Chapter One

Introduction

1.0   Introduction to the study

The research presented in this thesis seeks to gain an understanding of the role of Queensland Health (QH) occupational therapy clinical leaders (OTCLs) in terms of the clinical and management domains. This chapter provides a background to the development of the OTCL role in Queensland in light of the recurrent structural and policy changes that have impacted on the Australian health system. The researcher's pre-understandings of the study, a statement of the research problem and aims, the significance of the study, and an overview of the theoretical framework and the methodology used to guide this study, are presented in this Chapter. A definition of key limitations of this study and an outline of the thesis structure concludes this Chapter.

1.1   Background to the Queensland Health Occupational Therapy Clinical role

Christiansen (2007, citing the World Federation of Occupational Therapy), describes occupational therapy as a profession that is concerned with promoting health and well-being through engagement in meaningful and purposeful occupations. Central to the philosophy of occupational therapy is the concept of occupational performance. In considering occupational performance the therapist must consider the many factors that comprise overall performance. Douglas (2004) points out that the philosophy of occupational therapy has changed over the history of the profession.

There is also a well-documented history of the expansion and evolution of the occupational therapy role within the Australian public health care setting and at international level (Anderson & Bell 1988; Matuska 2011; Queensland Occupational Therapy Board 2012). As explained by Anderson and Bell (1988) in their book, *Occupational Therapy: Its Place in Australia's History,* the occupational therapy profession has experienced a significant number of challenges over the years, such as lack of status, lack of recognition of the value of occupational therapy contribution, and a demand to justify the humanistic practice approach and its existence in an economically rationalised health care environment. Previous occupational therapy studies carried out in Australia and abroad identify role challenges such as lack of professional status within health care teams (Morrison & Robertson 2011; Moore, Cruickshank & Haas 2006; Shiri 2006), lack of role clarity and blurred professional practice boundaries (Atwal 2002; Fossey 2001), and a demand to justify the value of occupational therapy practice (Addy 2006; Blair & Robertson 2009; Griffin & McConnell 2001; Shiri 2006).

The Australian public health system has experienced and is currently undergoing a number of structural and policy reforms. According to Palmer & Short (2010), these reforms have impacted on the structural arrangement and delivery of health care services, including occupational therapy services. Alongside these practice and professional challenges, as Unsworth (2011) argues, there is an increasing public demand for health professionals to exercise adequate control over health care resource utilisation and to improve clinical accountability. One such change according to Commenting, Denis, Lamothe & Langley (2001) outline the overall aim of clinical

leadership as that of ensuring an effective coordination of health services through developing, driving and articulating a shared vision and values, establishment of administrative systems and coordination of clinical activities. Whilst Touati, Robedge, Denis, Cazale, Pineault & Tremblay (2006) argue, clinical leaders as first-line managers often have very limited access to organisational power that is needed to achieve service integration and manage the process of change. In other words, the phenomenon of clinical leadership thrives in health practice contexts when there is an equitable access to the level of organisational power required to get the job done.

Within the context of Queensland occupational therapy services, the recent reforms have seen the introduction of this clinical leadership role that has dual clinical and management responsibilities in an effort to improve clinical accountability, cost-effectiveness and efficiency of services (Cretha, Phillips, Stafford & Duckett 2009; Rix, Owen & Eager 2005; Schreiber 2008). In QH, the role of an OTCL was created in 2007, following a 2005 QH audit review, to replace the earlier 'senior occupational therapist' position (Health Practitioners (Queensland Health)). The new role, as described in Appendix G, was created in response to the changes that occurred within QH that were characterised by health district services integration, increased clinician accountability and the need to improve efficiency. The previous role was mainly responsible for clinical service delivery with little authority for line management and decision-making duties. The new OTCL role has a central focus on improving clinical accountability, consumer involvement in care and clinical leadership as key factors to implement hospital changes.

