own performance and achievements rather than that of the institutions they work for.

It is prudent to explore if training in management enhances collective autonomy over individual autonomy when it comes to patient care. Many developed countries have called for more clinicians to be involved in budgetary and strategic decision making of the health care organisations to enhance operational efficiency (Spehar, Frich, & Kjekshus, 2012). Consequently, education programmes in clinical leadership and management have gained prominence over the years (Spehar et al., 2012; Chris Ham et al., 2011; Mcgivern et al., 2015; Sammut & Ngoye, 2019). This has started to encourage hybridity as a legitimate career path that clinicians might be willing to embrace. Thus, the study explored how the concepts of clinical autonomy of medical hybrids influences relations and accountability processes during delivery of clinical services and in the leadership and management processes used by these managers in their routine work. This was accomplished by looking at these three variables: peer relations, clinical autonomy, and accountability.

Understanding the outcomes of the influence of hybridity is crucial for creating an environment that allows hybrid clinical managers to become better managers. The findings will also influence and improve the curriculum used to equip hybrids on clinical management and potentially fill a knowledge gap in a low-middle income country setting in the private health care systems.

2.4 Conceptual Framework

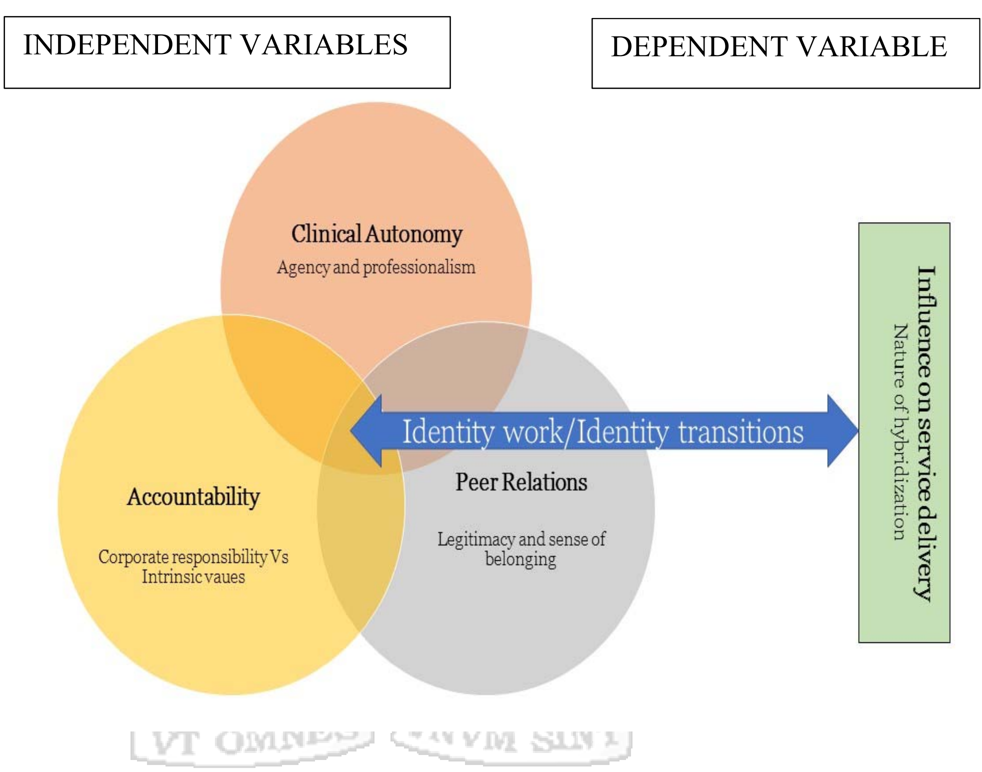

Figure 2.1: Conceptual framework depicting how hybrids transition journeys are influenced by their clinical autonomy, how they relate with peers and accountability mechanisms in their place of work

Conceptual framework is a systematic presentation which identifies the variables that when put together explain the issue of concern. The conceptual framework is therefore the set of broad ideas used to explain the relationship between the independent variables (factors) and the dependent variables (outcomes). The use of these variables was informed by the scope of the study which focused on assessing the impact of hybrid clinical managers on service delivery. The independent variables include hybrids

transition processes, hybrids' clinical autonomy and interaction of the hybrids with accountability process. These variables emerged from the literature review conducted whilst the dependent variable in this study was service delivery. The outcomes of service delivered were outcomes such as good clinical outcome, effective and efficient use of resources, good financial performance, turnaround times in different departments e.g., laboratory test, dispense of medication and customer certification.

The conceptual framework above shows how clinical hybrids' legitimacy stems from their expert power as doctors, giving them the liberty to defend their profession against outside intrusion. Their clinical training has given them a great deal of autonomy. Conflicts with their core beliefs and corporate responsibilities usually arise. To cope with them, hybrid managers need to devise a strategy to deal with these conflicts. Hybrid clinical managers are likewise concerned about losing their clinician identity but maintaining clinical legitimacy among their peers. As a result, this conceptual framework demonstrates the impact of hybridization on peer relationships, the transition process responsibility, and clinical autonomy, as well as the impact it has as hybrid clinical managers carry out their dual tasks and responsibilities. Thus, by focusing on the concepts of peer relations, accountability, and clinical autonomy, we explore how identity transitions impact the hybridization process and the consequences on service delivery in private health facilities in Kenya.

2.5 Definition of variables

Clinical hybrids were defined as healthcare professionals, doctors, nurses, and other healthcare workers with both clinical and managerial responsibilities. The clinical hybrid has been categorized as commercialized manager, the clinical manager, and the neo-bureaucratic manager. Clinical hybrids have also been classified as 'incidental'/'reluctant' and 'willing' hybrid clinical managers. The transition process of clinical hybrids was defined as the period in which a doctor takes over managerial role while still carrying out their traditional role of carrying out clinical duties. Peer relations were described as the professional associations or interactions between the hybrid clinical manager and the doctors that they were now in charge of once they took on their new role. Clinical autonomy was defined as the authority, freedom, and discretion of doctors to make judgments about patient care and the control over their clinical practice. Accountability was defined as degree to which hybrid clinical managers were

answerable to the different stakeholders in the healthcare context of the decisions they made and the outcomes of those decisions,

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Methodology provides a plan and procedure of getting information to achieve research objectives. It outlines research design, target population, data collection technique, research quality, data analysis and presentations and ethical considerations population, data collection technique, research quality, data analysis and presentations and ethical considerations

3.2 Study Design

The study was an ethnographic study design. Ethnography is the study of social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities. The main of ethnography is to provide holistic insight into people views and insights (Reeves, Kuper & Hodges, 2008). Qualitative methods were adopted for data collection and analysis an in-depth understanding of the complex issue of hybridity and how it influences how services are delivered.

3.2.1 Study Population and Sampling

A population is the total collection of elements about which inferences are made (Salkind, 2010). The study will be conducted at among several private hospitals in Nairobi of different organisational and institutional capacities. Due to the COVID-19 pandemic that has led to curfew implementation and curtailed movement, hospitals currently have competing priorities.

This study used the purposive sampling method in selection of participants -doctors with a background in leadership and management and in the frontline of direct clinical service provision and routine administrative and managerial practice. A total of 8 clinical hybrids were purposively selected. These population size was based on principles of depth and detailed exploration of the hybrid phenomena as well as bearing in mind the principle of saturation and pragmatism that is usually associated with the qualitative research (Vasileiou et al., 2018). Deliberate attempts were made to include

both male and female participants and a heterogeneous mix of hybrids with varying levels and years of both clinical and managerial experience and of different specialities.

Hospitals in Nairobi County with doctors working in both administrative and clinical roles were purposively included. This was because the inclusion criteria for the study population had to be doctors serving dual roles in private health facilities. The Hospitals Include Oasis Healthcare, Shepherds Hospital, The Nairobi Hospital and Kenya Airways Health Clinic and they provided for the target participants needed for this study. They hospitals were selected to be in Nairobi for ease of the interview process and to reduce cost on travelling to different counties. The mentioned health institutions vary from Non for profit to Parastatal's organisations and for-profit health organisations and in different parts of Nairobi, catering to different socio-economic populations. Shepherds Hospital has 3 health centres, two located in Middle to Low Income Estates which are densely populated areas and one in a high-income estate. The researcher interviewed 5 hybrids from this institution, two top level managers and three middle level managers. Oasis Healthcare as 3 centres in Nairobi as well that is in both low-middle income and High-Income parts of Nairobi. The researcher interviewed three hybrids from this institution. The Nairobi Hospital is a high-end Hospital, located in Upper Hill Nairobi and it has both outpatient and in-patient facility. The Kenya airways clinic is in Jomo Kenyatta International Airport and it serves both passengers on transit and employees of Kenya Airways. The diversity in size and locations of these private hospitals will give rich and diverse data which should be free from early saturation. See table below.

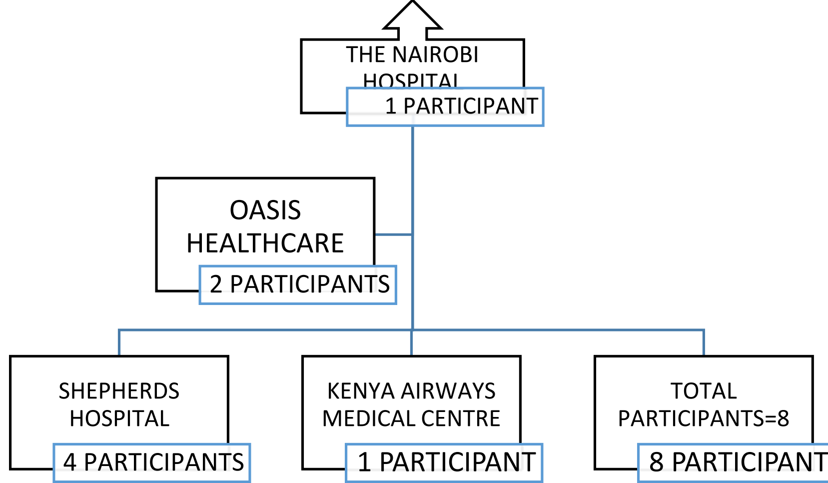

Figure 3.1 Target Population Table

3.3 Characteristics of Interview Participants

Interviews were held with 8 participants, 5 females and 3 males. The names of all eight research participants have been anonymised, to protect participant confidentiality. They are thus named P1 (Participant 1) to P10.The names of all eight research participants have been anonymised, to protect participant confidentiality as promised in the consent form. The private health care facilities that the clinicians worked for have also been coded H1 (Hospital 1) to H10.

