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Hospital restructuring and physician job satisfaction: An empirical study

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ABSTRACT

The adoption of clinical directorates through the internal reconfiguration of hospital organizations has been one of the most widespread restructuring interventions in many Western European countries. Despite its extensive adoption, a lack of knowledge remains on the analysis of how this reorganization affects professionals' job satisfaction. This paper contributes to the debate on clinical directorates by exploring how the structural characteristics of newly adopted organizational models influence physician's job satisfaction. More than 300 physicians in 18 clinical directorates in the Italian National Health Service were surveyed regarding their overall job satisfaction following the introduction of departmental arrangements. Survey results were then linked to another survey that classified newly adopted models according to the criteria used to merge hospital wards into directorates, by recognizing "Process-integration", "Specialty-integration" and "Mixed-integration" types of directorates. Our findings show that structural aspects of change significantly influenced overall job satisfaction, and that a physician's openness to experience moderated the adoption and implementation of new clinical directorates. Specifically, results demonstrate that physicians with high openness to experience scores were more receptive to the positive impacts of change on overall job satisfaction. Implications for how these findings may facilitate organizational shifts within hospital settings are discussed.

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1. Introduction

Organizational innovation and service change are important topics for healthcare policy makers. The increasing demand for better clinical safety outcomes, combined with the need for efficient economic resources, has encouraged substantial renovation of practices, models, and structures adopted within healthcare organizations. Restructuring and service change are especially relevant for many healthcare systems because hospitals are important repositories for specialized clinical knowledge and advanced technology [1].

Western countries have adopted numerous innovative organizational arrangements regarding the distribution of medical, surgical, diagnostic, and ancillary specialties. In the context of hospital care, the introduction of the clinical directorate model represents one of the most controversial examples of reorganization worldwide [2–9]. Clinical directorates have substantially changed the internal design of hospital organizations by replacing traditional acute health service structuring in discipline-based specialties with semi-autonomous divisional arrangements headed by clinical directors. New models were adopted to improve the quality of patient care while increasing healthcare value for the taxpayer by enhancing efficiency and accountability and by providing a higher degree

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of decision-making, decentralization, team work, and resource allocation within hospital organizations [3,10].

Despite significant resources dedicated to the adoption of clinical directorates, numerous factors have hindered the actual change and predicted benefits [3,7]. These factors include "top-down" coercive pressures toward adopting a clinical directorate model [7,11,12], a generalized lack of clinical leadership within adopting hospitals [13], a deficiency of a common language between colleagues working in different clinical wards [10,14,15], and high uncertainty with which professionals perceive the impact of the new arrangement on organizational internal processes and overall performance [16,17].

Although the characteristics and patterns of clinical directorate adoption have been assessed in recent years, research is lacking on the effectiveness of this form of hospital restructuring. In particular, little is known about how organizational aspects regarding newly adopted clinical directorates influence the job satisfaction of physicians.

In general terms, job satisfaction represents the projection of the extent to which an individual is positively oriented toward his or her job [18]. Within healthcare organizations, job satisfaction assumes relevance because it predicts several important job-related behaviors, such as citizenship, turnover intentions, and performance of individual physicians [19,20]. Since organizational change likely alters an employee's job satisfaction [21], policy-makers and hospital administrators should carefully assess how structural aspects of clinical directorates may influence a physician's job satisfaction.

To address this gap in the literature, the present paper aims to analyze the effects of hospital restructuring on overall job satisfaction of physicians. Drawing on data collected from the Italian National Health Service (I-NHS), in which a nationwide reform has reconfigured the internal design of hospitals through the adoption of new departmental arrangements [7,22], we explored how structural characteristics of clinical directorates relate to physicians' overall job satisfaction following the adoption of a new clinical directorate model. In addition, we explored how structural aspects of new hospital arrangements interacted with individual personal traits to influence physicians' job satisfaction.

2. Background and hypotheses

Clinical directorates (or departments) [23] may be considered similar to strategic business units, as they receive delegated freedoms to meet objectives and are individually accountable to the top management of hospital organizations [13]. Similar to business models, clinical directorates are managed and grouped according to specialty and support services, which are created specifically for resource management, control, and accountability [7,24].

The clinical directorate model was first implemented during the 1960s by teaching hospitals in the United States with the aim of integrating highly specialized clinical skills while exploiting economies of scale and scope through a constant sharing of costly resources [4,10,25,26]. The I-NHS has repeatedly stressed the importance of the clinical directorate as a new management model for public hospitals. With the corporatization process initiated during the 1990s in the I-NHS, the clinical directorate has been considered the most suitable model to balance the need for greater efficiency with quality improvement in healthcare organizations. A first Legislative Decree (502/92) introduced clinical directorates with the aim to reorganize emergency care within public hospital trusts. Some years later, a nationwide reform (law 229/1999) recommended the clinical directorate as the best model to organize hospital care, compelling all Italian hospitals to adopt the new arrangement [7]. By adopting the clinical directorate model, hospitals achieved the necessary legitimacy by obtaining formal accreditation by the I-NHS.

The national legislative framework regulated some organizational design aspects of the clinical directorates by establishing the new role of clinical director and several departmental collegial representative bodies [12]. Regional authorities contributed to the regulation of directorates with the introduction of additional guidelines aimed at favoring an effective implementation at the local level. Despite this central and regional regulation, many aspects regarding the organizational design of the new arrangement were not regulated and rested in the hands of hospital executives, who were free to decide how to implement the new model within their organizations [7,22].

Research shows that there is a great degree of heterogeneity in how hospitals choose to adopt clinical directorates. For example, different types and models of directorates have been related to the criteria (or logics) used to merge clinical wards into departments [7,27]. In particular, previous literature highlighted two specific criteria for merging hospital wards together into clinical directorates [3,7]. The first distinction, the "Specialty-integration" criterion (or institute design), encouraged hospital wards to be grouped based on medical specialties (e.g. directorate of surgery). In this case, as Braithwaite et al. [28] note, the clinical directorate is "rationally derived from the pre-existing organization of medicine". The second distinction, the so-called "Process-integration" (or divisional design) criterion, encouraged preexisting hospital ward units to be grouped based on specific patient conditions (e.g. directorate of cancer). In this case, directorates are logically structured based on the way services are delivered to patients; interdependent wards are grouped together with regard to specific body parts or organs, as well as to patient age.

In addition to the two criteria described above, Italian hospitals have constructed clinical directorates according to a third criterion: "Mixed-integration" [12]. In this case, directorates are rationally derived aggregating clinical wards that are geographically close and/or hospital units in which healthcare professionals have strong and intense work relationships. The result of using this criterion is the creation of a departmental structure in which both the Specialty-integration and Process-integration logics coexist [12,27].

The adoption of one criterion over another appears to be extremely important for internal processes and expected outcomes within hospitals [3,7,24,29]. For example, prior literature has shown that, because some hospital wards are grouped based on similarity among

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