The Health Practitioners (Queensland Health) Certified Agreement (no. 1) 2007 District Health Services Employees State Award 2003, describes the clinical leader role as accountable for the provision of specialist clinical skills, leadership during change management processes, as well as operational management and resource allocation responsibilities for a medium-sized team. The OTCL role is expected to demonstrate advanced clinical knowledge and sound management and leadership skills in areas of operational and resource management across a district or service area (Health Practitioners (Queensland Health) Certified Agreement (no. 1) 2007 District Health Services Employees Award-State 2003. Appendix G provides the full job description which demonstrates that the OTCL role is composed of dual patient care delivery and management domains that are undertaken across a district or health service area. Furthermore the scope of the role has recently been expanded to cover the entire health service and district occupational therapy service. Briefly, the core function of the OTCL role relates to providing effective clinical leadership and advanced occupational therapy services in a rapidly changing practice context. As this new type of clinical leadership role was introduced to meet changing health service demands, this study will assist in exploring how participants experience this role. It will add to the wider body of knowledge regarding what is known about first-line management roles in the health care sector.

The constant exposure of Australian state health services to a number of health reforms directly impacted on the service delivery and management structures of occupational therapy services. The dominant features of these ongoing health care reforms have been the economic rationalisation of health services, increased demand for clinical

accountability, and integration of health services. However, there have been inconsistencies in the title given to the role with other state health services such as New South Wales (NSW) Health, Australian Capital Territory (ACT) Health and South Australian (SA) Health preferring the titles 'occupational therapy manager' (Braithwaite 2004; Meade, Brown & Trevan-Hawke 2005), 'occupational therapy clinician-manager' or 'manager-administrator' (Gamble et al. 2009), 'charge' or 'chief occupational therapist' (Meade et al. 2005), and 'Director of Occupational Therapy' (Moore, Cruickshank & Haas 2006). In QH, the role of an OTCL was created in 2007 to replace the earlier 'senior occupational therapist' position (Health Practitioners (Queensland Health) Certified Agreement (no. 1) 2007 District Health Services Employees State Award 2003). The new role was created in response to the changes that occurred within QH that were characterised by health district services integration, increased clinician accountability, and the need to improve efficiency.

Previous occupational therapy studies carried out in Australia and abroad identify role challenges such as lack of professional status within health care teams (Moore, Cruickshank & Haas 2006; Shiri 2006), lack of role clarity and problems presented by a dual role and responsibilities (Gamble, Lincoln & Adamson 2009; Meade, Trevan-Hawke & Brown 2005), and a demand to justify the value of occupational therapy practice (Craig, Michigan & Robertson 2004; Shiri 2006). Briefly, Moore et al (2006) investigated the influence of urban-Australia occupational therapy managers on staff job satisfaction, whereas Shiri (2006) explored the perspectives of New Zealand acute care occupational therapists on factors that contributed to their job satisfaction, dissatisfaction, and strategies to manage both job satisfaction and dissatisfaction. In

addition, Craig, Michigan & Robertson (2004) explored the nature of roles and responsibilities for physical occupational therapists' practice in New Zealand. Gamble et al. (2009) undertook a case study investigation of NSW occupational therapy managers' experiences in the role, in terms of roles, responsibilities and work satisfaction, and findings showed that the role had clinical and managerial components that influenced the responsibilities and participants' work satisfaction. Lastly, Meade et al. (2005) investigated factors that influenced job morale issues for Queensland occupational therapists within mental health settings. In this study by Meade et al. (2005), a lack of role clarity was identified as one of the significant contributing factors to participants' perception of low job morale issues.

Denis, Lamothe & Langley (2001) outline the overall aim of clinical leadership as that of ensuring an effective coordination of health services through developing, driving and articulating a shared vision and values, establishment of administrative systems, and coordination of clinical activities. A copy of the OTCL job description presented in Appendix G shows its core function as that of providing clinical leadership and line management.

Whilst the role of clinical leaders in general has been described by Beer and Nohria (2000) as pivotal in their capacity as health care change managers, there is a paucity of published research that has provided insight into the lived experiences of OTCLs. It is hoped that this study will inform employers and other occupational therapists about the experiences of those in this role. Therefore this study seeks to contribute to understanding the working world of Australian OTCLs and their perception of

experiences of the scope of the role both in terms of the clinical and managerial domains.