Participant code	Sex	Location	Management Level	Healthcare facility	Professional Speciality
P1	Male	Nairobi	Senior	H1	Surgeon
P2	Male	Nairobi	Senior	H2	Orthopaedic Surgeon
P3	Female	Nairobi	Middle	H3	MBA in Business Administration and General Practitioner
P4	Female	Nairobi	Middle	H4	General Practioner with an MBA in Healthcare Management
P5	Female	Nairobi	Middle	H5	General Practioner with an MBA in Healthcare Management
P6	Female	Nairobi	Middle	H6	General Practioner with an MBA in Healthcare Management
P7	Female	Nairobi	Middle	H7	General Practioner with an MBA in Healthcare Management
P8	Male	Nairobi	Middle	H8	ENT Surgeon

Table 3. 1: Characteristics Sample – Interview Participant

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3.4 Data Collection Methods

In-depth one on one and online narratives were used to collect data on the experiences of clinical hybrids (with relation to the pandemic) when was practically feasible to do so, without being intrusive or disruptive to the managers who are responding to this shock. Brief and focused interviews were conducted by phone on times that were convenient to the study participants. Four of the interviews were done via zoom due to the Covid 19 pandemic. All in depth interviews whether online or one on one were conducted while the participants were at their place of work. The in-depth interview where one hour to one hour thirty minutes long.

An interview guide with open ended questions derived from the aims and objectives of the study was used. The interview guide was iterated during data collection with relevant changes made after interviewing different manager to reduce redundant questions, include emerging themes and improve content of the data collection tool.

3.5 Data Analysis

(Braun & Clarke, 2006) provided a six-phase guide. I used in my study as a foundation in conducting thematic analysis.

Phase one: "Familiarizing yourself with your data, is focused on reading and re-reading the data, noting down initial ideas" (Braun & Clarke, 2006). To ensure I completed this 48 phase of analysis and immersed myself in the data, I transcribed the interview sessions of each participant, I reread the transcripts at least twice to begin to identify patterns and meaning, taking notes as I went along. By doing this, I was able to pull out the significant language, patterns, and themes that were discovered throughout the participants' interview transcripts.

Phase two: "Generating initial codes: coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code" (Braun & Clarke, 2006a). This phase was focused on reducing the data and the production of initial codes (Braun & Clarke, 2006a). The data was coded into "meaningful and manageable chunks of text, such as passages, quotations, single words…" (Attride-Stirling, 2001). This phase was focused on the development of themes; it is the first and most basic level of analysis that is used as an organizational tool (Braun & Clarke, 2006). The initial codes were:

- Professional legitimacy
- Peer relations
- Medical Curriculum
- Conflict resolution
- Willingness
- Career progression
- Organisational support

Phase three: “Searching for themes, collating codes into potential themes, gathering all data relevant to each potential theme” (Braun & Clarke, 2006b). In this phase, I analysed and sorted the codes to identify themes (Clarke & Braun, 2014). This phase was used as the draft of theme development and code placement.

Phase four: “Reviewing themes, checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis” (Clarke & Braun, 2014). This phase was focused on refining the draft themes identified in phase three using a two-level analysis of the codes. The first level involved reading through the codes for each theme and determining if a coherent pattern has developed(Braun & Clarke, 2006b). If a coherent pattern was identified, I moved on to the second level of analysis, if codes did not fit, I had to determine if the theme itself was the issue or the codes and information for that specific theme. To complete the second level analysis, I read through the entire data set to ensure the themes fit in relation to the data. This also gave me the opportunity to check if I missed any additional data that needed to be coded.

Phase five: “Defining and naming themes, on-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definition and names for each theme” (Braun & Clarke, 2006b). The goal of this phase was to be able to “…clearly define what your themes are and what they are not” (Braun & Clarke, 2006b). To meet this goal, I focused on defining each theme, identifying the essence of the theme, and determining what aspect of the data and research questions the theme fits under.

Phase six: “Producing the report: the final opportunity for analysis. Selection of vivid, completing extract examples, final analysis of selected extracts, relating back of the analysis to the research questions and literature, producing a scholarly report of the

analysis''(Braun & Clarke, 2006a). This is the final phase which focused on analysing the data and writing a narrative about the data that "…goes beyond description of the data and make an argument in relation to your research questions"; while it also "…provides a concise, coherent, logical, no repetitive and interesting account of the story the data tell-within and across themes"(Braun&Clarke, 2006, p. 93).As such, the thematic data analysis steps outlined below (see Fig 3.2) were used to produce a final report.

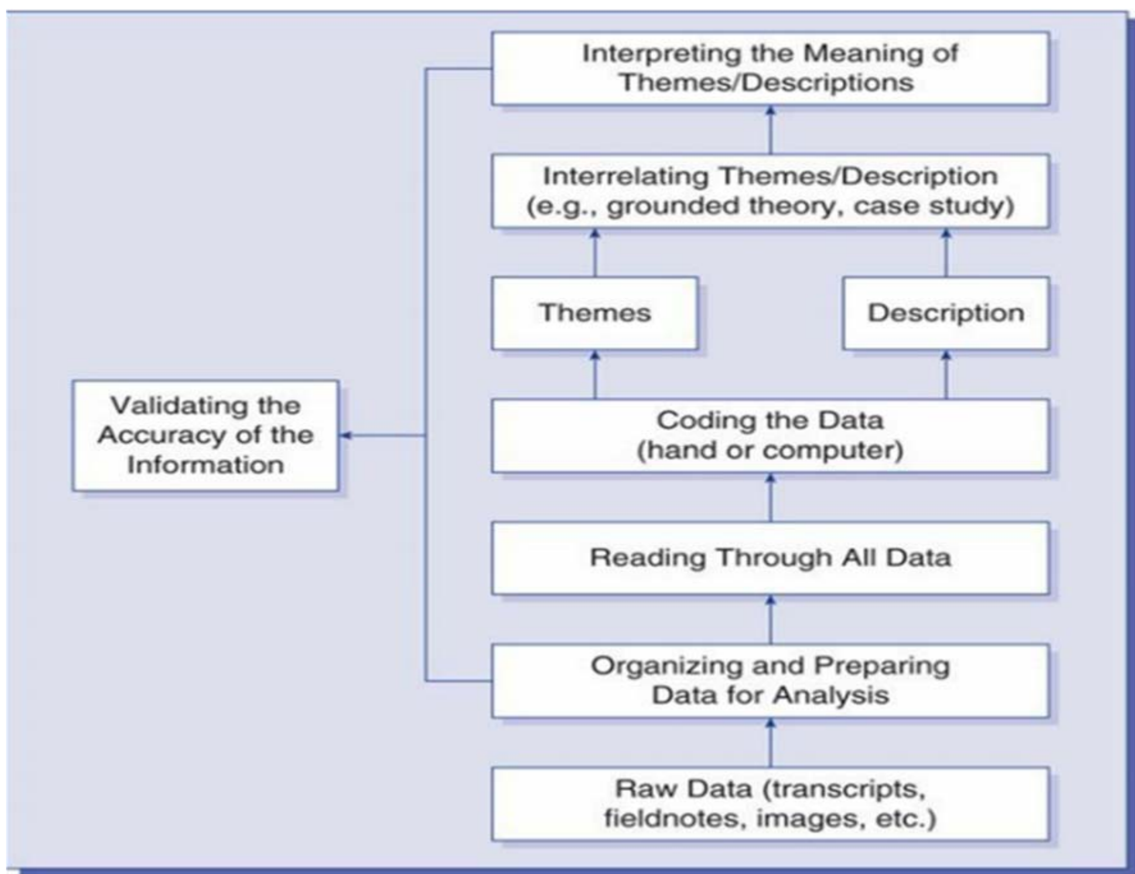

Figure 3.2: Thematic Data Analysis steps

3.6 Research Quality

Data quality is an insight and assessment of whether data is suitable and capable to serve its purpose. With this research, the data that will be collected should be of good

quality, without falsification or biasness to ensure accuracy and validity of the information that will be gathered.

The study focused on primary data, which offers originality and relevance to the topic of research study. Therefore, the data acquired was accurate and understandable. Research ethics were adhered to during the entire process of data collection. An in-depth narrative guide with pre-set questions was used during the data collection, alongside audio-recording and note-taking to enhance data validity and quality.

3.6.1 Validity of the Research

In qualitative research, validity is replaced with the concept "trustworthiness" as the central concept in appraising rigor and validity of a qualitative study. Lincoln and Guba (1985) used "trustworthiness" of a study as the naturalist's equivalent for internal validation, external validation, reliability, and objectivity. Trustworthiness is achieved by credibility, authenticity, transferability, dependability, and conformability in qualitative research. Credibility, the accurate and truthful depiction of a participant's lived experience, was achieved in this study through meetings and discussions with the supervisor (an expert qualitative researcher) to allow for questions and critique of field journals and research activities. Transferability was enhanced by using purposive sampling method and providing a thick description through the detailed and accurate descriptions making sense of the transcribed data by immersing myself into the phenomenon to know, describes, and understand it fully, comprehensively, and thoroughly. Dependability was achieved by having the supervisor iteratively review the transcribed material to validate the themes and descriptors identified. Conformability was met by maintaining a notebook of the research process to keep of early impressions of the emerging data and interpretations made as a form of documented audit trail.

3.7 Ethical Consideration

Undertaking a research process calls for the researcher to be aware of both the legal and ethical issues that must be well taken care of during the duration of the study. Permission was obtained from the Strathmore University Institutional Ethical Review Committee. The participant's confidentiality was assured, by seeking their informed consent and no coercion or financial incentives were used. The participants were

assured that they could pull out at any given time and no names are used. Anonymized codes were used for the facilities and participants to ensure confidentiality. All the data collected was kept confidential.

CHAPTER FOUR

PRESENTATION OF RESULTS FINDINGS

4.1 Introduction

This chapter contains details of presentation of data analysis, results, and findings. Results presentation is organized based on the specific objectives of the study. The purpose of this thematic study was to explore the impact of the construction of hybrid roles in Kenyan Private Hospitals. The chapter focuses on the participants by providing background information for each participant. A narrative of the findings follows; the chapter then ends with an overall summary. For this study, I used thematic analysis to code the data and identify the emergent themes of the study. I completed in-depth interviews with each participant to focus on their lived experiences and analysed the data in relation to the research questions.

4.2 The Participants

8 participants agreed to participate in the study. They were all doctors who were working as willing hybrid clinical managers in different private healthcare institutions in Nairobi. Each participant provided general background information such as family composition, social life, educational background, and work experience. They held different positions from middle management to senior management positions and different specializations in the medical field as highlighted in Table 4.1 6 of the participants were married, while two were not. Four of the participants were in senior management level for the facilities they worked for. These four participants had also specialized in Master of Medicine in different fields which included Surgery, Orthopaedic Surgery, Psychiatry and Ear, Nose and Throat surgery in addition to the MBAs they had studied later. The remaining 5 participants were all General Practitioners who had done MBA in Healthcare Management without doing any Master of Medicine specialization. Sixty percent of the of the participants had over 7 years of clinical experience and 3 years of managerial experience while the remaining 40% had over 15 years of clinical experience and 10 managerial experience in the healthcare industry. Of the 40% participants interviewed they were all equity shares in the health facilities they managed.

4.3 Emergent Themes

A total of six main themes and one sub-theme were generated using (Braun & Clarke, 2006)six phases of thematic analysis. Some of the themes were also informed by the literature review and conceptual framework guiding the study.

MAIN THEMES	DESCRIPTION
Transitioning into a hybrid role	Transition explains how the participants found themselves in their dual roles. It focuses on different paths and circumstances that led them into their hybrid clinical roles. This is a theme that has come out strongly in the literature review.
Medical versus managerial training	The undergraduate medical training curriculum offers no training in financial management, accounting, and administrative roles. This leaves graduates with no knowledge of these key roles, which with prior knowledge of, would lead to more doctors taking up hybrid roles easier.
Navigating role conflict	Hybrid clinical managers have dual roles to perform. There are times when these roles come into conflict and they must come up with solutions that enable them to meet the objectives of each role.
Hybrid-peer relationships	The aim of this theme is exploring the working relationship between medical Doctors and hybrid clinical managers.
The value of professional recognition	Professional recognition is about hybrid Doctors feeling unaccepted by their peers who took more traditional clinical roles that have nothing to do with management?
Role of hybrids in implementation of standards and guidelines	To explore how easily policies and administrative directives are taken up their peers or they are met with resistance.

4.3.1 Transition into a Hybrid Role

Transition refers to the process or pathway taken by the eight participants as they became hybrid clinical managers by taking up managerial positions. Their journeys were all different, but they all pointed out that they saw a need or a gap in the healthcare space or in health systems. Some became hybrid clinical managers, without any prior training in healthcare leadership and or financial management. The participants noted they had a knowledge gap in many areas of leadership and management. They mentioned some key skills they lacked for example financial accounting, interpretation of budgets, strategic planning, and lack of communication skills to mention just but a few. This led them to gain further training in management, making transition the overarching theme that reappears throughout this study. P1, made the following comment about transition.

'The medical superintendent of the facility I was working for left for further studies, and I was the second most senior doctor in the hospital, so I was automatically promoted to be the medical superintendent. They had just launched a program called 'Facility Fund Improvement', and I had seen the numerous financial issues the facility had been facing. To adequately manager the funds and administrative duties of the facility, I knew I had to take up a course in healthcare management, financial accountability, and all that, which is how my journey began. Sometimes I would have to rely on the medical administrator who would sometimes mislead me.' P1, Male

Participant two, three and four shared the same sentiments about their transitioning. They all reported that they were willing to take up their new roles as managers; they however did not expect to find challenges in key knowledge areas of management such as finance, human resources management and budgeting.

"I was quite overconfident when I became a medical administrator; I thought to myself, if I can save lives, how hard it will be to sign cheques and interview staff. Three months into the job, I was frustrated, I could not understand anything when it came to looking at budget reports, and I felt more of a secretary. This realisation led me to acquire the skills needed in healthcare leadership". P3, Male

The P2, P3 and P4 participants can be described as willing hybrids. They went into these administrative roles willingly but lacking the knowledge and skills to administer

or run a health facility. The discovery of their incompetence on matters of budgeting, accounting, human resource management led them to seek professional training on these key matters to improve on the above knowledge areas, proving their interest and willingness to take on managerial roles.

Participant 3 found herself as a willing hybrid clinical manager. She says, '*I saw an advert on a social media platform, from the job description I felt I was competent enough to do health administration. I applied for the job, I passed the interview and I was elated. Then the real work began, I had to ensure all shifts were covered, I found myself googling about a show course letter when dealing with some difficulty employees. I had never done a stock take; words like payable receivable were all new to me. So, I knew to succeed, my clinical skills were not enough to run the clinic. I went ahead and did an online certification on Leadership and Management in Health and am currently doing my MBA at the University of Nairobi'.* P2, Male

This shows how lack of managerial and administrative skills can be a hindrance to perform with efficiency the managerial roles assigned to these hybrids. However, their awareness of their lack of knowledge served as a motivating factor for them to take up training to learn these key managerial skills to fully equip them as managers.

Participant 4 is a willing hybrid because of his sentiment *'My colleagues and I decided to open an Ear, Nose and Throat Clinic. This was purely a speciality clinic. We all invested financially. I got keen about hospital management since I was the only one interested in purposely running the clinic from an administrative point of view. I took classes on Health Financing for Non-Finance Manager and a short course in human resources.*

This again goes to show the lack of skills and knowledge in administration and leadership was a challenge experienced by all the participants. They however have one commonality in that they knew to effectively manage and lead these healthcare institutions they had to go gain the relevant professions skills to complement their clinical skills and became competent hybrid managers.

Participant 7 shares her journey. She was promoted after going through a formal interview process; however, she states the following: *'I was excited to be a manager, I however I wasn't taken through any orientation space. I was given an office and told to run the clinic. Basically, it was on the job training and it frustrated me so much. I did*

not know how to come up with a business case and I could not interpret a budget to make strategic decisions to grow the health centre. I can admit that I made some uniformed decisions that led to an increase in the direct costs of the business unit, I wasn't using resources effectively and consequently the financial bottom line of my facility was affected for over three months, I was making losses. This greatly encouraged doing MBA in Healthcare Management'. P7, Female

Despite going through a formal interview and getting a managerial job, lack of skills in areas of strategy, financial acumen and other administrative skills proved to be a challenge as Participant 7 transitioned into her new role, making her must learn the necessary skills in management for her new dual role.

Participant 2 shared his transition process. He and his colleagues had opened an Orthopaedic group practice. Every partner was given a specific administrative role. He was put in the Quality Assurance Committee. This is what he had to say about his role.'

'*I am only a member of the committee since I partly own the group practice. We are three of us in the committee but I only put in effort when my two other colleagues are not around there. I feel as if we should outsource and hire someone competent in Quality Assurance since half the time, I don't know what am doing and I prefer if my two other colleges did it.*

However, I had already attained my MBA, so now my interest was to use it to ensure that our assets were being used well, this led me to be more proactive in the committee. This is despite being a member of the committee we had hired a financial expert, so I had to act as the oversight head. It took me time to be able to put into use what I had learned from my MBA but I think having the background in management made it easier than my colleagues. P2, Male.

Studies done have shown that due to the increased burden of healthcare processes and technology, doctors are going back to business schools in order to work in healthcare administration roles(Williams, 2020).

Participant 3 explains her transition process like this *'I was working as a General Practioner in a private clinic in Nairobi for four years. The then manager quit and the human resource advertised for the open position. I passed the interview and since I had worked in the clinic for four years, I felt I was up to the task. I knew nearly nothing and*

*for the first 6 months I relied heavily on the clinic administrator who is a nurse. I noted that the entire team felt like I was in competent, this is when I decided to fully equip myself with leadership, management, and accounting skills by doing several online classes and finally my MBA in Healthcare leadership.'*P3, Female

The theme on transition into management brings out the challenges in terms of lack of skills and knowledge in key areas like financial management, human resource management, leadership. This was a challenge faced by all the ten participants as they transitioned into these roles. The participants however demonstrated the willingness to acquire these skills because without these skills, service delivery would be negatively affected. Studies have shown that doctors who take up managerial positions without proper knowledge of the aforementioned skills perform poorly and consequently service delivery our dependent variable is[i] negatively affected (Clay-Williams et al., 2017a). Transition which is our overarching theme is supported by the sub theme of 'willingness' which was identified as one of the codes. All the 10 participants cited that during their transition into their managerial roles they realised lack of crucial skills needed in the management and administration of the health facilities. They all willingly took up courses in management to gain the required skills which they used symbiotically with their clinical skills to manage the health centres. This is because sound business practices are needed and doctors with MBAs or training in finance, human resource and other important business kills are in a position to understand and apply this(Regan, 2017)

4.3.2 Medical versus Managerial Training

This theme revealed how the undergraduate medical curriculum prepared doctors to enable them to take up leadership and managerial or administrative roles post-graduation. Generally, all the participants felt that the medical curriculum did not equip them with skills such as accounting, reading budgets, supply chain of medication, leadership, and management: anything to do with running a medical facility. All the participants found that these skills were essential and should be included in the medical curriculum. All the ten participated and they shared different opinions on when clinicians should be taught managerial/administrative and leadership skills.

Participant 6 had this to say *'the medical syllabus should be changed to introduce leadership, financial and managerial skills to clinicians. As a clinician you are already*

managing lives by trying to give the best quality and affordable clinical services. I believe that this training should be linear, cutting through undergraduate to postgraduate. Then a masters to offer a clinician as a medical specialist should be introduced and added to the list of medical specialists.' P6, Female

Participant 6 is of the opinion that the medical curriculum should incorporate modules like financial and managerial classes starting from undergraduate through medical masters training. The importance of this is for doctors who want to enter management and healthcare leadership roles can already be equipped with these skills. This allows hybrid management to be more accepted as a career path.

Participant 5 said *'Training in leadership and administration should be done after post graduating training as done by doctors who work for government institutions. These because this is the age that most doctors start thinking about opening their own practices or feel old enough to seek administrative roles'*. P5, Female

Participant 5 quotes goes to what studies have shown about doctors who want to end up running their own facilities or entering healthcare leadership. Private practice doctors must wear two hats: they must provide quality care to patients while also running a profitable business. While large hospital systems often have business administrators handling the commercial side of things, at smaller practices, this responsibility tends to fall to the doctors. These doctors must be well equipped with these skills otherwise service delivery form a managerial and administrative point of view is negatively affected(Gawor, 2020).

Participant 3 shared a different view, '*There is enough data done in the world that has supports clinicians to take up leadership roles. Training should ideally be done during undergraduate and internship. They need to be able to rotate in these different departments like finance, administration, human resource etc. This exposure earlier on can lead them to make educated choices and choose clinical leadership as a career choice*'. P3, Female

Participant 3 cites what most of the literature review discusses. As one of our independent variables was accountability, there needs to be accountability on many levels in the health organization especially when it comes to financial accountability. They need to understand the financial language to better communicate and understand the reasons behind some of the financial decisions being made by the finance team.

This allows also for the hybrid manager to communicate with them by explaining clinical things, to them in terms that make both financial and clinical sense.