1.2   The researcher's perspective

Hermeneutic phenomenology, as is the case with all qualitative inquiries, is inevitably exposed to the researcher's bias, especially relating to the process of describing the lived experience and recognising the significance of the embodied inter-subjectiveness of the life world. Furthermore, one of the greatest strengths of phenomenological research, as Garza (2007) identifies, is the flexibility and adaptability of its methods to the ever-widening arcs of inquiry. In this context, according to Denzin (2005), the researcher brings a set of beliefs and values developed over time from the researcher's experiences that will inevitably influence the interpretation of the data.

My personal interest in the phenomenon of working as an OTCL began 10 years ago in Zimbabwe when I was appointed as an OTCL barely three years' post-graduation from the School of Health Sciences, University of Zimbabwe. In this role, I was tasked to lead a team comprising eight staff members in the delivery and management of occupational therapy services within a four hundred-bed hospital. I commenced in this role with a combination of excitement and apprehension because of the challenges that were inherent in it, such as balancing the two potentially non-complementary domains of clinical delivery and management with lack of experience and skills needed for the role. In particular, I realised that I needed senior practitioners' support, appropriate skills, and relevant experience to undertake the role, which was very different from the academic orientation the researcher had received whilst at university.

Four years' later I was practising in a similar role in New Zealand and then in Australia. Despite differences in the health care environment between Zimbabwe, New Zealand, the United Kingdom and Australia, the structural clinical and management arrangements of occupational therapy services were quite similar. The dual clinical delivery and management domains remained a key feature of the role. In these work contexts, I handled the challenges brought by this role by acquiring new skills, which involved undertaking some postgraduate studies in both occupational therapy and health services management. I also received professional support and mentorship from senior practitioners. However, to date I am still exploring the meaning and realities of practising as an OTCL, especially in an economically rationalised public health care environment. When I decided to undertake this doctoral program, the notion of working in a dual role as an OTCL became a research focus due to personal interest, previous work experience, and a lack of existing research specific to management roles in Queensland occupational therapy.

Furthermore, it is vital that I acknowledge my role and motivation to take this researcher's learning journey as characterised by key observations, emotions, attitudes and perceptions. I have chosen the phrase, 'oscillating pendulum' to represent my fluctuating emotions, attitudes, observations, and perceptions inherent in my experiences as recorded in a researcher's journal. The fluctuations ranged sometimes from very low and negative emotions, neutral emotions, and very high and positive emotions as a result of challenges and successes I encountered during the research journey. However I have remained focussed on the study by attending to positive

experiences in an effort to be empowered, sometimes suppressing negative emotions and keeping my focus on meeting the study objectives. Relatively, the oscillating pendulum is kept suspended in air by the weight that is attached to its end. Therefore the phrase fits well into the description of my experiences.

As an example, the initial stages of the study were marked by some very positive experiences, such as gaining formal admission approval into the Doctor of Health Services Management Program, confirmation as a candidate for the DHSM degree program by the Postgraduate Research Committee, relevant human research ethics committee approvals, and successful recruitment of study participants. These experiences positively empowered me to pursue the area of study. However the positive feelings were short-lived as the researcher became aware that the project produced a large quantity of data that demanded more time than the allocated timeframe. This experience resulted in some anxious moments. Furthermore family and work demands as a part-time candidate took their toll just after completing data collection. I had to negotiate for personal emotional space from the study by taking a two-month overseas family holiday. The study break re-energised me and on return I was quite motivated to focus on the research project. I became embedded in this project by utilising my prior knowledge on the subject of inquiry, which enhanced my understanding and interpretation of the subject of investigation. In doing so, I have not attempted to 'bracket' myself, but rather I openly declared my interest and biases regarding the research topic. I kept focussed on the study because of the personal and educational desire to complete the project.