Participant 2 had this to say about the importance of having financial and strategic skills while running a health facility.

'I did my Master of Medicine in Surgery and I got a job in one of the leading private psychiatric centres in Nairobi. I wanted to move into management but I knew to position myself well, I needed some knowledge in administration. My colleagues who had a worked for the county government had an advantage over me since they had done a short course on management called Senior Management Training, so I got bypassed on a lot of promotions. This made me enrol for an Executive MBA. This led me to be promoted and oversee the Strategic Committee. But the most important things I have learnt are in finance and accountancy: for a doctor involved in the management for such a hospital it is essential to have a good understanding of accountancy. My take on the medical curriculum is that it should include courses such as financial management, strategic planning and administrative skills in undergraduate to prepare doctors for the changing healthcare context'. P2, Male.

The above statement is supported by studies that have in the recent past that most doctors are leaving medical school and pursuing courses that enhance their knowledge in key areas such as financial skills, management skills, technical training in IT due to the evolution of medicine and the increased use of IT in medicine(Gawor, 2020) (Regan, 2017)

Participant 4 said *'Training in leadership or matters to do with leadership should be started in undergraduate. We learn in hospitals, these hospitals themselves have successful senior doctors who have leadership roles for example head of the surgery department who usually have training in finance and administration and management. By incorporating this module as part of the medical curriculum is crucial. These senior doctors can act as mentors for the undergraduate students looking to enter in management. This opens them up to a different nonclinical experience. They can observe how he or she goes about ordering surgical equipment's or looking into staff shortage etc'.* P4, Female.

Mentorship by senior colleagues during training is a motivational factor for one to take up the hybrid role. This is because it opens young doctors' minds to non-traditional

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clinical practice by offering them an understanding of management during their undergraduate training. Studies have shown that with more and more exposure to management more and more doctors are leaving medical schools and pursuing courses in finance, strategic planning, hospital admission and (Tim, 2021).

All participants agreed that the medical curriculum needs to be changed and expose them to skills sets like leadership, financial management etc. They all agreed that it was only when they got into these administrative roles that they realised the many skill gaps they lacked for leading a healthcare facility. The 10 participants agreed that effective formal training would better equip them as efficient managers. They all agreed that to effectively ran a health facility and retain their clinical autonomy, ensure accountability on the use of resource and delivery of good clinical autonomy while maintain good working relationships with their peers, modules in business acumen, management skills, technical skill and career growth in large healthcare management needed to be introduced into the medical curriculum. These findings are analogous with the findings from (Taylor et al., 2008)(I Spehar, 2012).

4.3.3 Navigating Role Conflict

Hybrid clinical managers find themselves in a position where they must perform dual roles which are their clinical duties and their administration and leadership roles. The performance of these roles at times puts them in conflicting situations whereby they need to protect their clinical autonomy and at the same time meet the organizational goal. Two sub themes have emerged from this main theme and these are: Role of clinical autonomy in reconciling conflicts and Chasm between clinical and organisational goals. These two sub themes provide a better understanding of the role conflict experienced by hybrid clinicians and the mechanisms used to navigate these conflicts.

4.3.3.1 Role of clinical autonomy in reconciling conflicts

Clinical autonomy as previously defined as the responsibility of the health practitioner to decide on the modality or clinical intervention that is best suited for the diagnosis

they have made. Hybrid managers need to perform their clinical roles and meet up to the organisational standards and goals. Oversight of clinical quality is only one of hybrid managers' multiple responsibilities. With the move to value-based care, organizations need sound management to navigate this evolving healthcare landscape. Previous research has not explored how conflicting priorities affect hybrid clinical managers' oversight of clinical quality. The purpose of this study was to create a preliminary model of the competing priorities, motivations, and responsibilities of managers while overseeing clinical quality and other organisational obligations(Hoekstra et al., 2021). Organisational needs at times might differ with the hybrid managers practice of treatment of patients because the organisation has financial and strategic targets to meet. For the organisation to meet their financial bottom line they create administrative directives that come from top bottom to be enacted by the hybrid clinical managers, while the managers are expected to pass on these directives to the rest of the team.

The directives as mentioned by the participants would be encouraging administration of IV antibiotics for a period on outpatient basis before a patient is switched to oral medication. Unless really warranted and supported by evidence-based medicine, this can be a conflicting decision on the manager. Another scenario is encouraging patients to use certain services e.g., pharmacy, physiotherapy and radiology services offered by that institution even though especially for patients without insurance the pricing in these facilities is usually high and this leads to out of pocket expenditure consequently which leads to catastrophic health expenditure.

Hybrids when put in such scenarios, felt the need to protect their clinical autonomy. Whilst medical hybrids may perceive themselves as doctors first and managers second(Louise Kippist & Fitzgerald, 2009), they are relatively successful in occupying an influential formal role in the managerial structures of the organization(Griffiths & Hughes, 2000). Pratt et al. (2006) suggest that, despite a continuing commitment to their professional ideology which is their clinical autonomy, doctors will adapt their identity to make it fit with the demands of their new role. Hybrid clinical managers want to provide the best clinical outcomes while at the same time meeting their organizational obligations. The use of evidence-based medicine was one of the ways that the hybrids used to navigate the conflicting roles. The hybrids that participated in the study all reported they had to meet their organisational goals, treating patients using

the best kind of evidence-based treatment and at the same time protect their clinical autonomy.

Participant 3 said *'I put my patients' welfare first; I use the best methods of treatment in the market to ensure I give good service delivery. For me this is a personal choice, I took an oath to put my patients first and I always use this as a point of reference. Is the organisation always happy about some of the clinical decision I make, no, especially when they have a negative impact on the financial bottom line.'*P3, Female

Participant 3 points out that the use of evidence-based medicine to offer the best quality of services as one of the methods she employs to protect her clinical autonomy. It is however important to point out that the use of evidence-based medicine does not always align with organisational objectives and this leads to conflict between her and supervisors. She explained how she fills the gap to meet the organisational financial bottom line and other strategic goals.

Participant 3 *'To make sure that I still meet the organisational obligations, I try to market the clinic aggressively. We give health talks for example on lifestyle diseases to corporate companies and this stakeholder engagement brings us more visits and financial obligations are met. I ensure our drugs are priced competitively and this also attracts patients directly to use our pharmacy and this leads to revenue generation.'* P3, Female

Participant 3 explains how she protects her clinical autonomy while using evidence-based medicine and the mechanisms she puts into play to help her achieve her organisational expectations whilst still giving the best quality of care. Some of the mechanisms put in place was marketing of the services offered by the clinic using billboards, digital marketing flyers and distribution of fliers to attract more clients, competitively priced medication and laboratory tests which attracts many patients to use these facilities and engaging with different stakeholders e.g., insurance companies to have her health facility put on their panel of providers again to increase the client base.

Participant 6 had an interesting take on the main theme of evidence-based treatment. While she understood that evidence-based care meant giving the best quality, effective and efficient medication, she added it had to come with a price. She stated:

Participant *6 'There is a balance when it comes to clinical autonomy and evidence-based care. We give good quality care that is supported by scientific evidence and this allows us to practice medicine within what we feel is our clinical autonomy. However, we have patients who have large capitations and large medical insurance schemes that we try our best to exhaust. I do not think it is unethical but more of we do need to meet our financial obligations, we have employees to pay and we still have good clinical outcomes'.* P6, Female

Participant 6 states that while using evidence-based treatment can protect her autonomy, it comes with a high price e.g., using good quality medication which led to a high rate of good clinical outcomes, the use of multi-disciplinary care teams to offer well rounded medical treatment, creating a safe and good working environment for the employees and engagement in Community Service Responsibility as a way of giving back to the community. The importance of using evidence-based treatment is to achieve the best quality of medical care but was also useful in protecting the clinical autonomy because they are practicing using methods scientifically proven to give good clinical outcomes. The participants demonstrated that as much as they needed to protect their clinical autonomy, they needed to be creative in other ways to meet organisational needs and the mechanisms have been explained above.

4.3.3.2 Chasm between clinical and organisational goals

Despite attempts used by clinical hybrids to manage the conflicting roles expected of them as frontline health care workers tasked at giving the best quality and as managers expected to meet their organizational goals, the task of reconciling the different expectations often failed. As managers hybrids have the technical knowledge laid on a foundation of their clinical skills which allows them to make long term strategic plans to ensure continuity of good service delivery. The organisation on the hand has it owns goals and targets to meet. The goals ranged from expansion of services, acquisition of new medical equipment to financial targets that make the hospital operational. These goals however conflicted with clinicians' goals. The organisational structure in terms of leadership also plays a role in this conflict. Of the study participants, 3 of them, shareholders in their health facilities faced different experiences to the other 5 who were employees with direct supervisor as illustrated below.

Participant 7 *'I work in a very controlled environment; I am assessed weekly, monthly, quarterly and yearly. This assessment focuses more on the financial performance of the health centre. I want to treat patients by offering quality, available and affordable treatment, unfortunately if I employ all these mechanisms, I might not be able to meet the organisational financial goals. Sometimes I end up sending patients to the lab even when there is no indication because at the end of the day, the financial bottom line is what matters. The line between achieving good clinical outcomes and achieving organizational goals is quite blurry'.* P7, Female

The above comment shows that the complex role of hybrid clinician-manager leaves limited time beyond direct patient care for meeting organisational obligations especially when held to high scrutiny from the organisation. This negatively affects service delivery because ordering unnecessary tests does not equal to offering good clinical service and it also affects the accountability of the hybrid manager in terms of the clinical duties whereby their key stakeholder whom they should be accountable to is the patient.

Participant 8 seemed to share similar sentiments with participant 7, especially on the sub theme of accountability to the organization and other stakeholders.

Participant 8 said *'I am accountable first and foremost to my employer. The rest of the stakeholders take a line back. The main accountability channels I use with employer are monthly reports, attendance of management meetings quarterly and weekly monitoring of the budget to date with the accountant. What this does is put one under so much pressure and I think that has a negative impact on clinical service delivery. I have less time to perform my clinical duties and even as I do my work as a doctor there is a cloud hanging over me on how my choice of treatment will affect the organization. I am more concerned on financial outcomes than clinical outcomes.* P8, Male

Participant eight sentiments are like participants seven. They all agree that by putting organisational objectives first, it does not translate to the delivery of good clinical service.

Participants 7 and 8 who had little bargaining power because they were in middle management had to be creative to still use evidence-based treatment guidelines and protect their autonomy and accountability. For Participant 7 explains.

'I know the importance of using evidence-based treatment to get better clinical outcomes. I approach the head of quality assurance and chief pharmacists and accountant when coming up with treatment algorithms for my clinic. Having the knowledge and equipped with scientific data, I would present the new treatment modalities, show them the type of medication I would need to stock and with the help of the accountant create a persuasive business case which showed the positive impact the new algorithm on the financial bottom line. By including the head of quality assurance and the chief pharmacists and incorporating their ideas, the algorithms were easily adopted.' P8, Female

Despite organisational pressure on some of the participants to concentrate more on meeting organisation goals at the expense clinical goals and outcomes, participants also had to implement other conflicting changes to grow the financial bottom line.

Participant 7*, I was also expected to make sure the resources of the facility were used efficiently and effectively. This meant operating with a lean staff, saving on locum hours and this affected service delivery negatively due to long turn over times and constant negative customer feedback. Working with a lean staff also lead to many patients coming back to health centre within 48 hours with worsened symptoms, this meant we weren't giving the best quality of service and this I personally allocated blame to staff burn out.'* P7, Female

Most directives on clinical or organizational goals were hierarchical. Changes or new standard operating procedures would only be accepted only when they came from senior management as experienced by participant 8.From the narratives the participants who experienced this were the ones in middle management.

Participant 8, *as a facility I wanted to come up with an algorithm on how to monitor patients who were pre-hypertensive. These are the type of patients with moderate elevations in their blood pressure but enough scientific data had been collected that showed with lifestyle modification, diet change, exercise and serial monitoring of their blood pressure would prevent them from becoming hypertensive. However, despite the evidence, this algorithm was met with resistance and no support from senior management and if senior management did not sign accept the algorithm, it was deemed null and void and it couldn't be used.'* P8, Male

For the 3 participants who were shareholders in the health facility, things were different because directives, strategic plans and administrative actions are always discussed among the shareholders.

Participant 9 said, '*for us when it comes to clinical goals, we chose the best way to treat the patient. Our clinical goals are also very patient centred than organisational centred. We also consult a lot amongst ourselves. We do have organizational goals but for us the patient comes first. This has so far worked for us as a group practice because we have created a brand name in the psychiatric healthcare industry due to our affordability and effectiveness of care, so we are planning to expand and this has only been made possible by putting good clinical affordable outcomes that has increased our clientele base.'* P9, Female

Hybrid managers in organizations that hold them accountable to quality-based metrics have more systematic clinical quality oversight processes. These processes allow them to retain their clinical autonomy and focus on delivery of good clinical services.

The chasm between clinical and organisational goals was also reinforced by the hierarchical nature of the administrative structures in the health facility. This also shows that for hybrids to carry out their dual roles especially where the roles have grey areas, there is a need for organizational redesigning to move from rigid bureaucratic structures to more flexible patient focused goals. Hybrid managers need and have demonstrated that they are able to come up with innovative ways of managing conflicts within the organisations. Organisational support is therefore a key needed factor to help hybrid managers navigate these conflicts.

4.4 Hybrid-Peer to relationships

The role of a hybrid clinical manager is both administrative and performance of clinical duties. They work together with other clinicians who have maintained the traditional role of pure clinical practice and therefore it's vital to explore how hybrid clinicians navigated this role. Some participants experienced challenges overseeing their peers who they once were colleagues.

Participant 3 said*, I first learnt that I need to lead by example. I cannot have policies at the health facility whereby I am the only who does not follow them. I also had to create trust and have an open-door policy. While studying for my MBA, I came across*

transformational leadership and this is my chosen style of leadership. I constantly push my colleagues to further their education. Sometimes I do meet resistance; this is especially now with COVID-19, due to curfew implemented I had to make changes on the doctors' shifts which was meant with a lot of resistance. I decided then we have a sit-down meeting and agree on working hours that were favourable to everyone, at that time I decided to be a doctor not a manager and this led to a successful rota.' P3, Female

Participants 3 use of transformational leadership which she came aware of during her MBA training goes further to support how important training of medical leaders is. She also uses motivation and persuasion when leading her team which consequently helps them accept new action plans even in difficult working environments.

Participant 1 had the following to say about peer-to-peer relationships.

'You have to create an environment where they respect your clinical and managerial skills. You also need to give them a conducive environment to work in, well-furnished offices, branded lab coats and most importantly involve them in key decision making about the facility. In terms of conflict resolution, it always starts at the departmental level, then if the matter cannot be resolved on that level, we escalate to the medical advisory level where I chair and whatever decision is made, I execute it'. P1, Male

Studies have shown that hybrid clinical managers receive more support and respect when they show competency in their clinical work as well in managerial word(Spehar et al., 2014). Other studies have been done to show attributes that a hybrid manager needs to have in order to receive support from their peers and they include credibility in clinical skills and knowledge attitude, and experience in management (Berghout et al., 2017a). These are sentiments expressed by participant one.

Participant 8 said this, *'when I became the health facility manager, my former colleagues automatically became cold towards me. They had an expectation that since we were colleagues and friends that they could lay back, come to work late and sometimes even intentionally see patients slowly hence the turnaround time for the patients became too long. This was followed with multiple customer care complaints, several disciplinary meetings and initially I can say for sure that the service delivered then was negatively affected. I had to learn to separate myself from them and became a manager first and a colleague second. Then with time and of course talking to them*

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individually and as a team, we started working well together. I had to also remind them that I had relationships that I needed to maintain with my superior and this also helped see why I was doing things the way I was'. P8, Male

Not all participants had an easy relationship with their peers. Some participants peer to peer relationships changed when their colleagues got promoted to oversee them leading to strained relationships including customer complaints of long waiting hours, and employee's absenteeism increased. Some hybrids reported that the first months were hard, especially those who were promoted internally (Loh et al., 2016).This is supported by studies that have shown that fellow doctors go over to the ' dark side' when they take on managerial roles as cited by(Loh et al., 2016) and this led to conflicts at the work place.

Participant 7 said '*I first learnt that I had to be more assertive than when I was just a General Practioner. I was promoted to the hybrid role among my* colleagues *and they were all General Practioner so they did not understand why all over sudden I am giving or allocating them duties or reprimanding them when they did something wrong. So, my relationship was strenuous and they had issues taking orders from me. I had no support from even the non-clinical colleagues who before I became a manager, we were cordial. I learnt to put my foot down and after a while, they grew to respect me'.* P7, Female

Due to a lack of peer support, some clinicians experience social isolation after transitioning into management. Studies done on hybrid clinical managers who face social isolation have a hard time implementing actions plans which has a ripple effect and consequently service delivery is affected negatively(Doolin, 2002).

Participant 5*'since we are all shareholders, when a disagreement comes along, we always put it to a vote that is how we handle conflicts among us as shareholders. In terms of peer-to-peer relationships, we respect each other and have a professional working relationship. The rest of the clinical staff, that is the nurse, pharmacists and physiotherapist also respect us because we also view them as our colleagues. We however have a medical advisory board that handles conflict among the rest of the staff and if the matter cannot be resolved then it is escalated to human resource.'* P5, Female

The organisational structure of the facilities also affected the dynamics of peer-to-peer relationship and conflict resolution.5 of the participants were all employed by the

private facilities they were working for as hybrid managers. 3 were shareholders in their facilities. This affected peer to peer relationships because e.g., 5 participants received orders top down, meaning they too had to maintain their relationships with their supervisors. In terms of conflict resolution, the organisational structure shaped how conflict was handled in facilities e.g., where the participants were the actual shareholders versus being employees.

4.5 The value of professional recognition

Professional recognition is the formal acknowledgement of an individual's professional status and right to practice the profession in accordance with professional standards and subject to professional or regulatory controls. The Kenya Medical and Dentist Board is the main body that is responsible for the licencing and acknowledgement of medical specialities and sub specialities. Despite the growing number of medical doctors going into administrative roles, the board does not acknowledge hybrid clinical managers as specialists.

The lack of recognition of hybrid clinical managers, terms have been coined such as 'amorphous doctors' who many hybrid doctors consider inexact. There is an increase in different master's programme that aim to equip doctors with managerial and administrative duties. Some of the masters' programmes are 'MBA in Healthcare Management', 'Masters of Science in Health System Strengthening', 'MBA in Health Leadership and Management' all offered by universities in the country targeting clinicians. These masters' programmes are further strengthened by professional courses aimed to equip specific knowledge such as 'Quality in Health Care', Financial Accounting for Doctors', Hospital Management for Health Professionals' but the board does not recognise any of the trainings.

Their aim is to improve the state of the healthcare system in the different facilities they work for yet on the Kenya Medical Board still registers them as General Practitioners. The consensus among all the participants was that the registering board needs to register them as specialist.

Participant 7 stated '*we are doctors who have gone to acquire skills on how to improve the health systems of the facilities we work for; we are doctors first and managers*

second. We are more likely to understand the requests of the doctors, patients, and the rest of stakeholders.' P7, Female.

Research as shown that hybrid clinical managers identify as doctors first then as managers second.(Louise Kippist & Fitzgerald, 2009). The lack of recognition by the registering body leads to internal conflicts whereby the doctors who have taken up these roles feel left out by the medical fraternity. The duality in role identity is turbulent and unsustainable, making it difficult for clinicians to realign identities with new roles and this can lead to a negative impact of service delivery(Denis et al., 2015).

Participant 2 added *'the way medicine is being practised now and the emergence of new diseases, doctors with our qualifications will be more useful as we have acquired budgeting skills, risk mitigation skills and other skills which can help us direct the doctors in the traditional roles on how to plan and prepare for the changing health industry, the lack of recognition from our peers is wrong'.* P2, Male

Participant 4 said *'for one to come and do a master's programme in leadership or management in healthcare, they do have to have a medical background, hence doctors who have specialized in these courses need to be recognised as specialists. At the end of the day, they are working with other clinicians to enhance the quality of healthcare'. When we as hybrids are recognized as medical specialist by the Kenya Medical and Dentists Board, it offers a sense of legitimacy and belonging. The colleagues we supervisor will also give us more respect, reduce conflict and give them confidence in us that when we bring in change management or offer administrative directives, these are decisions made from our knowledge in health leadership and management,'* P4, Female

Studies showed the importance of credibility among medical peers in executing both clinical and managerial careers. Credibility is an important source of legitimacy, influence, and recognition, which are required to 'get things done'. For example, the reputation of clinical excellence "has put clinical directors in a relatively strong position vis-à-vis management. Moreover, credibility and maintaining a clinical identity and legitimacy are important for hybrid clinical managers, due to the fact that they retain their traditional role of clinical practice(Denis et al., 2015)

Hybrids are subjected to lack of professional recognition by the board and their peers despite their conviction that they have a lot to offer in terms of improving the provision

of effective health services basically because they have skills in both the clinical and health leadership and management skills. However, a career as a hybrid clinical manager has not been formally accepted like in countries such as USA and Germany where they are recognized as clinical directorates. The essence of the hybrid manager is to act as a link between management and professionals. However, without proper professional recognition, it can lead to demoralization and poor role enactment.