1.3   Statement of the research problem

There is a strong indication in Australia and overseas that the role of health managers including OTCLs working in the public health sector has undergone significant changes (Craig, Robertson & Milligan 2004; Matuska 2011; Queensland Occupational Therapy Board 2012; Wood 2004).   These changes affect the broader public health system as well as the clinical and management domain of occupational therapy practice. According to Blair and Robertson (2011) and Lloyd and King (2002), these structural and practice changes mirrored changing trends in the wider global health care systems and were influenced by social, economic, global, political, and historical factors. This study sought therefore to gain insight into the lived experiences of the newly-established OTCL's role and explore the scope and responsibilities of this role in terms of both the clinical and managerial functions as a way to inform practice and policy. In doing so, this study identified future research directions in relation to the practice of OTCLs.

There has been limited published research in Australia about the experiences of Australian OTCLs in the face of recent changes to the Australian public health care system. Their role has been described as critical and pivotal to the health service delivery (Cretha et al. 2009; Duckett 2007; Foster 2005). The limited research done in Australia that informs this research, although not directly related to the current study, explored the experiences of a physiotherapy department and allied health professions utilising a decentralised management structure. There was also a study on the influence of urban-Australia occupational therapy managers on staff job satisfaction, and finally a NSW investigation of occupational therapy managers' roles, responsibilities, and work

satisfaction, together with another study that explored the duality of the Nurse Unit Managers' (NUM) role (Gamble, Lincoln & Adamson 2009; Law & Boyce 2003; Meade, Trevan-Hawke & Brown 2005; Moore, Cruickshank & Haas 2006; Paliadelis 2008).

In the context of this project, it is vital to gain a clear understanding of the newly defined role of OTCLs from the study participants' viewpoints as a way to inform practice and policy. The researcher, as part of the OTCL workforce has witnessed over a three-year period a high staff turnover in this role. Attracting occupational therapists into clinical leadership roles has been a problem as the researcher has observed job advertisements seeking OTCLs being re-advertised in the press at a national level. According to Tuohy (2010), high staff turnover has a negative effect on ensuring a continuous service delivery. This has created an interest for the researcher to investigate from the participants' viewpoint what constitutes their role, opportunities, and challenges they encounter, and recommendations they would make to others considering such a role.

Notwithstanding the importance of and previous reforms to this role, to date, there is no published research specific to Queensland that investigates the working world of OTCLs. It is therefore imperative to explore the target population's perceptions on their views of the new role in order to gain insight into their lived experiences of the OTCL's role and explore the scope and responsibilities of this role in terms of both the clinical and managerial functions. Also, there is an expectation that the study findings will provide vital information to employers regarding OTCLs' recruitment, retention, and development.

1.4   Research aim and objectives

The overall aim of the study is to gain insight into the lived experiences of newly established OTCLs' role and explore the scope and responsibilities of this role in terms of both clinical and managerial functions. This aim will be examined through the following objectives:

- To explore, describe and interpret the lived experiences of OTCLs in terms of the dual clinical and managerial roles and responsibilities to facilitate understanding of OTCLs.

- To articulate common issues experienced by occupational therapists who participated in this study.

- To inform the future practice and policy formulation of the OTCLs' role.

1.5   Significance of the study

Health care is a constantly expanding global industry that is characterised by significant international movement of the health workforce and health care performance similarities between and across national health systems in a range of developed countries (Briggs 2010). As McDaniel & Driebe (2001) observed, the rate and pace of growth is rapid for individuals taking up organisational roles and for health organisations as complex adapting systems. Employees such as OTCLs are at the centre of these complex reforms.

However, there is paucity of published research in Australia about the views of QH OTCLs regarding their role. The role's responsibilities resonate with current health care

reform practices that emphasise curtailing the spiralling health care budgets because of increasing consumer demand for health services (McKenna & Richardson 2003). This process of cost containment in the health sector is achieved by providing effective clinical resource management, increased provider accountability and cost effectiveness of health services delivery practices (Beer & Nohria 2000; Boyce 1993; Clouston 2012; Law & Boyce 2003; Robinson & Compton 1996). It is essential for researchers, practitioners and policy makers to understand employees' reactions to these changes by investigating their experiences of working within different roles. Weight (2001) links successful complex adaptive systems to their ability to strategically deploy key employees to front line management roles as an interface between organisations and senior management.