4.6 Role of hybrids in implementation of standards and guidelines

All the participants stated that they had at one time in their hybrid managerial roles been involved in policy development and implementation at the facility level. They emphasised the need to contribute their skills on all matters that affected the health facilities in both clinical and non-clinical areas. This included involvement in development and implementation of standard treatment guidelines, standard operating procedures, services charters, long term strategies on facility and clinical service expansion.

*'I coordinated the creation of the budget when we started to build the doctors plaza to increase our capacity to care for more patients. I was dealing with architectures and accountants. But by this time, I had done a course called 'Financing for Non-Finance Managers' so when they were talking about fore casting budget and short- and long-term liabilities and assets, I was able to follow through. My colleagues had confidence in me. This I felt was because I was one of them, a doctor, so it was easier for me to translate the action plan in a simple way that they as doctors could understand P*1, Male.

Hybrid clinical managers can effectively lead front-line service improvements which impact on patient care(Fitzgerald et al., 2013). This is because they have a better combination of experience and skills than general managers with no clinical experience. Essentially, hybrid clinical managers have more credibility with their clinical colleagues and can therefore engage their support

Participant 5 *'I am the chairman of the expansion committee and an equity shareholder. Some of the policies I have been involved in were one where we intent to open another branch since of the growth of numbers in our current hospital centre. This involved a lot of strategic planning and implementation of the action plans. My clinical*

background and my MBA really help when making decisions. Also having done several courses on equity sharing, knowledge about fixed costs gives me insight and allows me to give my opinion during these meetings.'P5, Female.

Studies have shown that, trained medical professionals in leadership positions tend to be more aware of organizational goals and results, and declare to adopt a more systematic use of managerial operating systems (e.g., budgeting, and strategic planning) and performance information to support day-to-day decision-making and to get more involved by the top management in decision-making as seen by the above narrative (Giacomelli et al., 2019a).

This also addressed how administrative directives and following of standard operating procedures was accepted and implemented by their peers having those orders coming from hybrid managers.

Participant 1 said '*The most difficult people to try change management or accept a new policy are my fellow doctors. They believe they know everything, even financial terms that took me years to understand they pretend to know. So, what I noticed helps when it comes implements change or coming up with a new policy is to involve the doctors by having one or two representatives working with us as we make the policy. They feel that their voice has been heard.'* P1, Male

Studies done have shown that doctors prefer to take orders from their fellow colleagues. This is because of the credibility that the hybrid managers have because first and foremost they are doctors too. Hybrid managers too interface with patients and are in direct contact with clinical colleagues and this enables them to prioritize improvements(Fitzgerald et al., 2013).

Participant 3 said, *'I am an equity shareholder at the medical facility, I head the market analysis committee. As a shareholder I really want to be in all meetings because I am interested in the way the business is performing, but I do not think I have ever sat through a meeting due to surgical emergencies.* P3, Female

The process of coming up with guidelines and standard operating procedures at facility level was done in consultative meetings. Hybrids carry out dual role so time management was very crucial. Conflicts over roles came out during the interview

process with all participants saying that time management was the one of the biggest challenges in their dual roles.

Participant 7 *'As a health centre we identified the main diseases that we treat. We came up with standard treatment guidelines for these diseases and it is our policy that patient be treated using these guidelines. We saw a reduction in revisits and the pharmacy was able to coordinate its supply chain so that we do not experience drug stock outs'*. P7, Female.

The need of improving the governance of healthcare services has brought health professionals into management positions, thereby performing hybrid management roles. Professional and managerial knowledge is growingly perceived as complementary and more evidence has showed that hybrid managers enhance clinical and management outcomes. Frequently the medical profession has supported this policy change by encouraging skill acquisition in medical leadership, therefore making doctors keen on quality, innovation, and performance. Studies have also shown that engaging hybrid managers in top decision making makes it easier for the implementation of strategies and action plan since hybrid managers are in direct contact with frontline healthcare workers.

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CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents a summary of interpretations of the findings from the study. It interrogates the findings linking them with existing theoretical literature, previous research and explains how the study advances theory, knowledge, and practice in the health sector.

5.2 Discussion of the Findings

The main objective of this study was to gauge the impact of hybrid clinical managers on service delivery in private health facilities in Nairobi. To do this, 10 hybrid clinical managers were interviewed using a semi-structured interview guide that was tailored from the literature review and conceptual framework. The analysis revealed a total of six emerging themes with the overarching theme centred around the transition process for each of the hybrids and how that influences their roles in everyday service delivery in different health facilities with different hierarchical structures.

5.2.1 How Hybrids Transition and Navigate Their Clinical and Managerial Roles

Prior research has shown how transition processes of hybrids are determined by the position of the clinician within the organization. The interest of the organization in involving clinicians in management and decision-making roles either motivates or deters them from taking up hybrid roles (Denis & Van Gestel, 2016).

All the participating hybrids in this study reported a realization of knowledge gaps in managerial and administrative skills on taking up the dual roles of health service provision and management. The lack of these skills in hybrid managers echoes what previous studies have found about lack of role related skills such as finance, budgeting, technology, and strategy formulation skills(C. A. Taylor et al., 2008)(Nzinga et al., 2019b). For example, one key skill that they pointed out that they ought to have had was communication skills. All the ten participants pointed out communication skill to be important since being a hybrid manager one needs to influence staff to work towards meeting organisational goals. A hybrid manager also needs to formulate strategy and

communicate any restructuring or implementation of new standard operating guidelines in a way that will enhance commitment to the new changes aimed at improving productivity to their staff. To achieve this, hybrid managers need to have the skills and capacities of translating strategy into action plans in a clear and concise manner. The importance of communication skills has been reported in previous stud (Birken et al., 2012) (Ghiasipour et al., 2017). The lack of proper communication skills had a negative impact on service delivery as reported by the participants. Failure to articulate new organizational directions or give proper directives led to lack of implementation of standard policies or change in practice, ineffective use of resources and discord among the staff leading to poor service delivery, this finding echoes findings by (Ghiasipour et al., 2017). The hybrid managers also noted the importance of learning to listen and that, beyond giving directives, during negotiating with different stakeholders it was necessary to learn how to accept criticism or feedback.

Another skill gap for the hybrids was the lack of financial skills including financial analysis and budgeting which was perceived to have a negative impact on service delivery by the participants as supported by other studies from high-income and low-middle income health contexts (Figueroa et al., 2019). Hybrid clinical managers need financial skills to help in allocation of the limited resources in the health sector especially as the health context is constantly evolving and health facilities are adopting new business models(Figueroa et al., 2019)(Spehar et al., 2012)

Beyond skills training, hybrids need mentorship and involvement in organizational strategizing to build their commitment to meeting organizational goals and to achieve good clinical outcomes (Lega, 2017). The participants in the study felt that they needed to be involved in the process of strategy formulation since they were the ones who knew the resources currently available, the immediate needs of the health facility and the competencies of the employees who would be expected to execute the strategies a finding supported by (Birken et al., 2012). Previous studies have shown that the involvement of hybrid managers in implementation of new strategies, directives led to better organizational outcomes (Giacomelli et al., 2019). However, it is imperative that strategy formulation processes consider the different organizational structures that exist. For example, from this study, despite all the participants being willing hybrids, varying organizational hierarchical structures meant that the senior managers (4 of the hybrids) were given more voice in strategy formulation while the 6 were middle level managers

were often overlooked and left out of strategy formulation discussions. This finding is echoed by (Birken et al., 2012) who states that sometimes top managers might neglect potentially important determinants of effectiveness during strategy formulation by not involving hybrid MLMs. The back and forth that came with missing out key determinants or crucial information had led to delayed service delivery a negative impact on clinical care. The consequences of being shunned form strategy formulation discussions led to mid-level managers preferring to spend more of their time in performing clinical roles, findings that have also reported been reported elsewhere. (Nzinga et al., 2019). When MLMs are left out of key decision making or change management discussions this undermines their legitimacy among their peers. This similar findings have been reported by(Currie, 2014) . Consequently, this presents an added a challenge as they were already dealing with role identity and a fear of loss of their clinical legitimacy and autonomy as described by(Byrkjeflot & Jespersen, 2014a)(Cascón-Pereiraa et al., 2016).

5.2.2 The Influence Hybrid Relationships with Their Peers Have on Service Delivery

Even with calls for training in managerial skills, hybridization in the Kenyan clinical context is till unpopular. Our ten participants were all willing hybrids but from the interviews conducted, the findings were different, they all are agreed that their colleagues did not acknowledge hybridization as a career, and they undermined the legitimacy of this career path. The participants cited several reasons why their peers did not recognize the legitimacy of hybridization as a career, and they included 1) their peers did not believe in their managerial and administrative capabilities 2) they lacked an understanding of the importance of the hybrid role and 3) there would be resulting conflicts between hybrids and their peers when hybrids had their directives either ignored or were always being questioned about the expected goals that they were meant to achieve.

Research findings(Berghout et al., 2017b) by research also reported similar findings that the lack of administrative support and a lack of understanding of the of hybrid clinical role by their peers led to their low productivity . The participants explained that to navigate this conflict with their peers they had to demonstrate competency in both clinical and managerial skills. From analysis of the data conducted, it emerged that the

clinical qualifications of a hybrid played a role on how much the hybrid was accepted as a leader. Four of the participants had Masters in different fields of Medicine. There was a surgeon, an orthopaedic surgeon and an Ear, Nose and Throat specialist and a psychiatrist. Although these four participants had other qualifications and certifications in management, accounting, leadership, they firmly believed that their clinical specialization is what led them to gaining more respect when it came to giving out administrative directives rather than their qualifications in managerial capacities. The level of maturity, years of clinical experience gave senior hybrid managers to have more authority on the use of resources allocated to them and the enactment of top down directives given compared to their junior hybrid clinical managers as reported by research findings by(Mcgivern et al., 2015b) Nonetheless, the four hybrid managers who had clinical masters reported positive experiences in introducing change in their health facilities because of the credibility associated with many years of clinical practice that gave them legitimacy within their peer groups. Clinical directors who were specialists/had medical masters and many years of working experience have been shown to have more credibility and organizational support which gives them authority to issue top-down directives and due to this support, the changes or adoption of new standard operating procedures was easily implemented (Giacomelli et al., 2019b)

Although the remaining six hybrids had no clinical masters, they had post graduate training for example, MBA, MBA in Healthcare Management they reported a lack of recognition and only got their respect as leaders due to the titles given by the organization for example, a medical director, health centre manager, director of outpatient services. This is because these masters' programs are not recognized by the Medical Board as areas of specialization as indicated in ("MEDICAL SUB-SPECIALITIES," 2006).They reported that the lack of recognition led to conflicts that affected the day-to-day operations of the health centre. One of the participants gave an example on how all clerkship notes of a patient's illness was meant to be captured on the new hospital records management system. The older doctors who had masters in the clinical field resisted this new directive choosing to continue with handwritten notes. The ones who agreed wrote very few clerkship notes. This led to the facility failing its clinical audits because key elements were missed out for example diagnosis, medication especially for patients on medication for chronic illness. This made multi-disciplinary care of patients hard due to lack of proper documentation of their illness or the drugs

they were discharged on. Time as a resource was also wasted as sometimes one had to go look for the actual hard copy file of the patient. This similar finding has been reported by (Imran et al., 2021) whereby research shows that senior doctors worked autonomously and loathed to being instructed by anyone particularly ‘hospital management’ who they felt do not appreciate their work.