This rapid and unpredictable growth in the health sector industry presents a challenge to cost-effective management and delivery of safe, responsive patient care services because of differences in social, political, historical and economic factors between national health systems. Furthermore, as McKenna (2007) argues, health management particularly operates in highly professionalised practice contexts that are notable by a predominance of professional sub-cultures during decision-making processes.

Beer and Nohria (2000) underscore the value of clinical leadership in setting the direction of successful global health reforms. In this study context, there is paucity of published research in Australia investigating OTCLs' lived experiences, in their capacity as change managers, as a way to understand the role. Appendix G contains the OTCL position description and as stated it has a dual clinical and managerial component that has a strategic district-wide focus to integrate occupational therapy

services. Notwithstanding the paucity of published research, this dual responsibility focus resonates with current health care practice of integrated health care that emphasises effective clinical resource management, increased provider accountability and cost effectiveness of services (Braithwaite 2004; Law & Boyce 2003; Robinson & Compton 1996; Smith Randolph 2005; Weight 2001). The performance and development of OTCLs in terms of resource utilisation and quality patient care delivery is important to QH (Forster 2005). In other words, identifying and developing key employees for strategic leadership roles in terms of their competence and organisational health reforms sense-making abilities is a critical factor for both practitioners and organisations.

Limited research regarding the role of OTCLs demonstrates the importance of this study. Furthermore, the Australian public health sector continues to present as a complex adaptive system that is constantly faced with unpredictable changes and economics of health care that make the practice of health management a unique challenge (Anderson & McDaniel 2000; Briggs 2010; McKenna & Richardson 2003). However as previously discussed, some of the limited research undertaken in Australia focussed on the experiences of NSW occupational therapy managers as both clinician managers and manager-administrators in terms of the scope, responsibilities, and work satisfaction of the role (Gamble, Lincoln & Adamson (2009). Nevertheless, the increasing emphasis on clinical leadership in QH as a way to achieve an effective integration of health services as put forward by Cretha et al. (2009) underscores the significance of this study at various levels. Firstly, as a guide at policy level for the policy makers to understand why the implementation of safe, sustainable, efficient,

quality, and responsive health services for all Queenslanders is still a work in progress. At this stage it has failed to achieve the desired results for all key stakeholders, and devise strategies that can best be implemented to achieve sound health care reform. Secondly, the findings are significant at practice level for OTCLs to adopt and implement models of practice that support the mainstream health policy to contribute towards better health outcomes. Thirdly, the findings by contributing new knowledge to existing literature on clinical leadership, in the context of the Australian public health care system's rapid and unpredictable constant changes (Palmer & Short 2010), sets the foundation for future research directions to enact new ways to lead health reforms.

This investigation is necessitated by the fact that the Australian public health care system has recently and is still undergoing a series of changes (Palmer & Short 2010). The study aims to interpret and represent the participants' perceptions on the phenomenon of working as an OTCL both in terms of its clinical and managerial functions. These meanings will be represented as themes drawn from participants' experiences gathered during interviews. It is also hoped that the study will provide information to assist employers with the recruitment and retention of OTCLs.

1.6   Introduction to the methodology

This research drew on two philosophies: hermeneutic phenomenology, mainly informed by Heidegger (1962); Gadamer (1975) and van Manen (2001), and Interpretive Phenomenological Analysis (IPA), as components of the research methodology in order to qualitatively gain an understanding into and interpretation of the lived experiences of 10 Australian OTCLs. Data about the lived experiences of the participants was collected using semi-structured individual interviews, researcher's

journal of events that took place during the course of research, and field notes that were recorded during the process of data collection. Each interview lasted between 60 and 120 minutes. The interviews were collected between July 2010 and November 2010. Each participant was offered an opportunity to choose a pseudonym to protect their identity.

A pilot study was carried out with a physiotherapy clinical leader to test the rigour of the interview format and interviewing skills: these results were not included in the main study. No major changes were deemed necessary to the interview questions and format as the participant in the pilot study freely shared her experiences based on the pilot questions. Open-ended questions relating to each participant's work history and experience were asked in a conversational manner at the start of each interview to build rapport.

Pursuant to Finlay (2006) and Richardson's (2000) recommendations about the importance of ensuring study rigour, a researcher journal was kept as a documented reflection of each interview. This process assisted the researcher to remain focussed on the study task and draw lessons from each interview, which improved both the style and process of subsequent interviews. Following the notion of hermeneutic circle of understanding of human phenomena described by Heidegger (1962); Gadamer (1975); Smith (2004), and van Manen (2001), a thematic data analysis and an IPA methodological triangulation approach was employed in this study to conceptualise and capture the core essences of the OTCLs' lived experiences. The study methodology is discussed in detail in Chapter Three.

1.6.2   Introduction to the theoretical framework

Kanter's (1977) theory of organisational power was chosen to assist in understanding and interpreting the lived experiences of OTCLs. This theory underscores the importance of accessing sufficient organisational power for employees to get the job done. In this respect, Kanter (1977) views formal and informal structures of power as sources of workplace empowerment. Job description, recognition and relevance to organisational goals are important features of formal power. Informal power comes from the employee's network of interpersonal and intrapersonal alliances and relationships with people at higher hierarchical levels and peers within and beyond an organisation. Employees with high formal and informal power have greater access to structural lines of power and opportunity, and are more productive. These lines of power refer to lines of information, support and resources. Opportunity relates to expectations and future hope for employee mobility and growth in the workplace. Conversely, employees with limited access to formal and informal power and opportunity are less able to get the job done effectively. Kanter's (1977) theory remains relevant to current research contexts.

Kluska, Laschinger & Kerr (2004) tested the relevance of Kanter's (1977) theory by examining the relationship between 112 staff nurses' empowerment and their perceptions of effort-reward imbalance as conceptualised by Siegrist (1996). Findings showed that these participants were moderately empowered and 24.1% perceived their work to have more efforts than rewards. As was the case with Kanter's (1977) theory, study conclusions revealed a direct link between staff nurses' structural empowerment, effort-reward imbalance, and psychological empowerment, whereas Ledewell,

Andrusyszyn & Iwasiw (2006) found a fit in the utility of Kanter's (1977) theory based on an exploration of seven postgraduate nursing students' experiences of empowerment with distance education and computer conferencing. This fit was interpreted in terms of feedback from instructors, access to library facilities, and support from employers and family, which were regarded as essential elements of an empowering educational experience.

Similarly, Paliadelis (2008) associated nurse unit management roles' ability to get the job done with adequate access to lines of structural support, relevant job-related information, resources and opportunities, in an investigation of the lived role experiences of NSW NUMs. Intuitively, Kanter's theory is applicable to OTC leadership contexts, where the work of these employees is to provide effective team leadership by implementing both the organisation and occupational therapy's vision and values. To achieve effective team leadership, these employees require higher access to lines of formal and informal power and opportunity in their workplace. It is therefore vital to demonstrate how OTCLs' lived experiences may be influenced by lines of formal and informal power structures in the workplace.

1.7   Limitations of the study and key assumptions

With any research there are limitations and parameters with restrictions often outside the control of the researcher, and in that respect this study is no different. Hermeneutic phenomenology, as an interpretive approach, endeavours to make the meanings that circulate in the world of lived experience accessible to the reader. To achieve this purpose, I intentionally sampled a homogenous professional group of OTCLs because they were considered to be information-rich informants regarding the subject of

inquiry. These participants were 10 females who worked across two public health facilities, consistent with national occupational therapy demographic figures (Occupational Therapy Board of Australia 2012). In doing so, the study phenomenon was gender-confined. Interpretive phenomenological analysis advocates for purposive sampling of a small homogenous and defined sample (Reid et al. 2005; Smith & Osborn 2003). This process allows an in-depth interpretive analysis of participants' perspectives linked with verbatim extracts (Smith et al. 2009), to extrapolate experiences and meanings within the data. The study conclusions, whilst substantial in quality, are grounded to a specific population group and are not generalizable. However, Reid et al. (2005) and Smith (2011) suggested that such conclusions, although not broadly generalizable objectively, may have commonalities that can provide useful insights to those in similar situations.