5.2.3 The Accountability Mechanisms Used by Hybrid Clinical Managers to Influence Service Delivery

The interactions that hybrids have within the organization are crucial in helping them deliver the expectations of the organization and in contributing to better clinical outcomes and overall improved service delivery. It has been shown that hybrids offered organizational support and motivation makes them the agents of change at both the frontline and managerial level (Birken & Currie, 2021). In this study, there was a clear difference between the type of support offered by the different organizations to MLMs and senior level hybrid managers. The participants worked for health facilities with different organograms, this affected how the hybrid interacted with senior management, patients, and other stakeholders. Those who received top-down directives were mainly the 6 middle level managers who also reported a lack of defined standards of operation, unclear job descriptions which brought challenges in enacting their dual roles and led them to make managerial decisions based only clinical knowledge. Similar findings have been reported by (Nzinga et al., 2019).

The lack of involvement and limited support for hybrids especially has been shown to have serious consequences on accountability. Studies have shown that leaving hybrids out of key in key decision-making activities for examples coming up with standard operating procedure, facility level guidelines formulation and strategic planning of the organization(Currie, 2014)(Nzinga et al., 2019) makes them feel more of enforcers than leaders and breeds conflict with their colleagues a finding also reported by (Kippist & Fitzgerald, 2009b). Furthermore, it leads to role conflict and accountability dilemmas on how to achieve both organizational goals and clinical fulfillment. A study by (Loh et al., 2016) reported that middle level managers who received top-down directives said they had no option than to be more accountable to the organization by putting up measures to meet the organizational goals at the expense of their clinical autonomy.

In this study, mid-level hybrids agreed that they had to come up with strategies to meet organizational goals and sometimes these had a negative impact on the quality of service they offered. A participant shared that to reduce overhead costs she would have to work with a lean staff. This led to a cascade of events starting with longer turnaround time in terms of time taken to see a doctor, time taken for results to come out to time taken to bill the clients. This cycle led to negative feedback from the clients and poor quality of service offered, with a significant increase in the number of return patients within 48 hours who reported worsened symptoms. The senior hybrids on the other hand, as majorly shareholders in the facilities they worked as hybrid managers, participated in key decision-making e.g., they discussed strategic plans, budgets, they came up with operating procedures together. Whenever they differed in ideology or some of their plans, they took the matter to a vote and these consultative work arrangements also led to a lot of peer-to-peer consultation on standard operating procedures and treatment modalities. Consequently, they were more patient oriented than organizational oriented which in turn protected their clinical autonomy and had a positive impact of the quality-of-service delivery they offered. This finding was also reported on clinical directors in Portugal who shared the ideology of patient centered care and got great organizational support as reported by (Correia & Denis, 2016e)

The use of EBPs as reported by the participants had good clinical outcomes especially when it involved algorithms of treatments. This finding supports the ideology that clinicians came into management because the incorporation of their clinical knowledge and managerial role one of the expected outcomes was good clinical outcomes. This finding has been reported by several researches.

Without all necessary managerial skills participants reiterated the importance of using evidence-based practices (EBPs) when coming up with standard operating procedures for their health facilities. The use of EBPs as reported helped in the efficient use of health resources because it touched on matters like the best treatment regimens for patients, channels of communications and allowed the hybrid managers to champion for the concerns of the frontline who had to be guided on how to implement the strategies into actions plans. Research has also shown that use of EBPs leads to effectiveness on use of resources and good clinical outcomes. The participants also reported the use of upward strategies of influence on their senior managers to circumnavigate the dilemmas of conflicting goal expectations. They mentioned coming up with business cases or new

operating procedures and involving the organization by showing the benefits of these new ventures to the organization...

Navigating ensuing conflicts meant dealing with identity conflict, whereby the hybrid managers do not want to lose their clinical autonomy but still had to meet organizational expectations. Consequently, the hybrids especially the senior managers occasionally abandoned their managerial roles for clinical roles because they did not want to lose their identity as doctor. One of the participants who practised as an orthopaedic surgeon said despite taking on managerial duties, he still needed to advance his orthopaedic career since it is quite a competitive field and he did not want to be known as *'the manager'* but he wanted his peers to recognize him first as an orthopaedic surgeon then a manager second. This means managerial, strategic decisions and administrative directives are undone or delayed leading to optimal delivery of services in the health facility and this leads to inefficiency in the running of the facility also reported similar findings in the Australian health context. The mid-level hybrids on the other hand, regularly abandoned their clinical roles for managerial duties leading to increased workload for the remaining clinicians which led to conflict as highlighted in several studies(Loh, 2015)(Nzinga et al., 2019b). Conflicts were also experienced when clinical role and managerial demands were opposed. This internal conflict came when they felt their clinical autonomy was under threat and wanted to put the patients' needs first but this clashed with the organisational needs aimed at reducing running cost to meet their financial bottom lines. This internal identity conflict was experienced mostly by the hybrid managers who were in middle level management. This is because unlike the hybrid managers in senior level positions who were shareholders in their facility or laid legitimate ownership of the health facility, middle level managers had to report to a direct supervisor and they were mostly interested on the financial position of the organisation. This finding was also reported by where the managements' main key interest was the financial returns.

In summary, while involvement of hybrid clinical managers in hospital administration leads to improved clinical governance, performance, and better clinical outcomes, hybridization is a complex process. The hybrids from this study used clinical skills and acquired principles and skills of management to help them in decision making and in reconciling their clinical and managerial roles. Furthermore, they also showed innovative strategies that they used when navigating organizational conflict and identity

conflict. These strategies involved top and downward strategies, where top up strategies were all about engaging their senior supervisors in professional conversations to buy into their innovations or new business cases. Downward strategies involved being the channel of communication that negotiated with frontline healthcare workers to implement strategic plans into actions plans to ensure efficient use of health resources and maintain good clinical outcomes. The hybrids were cognizant of the value of organizational support in enacting their dual roles that included having well described scope of managerial duties, continuous engagement in decision making discussions and enforcement of guidelines that helped also protected their clinical autonomy. There were still gaps that needed attention in the transition journeys of hybrids. The hybrids noted that due to the changing healthcare context with more emphasis put on patient centred clinical care and effective and affordable treatment, the management needed to invest in healthcare rather than initiating cost cutting mechanisms that led to negative impact on service delivery since at the end of the day, the hybrid clinical manager would be the one tasked with ensuring that such changes were acceptable to all.

5.3 Conclusions

Based on the findings of this study, the roles and actions of hybrid clinical managers can lead to both positive and negative effects on service delivery in health facilities. Without organizational support, hybrid roles can lead to neglect of managerial roles which would negatively impact service delivery. Continuous organizational support such as that accorded to senior managers was seen to lead to a positive impact on both clinical outcomes and organizational goals. During their transition into their dual roles it has been concluded that they need key skills in management and administration to be able to use them together with their clinical skills and make informed decisions,

This study also concluded that there was a difference between how senior hybrid clinical managers and middle level hybrid managers performed their dual roles. Senior managers had more years of clinical experience and hence more legitimacy. They received more support from management compared to middle level managers and their directives were easily implemented and accepted. In terms of hierarchical organizational structure, senior hybrid managers formed top management, and this is the group identified to give top-down directives.

However, middle level managers from this study are strategically positioned between senior management who formulate strategies and standard operating procedures and the frontline healthcare workers who are expected to translate strategy to action to meet the organizational objectives. The MLMs play a crucial role in synthesizing and disseminating strategies.

Finally, it has been concluded that with the support of hybrid clinical managers and close collaboration with the organizations they work for, a more positive impact on service delivery can be achieved. This study further concludes that managerial tasks interfere with clinical work due to lack of organizational support and limited skills in managing, leading to a negative impact on service delivery. Thus, there is a need to develop training of clinicians in management and formally recognize medical management as a distinct specialty.

Furthermore, continuous training programmes in management knowledge areas would also enhance the hybrid managerial skills in the health industry that is always adopting new healthcare business models with the efficient use of health resources that are constrained.

5.4 Recommendations

More clinicians are taking on administrative and managerial roles together with their clinical skills to take up leadership roles in the health sector.

To fully achieve the advantages of hybrid managers in leadership, administrative and managerial capabilities should be seen as an essential part of professional competency training for clinicians, and this should be carried out throughout their clinical training. It is necessary to ensure that clinicians not only gain medical knowledge but expand the breadth of their knowledge by having managerial skills taught to them as they train to be doctors. There is a need to formalize medical management into a distinct accredited medical specialty recognized by the Kenya Medical and Dentist board. A similar move by the Kenya Medical and Dentist board to recognize medical management or hybrid clinical managers as a specialization would encourage more clinicians to take up clinical management as a career path and would legitimatize this specialization to their peers.

Health organizations engaging hybrid clinical managers need to have clear job descriptions for them, elaborating the scope of work. This will reduce the challenges associated with either abandoning managerial or clinical roles by putting up boundaries on how hybrids can exercise power and their clinical autonomy. This recommendation applies to both the private and public health context.

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APPENDICES

APPENDIX I: Informed Consent

This informed consent form is for healthcare providers in private hospitals in Nairobi County and who are invited to participate in a research project, titled "The implication of clinical hybridity on service delivery. A case study of private hospitals".

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

Part I: Information Sheet

Introduction

I am Michelle Mwendwa Nguu, pursuing a master's business administration degree in healthcare management at Strathmore University. I am doing research on the implication of clinical hybridity on service delivery. A case study of private hospitals.

I am going to give you information and invite you to be part of this research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher assistant.