There are several qualitative data analysis approaches in use within interpretive inquiries. A narrative analysis approach for example, would have focussed on the structure and meaning of the participants' language (Biggerstaff & Thompson 2008), and thematic analysis (van Manen 2001) on standard inductive analysis that lacks depth. These methods could have reduced the quality and depth of analysis needed to produce rich data. In this study, the key quality in the data I was searching for was concreteness. According to Wertz (2005), concreteness is attained when researchers utilise details of the person's lived situation rather than their abstract interpretations, to explore the individual's lived experience. There was potential for this study to experience credibility concerns, as Patton (2002) alludes, because semi-structured interviews were utilised as the main data source. To counter this limitation, I employed

multiple data collection tools such as reflective journals and field notes. I also used reflective approaches to interrogate my own subjectiveness about the research process. This opened the research process to scrutiny by peers and academic research supervisors during the course of study.

There were also potential limitations relating to power relationships that existed during interviews. Reflecting on power relationships between the researcher and interviewee, Kvale (2006) viewed interviews as hierarchical, thus leading to an asymmetrical power distribution. Clarke (2006) and Nunkoosing (2005) envisage use of interviews as challenging and almost impossible in terms of distinguishing truth from authenticity and gaining non-coercive consent because of the existing asymmetrical power relationships. In this study, I mitigated against this happening by employing member-checking and paid attention to the preparation stage of data collection. As part of the preparation phase, I invited participants to select their preferred interview settings and to nominate preferred interview schedule times, which provided adequate confidentiality, privacy and meaningful participation during interviews. I also familiarised myself with the audio recording device and interviewing techniques through use of repetitive practice sessions involving the audio-device, and employed a pilot study. This pilot testing of research interview questions formed part of the preparation stage. I also paid attention to the context by always employing an informal dress code, which created an informal atmosphere.

The interpretive phenomenological analysis assumes that interpretations are always grounded and local to the particular population being studied (Giocomini 2001; Hammarsley & Mairs 2004; Higginbottom 2004; Mays & Pope 2000; van Manen

2001). In this study I recruited a population of occupational therapists whom I viewed as information-rich informants. My inclusion criterion for participation in this study was being an experienced and practising QH OTCL with clinical and non-clinical administrative responsibilities, to be able to 'tell it as it is'. This criterion extended to the conclusions from the study. These conclusions were contextual and cannot be broadly generalised.

Lastly, a major limitation of this study was the limited sample size. For quite pragmatic reasons of the length of candidature and lack of funding to support this study, this research was limited to a specific group of participants whom I was able to access and who met the inclusion criteria. The study was limited to a sample of participants chosen purposively from those employed by QH as OTCLs at Health Practitioner Level 5 and above. As discussed previously, this sample size was appropriate for a qualitative study of this nature where the aim is to gain insights rather than draw general conclusions.

1.8   Structure of the thesis

Chapter One*: <u>The Introduction.</u>* This chapter introduced the thesis by providing a background to the study, the aims, the significance, the researcher's perspective, and the research methods and theoretical paradigm. In this chapter, I provided an overview of the Australian Health Care System reforms with a particular focus on the changes that have influenced the Australian occupational therapy services and impacted on the Queensland OTCL role. In addition, I situated my pre-suppositions by outlining my personal interest, beliefs, and work experiences regarding the study topic. The chapter provides an introduction to the research methodology and theoretical framework and

concludes with a brief summary of study limitations and assumptions, including the contents of this thesis.

Chapter Two: <u>The Literature Review</u>. In this chapter, I reviewed recent and relevant literature about studies in the field of occupational therapy and related fields, including a detailed discussion of the Australian health system reforms in the context of changes that occurred to national and international occupational therapy services and gaps in published research literature, to set the scene for this research. I then discussed contemporary occupational therapy research. The second part of the chapter presents and discusses the theoretical framework chosen to underpin this study, which is Kanter's (1977) theory of organisational power. Following this, I identify and justify the use of this framework for this study by reviewing literature that draws on key concepts in Kanter's (1977) theory of organisational power.