Purpose of the research

Assessing the impact of hybrid clinical managers is important especially with the changing healthcare context, emergence of new diseases and an industry that faces resource constraint. Clinicians are moving into healthcare leadership and management willingly more than ever. One of the key driving factors is it has been reported that clinicians take instructions from their peers easily. Clinicians have also recognized that they need to acquire managerial skills like finance, budgeting, human resource training and communication skills to lead to effective and efficient service delivery of clinical services. We want to understand how willing clinical managers navigate their dual roles which at

times are conflicting. We also want to understand the challenges and conflicts they face with their peers and from the organization and what strategies they employ to navigate these conflicts and the overall impact all this has on delivery of clinical services. We also want to know the impact of organizational support on hybrid clinical managers to help organizations employing the services of hybrid clinical managers make the best use of their knowledge in two key core areas, that is use of their clinical and managerial skills.

Type of Research Intervention

This research will involve an in-depth interview. It will take about one hour and this in-depth interview will be recorded for future reference.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a willing hybrid manager contribute much to our understanding and knowledge of the impact of clinical hybridization on service delivery in private hospitals in Nairobi County.

Voluntary Participation

Your participation in this research is entirely voluntary. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Procedures

We are asking you to help us learn more about the impact of clinical hybridization on service delivery in private hospitals in Nairobi County. We are inviting you to take part in this research project. If you accept, you will be asked to.

Duration

The research take place for over 30 days. During that time, we will visit you once for an in depth interview which will last for about one hour each. Should I need t seek further clarification, I will give you inform you and we can schedule another interview

Risks

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the interview if

you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more about the impact hybrid clinical managers have on service delivery.

Confidentiality

We will not be sharing information about you to anyone outside of the research team. It will not be shared with or given to anyone except the research department of Strathmore university.

Sharing the Results

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. Each participant will receive a summary of the results and further disseminated via policy briefs, working paper, and journal articles.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in responding in the interview at any time that you wish without your job being affected.

VT OMNES UNVM SINT

Who to Contact?

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following:

Principal Investigator: Dr. Michelle Mwendwa Nguu

Address: Strathmore Business School

Mobile number: 0743710047

e-mail: michelle.nguu@strathmore.edu

Supervisor: Dr. Jacinta Nzinga

Mobile number: 0722243877

e-mail: JNzinga@kemri-wellcome.org

This proposal has been reviewed and approved by Strathmore university IREC, which is a committee whose task it is to make sure that research participants are protected from harm and can contact them if you wish to find about more about the IREC,

It has also been reviewed by the Ethics Review Committee of the NACOSTI, which is supporting the study.

Part II: Certificate of Consent

(This section is mandatory)

I have been invited to participate in the research on the impact of clinical hybridity on service delivery in private hospitals in Nairobi. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked to have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant__________________

Signature of Participant ___________________

Date ___________________________

Day/month/year

VT OMNES VNVM SINT

APPENDIX II: Interview Guide

INTRODUCTION

I am Dr. Michelle Nguu from Strathmore Business School pursuing a Master of Business Administration degree in the field of Healthcare management.

I am undertaking a study on the influence of hybrid clinical managers on service delivery. Your perceptions will help us have a better understanding of your role as a hybrid manager and how you navigate the duality of your role

I thank you for agreeing to participate in this discussion and would encourage you to speak honestly and freely on the issues to be discussed.

I. Demographic Data

AGE	25-29 YEARS	30-34 YEARS	35-39YEARS	40-44 YEARS	45 YEARS&ABOVE

II. Level Of Education

	Yes	No	Specialization
Bachelor's Degree In Medicine			
Executive/Professional Training In Leadership And Management			
Master of Business Administration			
Any other Professional Qualification			

III. Clinical Experience

Years of Experience	2-5	6-10	11-15	16 Years & Above
Clinical Practice				

IV. Managerial Experience

Years	2-5	6-10	11-15	>15

Managerial Experience				

V. **Brief Introduction**

i. Please tell me a little bit about yourself

ii. What position do you hold in this Private Health Institution?

iii. How long have you worked at this particular Health institution?

VI. **Transitioning into Clinical Management**

a) How did you become a clinical manager?

How did you feel about it then?

Were you confident about in terms of your skills and abilities?

Was there anything you felt was missing then?

b) Did you feel prepared for the leadership and management role?

If yes, why? If no, why not?

Did you feel it was necessary to seek further training in leadership and management? Why? What kind of training?

c) In your own opinion, did the training received on healthcare leadership and management adequately equip you in your administrative role?

What aspects did you find most useful in equipping you for the role?

What other aspects would have been more useful?

What are your typical roles as a clinical manager?

d) How do you currently feel about being a clinical leader?

Do you enjoy it? If so, why?

If you don't enjoy it, why don't you?

VII. **Peer Relationships**

a. How would you describe your relationship with your fellow clinicians? Has this relationship changed since you became a leader? If so how?

b. Have you been involved in any implementation of change or adoption of new policies?

If yes, which ones? Please give details

Has the implementation of these change management policies changed since you became a manager? Is it easier or harder? Why?

c. In undertaking your managerial role, how do colleagues relate to you?

E.g. would you say that your colleagues feel the need to take up more work log in your absence? If yes, why? If no, why not? How do you handle conflicts when they arise among your peers?

d. In terms of working with staff members and especially your fellow clinicians, what skills do you, as a leader, need the most?
which ones do you feel you already have? Please give examples
what other skills do you feel you need?MENDELEY CITATION PLACEHOLDER 190 Why?

VIII. **Clinical Autonomy**

a. What do you understand by the term clinical autonomy?
b. In your current role, do you feel the need to protect your clinical autonomy?
if yes, why? How?
How dos you dos that while at the same time ensuring you work within the set organisational goals and objectives?
if not, why not?
c. Do you ever experience conflict of interest while performing your dual roles in terms of clinical autonomy?
If yes, please give examples? How do you resolve these?
d. Does your management role influence your clinical autonomy?
if yes, how? Please give examples
if not, why not?

IX. **Accountability**

a. In your role as a hybrid, who are you accountable to?
what channels of accountability do you use?
what has been your experience in using these accountability channels?
b. Do you have any measures your OPC to enhance accountability to the external stakeholders(patients) in terms of quality service delivery?
if yes, please give details about these
if no, why not?
do you have any internal (to peers and facility) in place? If yes, please examples
if no, why not?
c. How do you ensure the efficient use of health resources in your outpatient centre? Please provide detailed examples

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Could you describe the outcomes of these strategies so far?

d. How do you engage with governmental agencies for example Ministry of Health? How do you go about accreditation, reducing delays while seeking permits etc.?

APPENDIX III: Research timelines

Name	Nguu Michelle Mwendwa				
Reg. no	100936				
Title	The implication of clinical hybridity on service delivery: A case study of private hospitals				
Project start date	11/08/2019				
Project lead	Self				
SCHEDULE	**START**	**END**	**DAYS**	**% DONE**	**WORK DAYS**
Research proposal	20/04/2019	01/06/2021	49	100	30
Proposal defence	20/01/2020	20/01/2020	1		1
NACOSTI/IREC approval	11/06/2020	18/06/2020	6		6
Data collection	15/02/2020	15/3/2020	30		25
Writing of dissertation	20/06/2021	04/07/2021	16		16
Dissertation Defence			7		7
publication					

APPENDIX IV: Budget

Item Computation Total (Kes)	KES
Printing Of Proposal 3 Copies*40*20 Kes	2,400

Data Collection	10,000
Data Analysis 1*Kes 30,000	30,000
Transport Kes 20,000	20,000
Printing Of Thesis 4 Copies*50*10	2,000
Binding Of Thesis 4 Copies*200	800
Total	65,200

APPENDIX V: Introduction Letter

Tuesday, 10 March 2020

Managing Director,
AAR Healthcare Kenya Ltd.
P.O Box 41766 00100, Nairobi,

RE: INTRODUCTION – NGUU MICHELLE MWENDWA

This is to introduce **Dr. Michelle Nguu**, admission number **MBA HCM/100936/2018** who is an MBA in Healthcare Management (MBA HCM) student at Strathmore University Business School (SBS). As part of our SBS MBA HCM Master's Program, Dr. Nguu is expected to do applied research and to undertake a project. This is in partial fulfilment of the requirements of the Master of Business Administration. She would like to request for appropriate data from your organization to help her finalize her research.

Dr. Nguu is undertaking a research project on **'The Nature of Clinical Hybridity and the Implications on Service Delivery: A case Study of a Private Hospital."** The information obtained from your organization shall be treated confidentially and shall be used for academic purposes only.

Our MBA seeks to establish links with industry, and one of these ways is by directing our research to areas that would be of direct usefulness to industry. We would be glad to share our findings with you after the research, and we trust that you will find them of great interest, if not of practical value to your organization.

Any assistance you can provide to her will be greatly appreciated and we shall be willing to provide any further information required.

Yours Faithfully,

Veronica Muniu,
Manager – Programs.

Strathmore UNIVERSITY

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Twitter:@SBSKenya

Strathmore Business School is a proud member of:

APPENDIX V: NACOSTI Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 277925

Date of Issue: 18/June/2020

RESEARCH LICENSE

This is to Certify that Dr.. Michelle Mwendwa Nguu of Strathmore University, has been licensed to conduct research in Nairobi on the topic: THE IMPLICATION OF CLINICAL HYBRIDITY ON SERVICE DELIVERY: A CASE STUDY OF PRIVATE HOSPITAL for the period ending : 18/June/2021.

License No: NACOSTI/P/20/5265

277925

Applicant Identification Number

Director General

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

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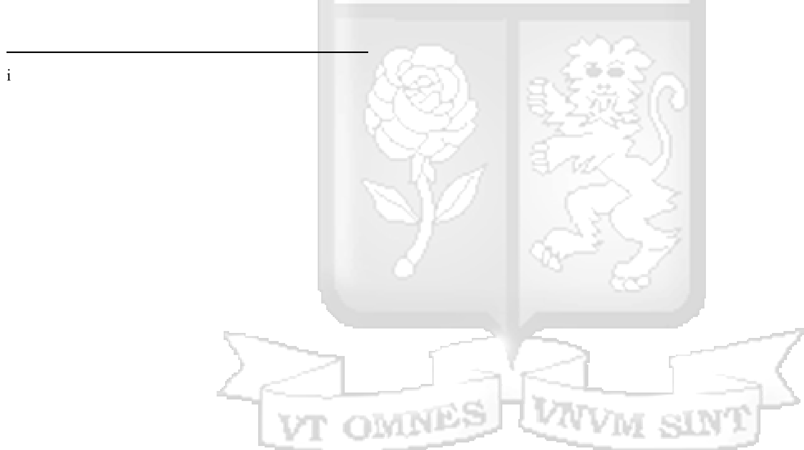

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