Chapter Three: <u>Methodology and Research Methods</u>. In this chapter I provided an overview of the study methodology in terms of the philosophical basis of hermeneutic phenomenology informed by Heidegger (1962) and Gadamer (1975) in relation to the research approach. Then, I expanded the discussion by locating and discussing key features of van Manen's (2001) hermeneutic phenomenology as the actual research method that I used to examine the lived experiences of Queensland OTCLs. The chapter presents a detailed description of the methods used to identify participants, collect and analyse data, and ensure the study was conducted in a rigorous and trustworthy manner. Ethical issues are discussed and addressed and the limitations of this methodology described.

Chapter Four*:* <u>Data Analysis</u>. In this chapter, an interpretive phenomenological approach to the analysis of the data is presented. Key themes that emerged from the interview data are identified and supported by participant quotes. Literature reviewed in Chapter Two is included where relevant, with a focus on interpreting the participants' experiences as advised by Butler et al. (2009), Cooksey and McDonald (2011) and Smith (2004).

Chapter Five*:* <u>Discussion and Conclusion</u>. In this chapter the major conclusions of the study are presented and discussed in relation to what is already known about the topic, based on the literature reviewed in Chapter Two. The utility of Kanter's (1977) theory as the framework is discussed. The implications of the conclusions to policy and practice are presented in relation to the OTCL role as it is experienced by the participants. I also identified future research directions. This chapter concludes with a summary of the thesis.

1.9   Conclusion

This chapter provided an introduction to this study by presenting a critique of the background, the significance, the research problem, the aims, and the researcher's perspective. An overview of both the methodology and the theoretic framework chosen to underpin this study are also provided. The chapter concludes with a summary of the contents of this thesis.

Chapter Two

A Review of the Literature and the Theoretical Framework

2.0   Introduction

The purpose of this chapter is to critically review existing research literature in order to provide information, background, and insights relevant to the two key research questions provided in Chapter 1. As stated previously there is a plethora of research in the field of first-line nurse management roles such as an exploration of the nurse unit manager's role (Paliadelis 2008), an investigation of the changing role of the charge nurse (Willmot 1998), a study on the perception of leadership traits that contributed to nurse leaders' job effectiveness (Upenieks 2002), and a case analysis of gender, power, and nursing (Ceci 2004). However, the review of literature has shown a paucity of literature specific to occupational therapy first line management roles.

In retrospect, Gamble, Lincoln & Adamson (2009) allude to this paucity in literature specific to occupational therapy first line management roles whilst investigating NSW Occupational Therapy Managers' work satisfaction, roles and responsibilities. This research study therefore utilises relevant literature from both occupational therapy and other health professions to review the impact of historical, global, social, political, and economic factors within an Australian context, on the management and delivery of occupational therapy services in Queensland. In this chapter, the introduction section describes the approach used to identify relevant literature and modes of accessing it.

Following this, a review of the historical changes that have occurred in international and Australian occupational therapy services is presented in the context of Australian health reforms to lay the foundation for discussing the development of the QH OTCL role.

This study seeks to gain insight into the lived experiences of those in the newly-established OTCL role, and explore the scope and responsibilities of this role in terms of both the clinical and managerial functions. This research assumes that any contextual factors that influenced the broader Australian public health system reforms have impacted also on the institutional and philosophical management and delivery of occupational therapy services. This chapter, therefore, extends the literature review by critically examining recent studies of Kanter's (1977) theory of organisational power to demonstrate why it is still relevant. In doing so, section two of this chapter lays the foundation for identifying and discussing Kanter's (1977) theory of organisational power as the theoretical framework adopted for this study to examine the working world of QH OTCLs.

A clear articulation of Kanter's (1977) theory is shown in the form of what it is and what it says about first-line management roles. Then a justification for the use of this theory is provided by comparing and contrasting other existing theories of power. The utility of Kanter's (1977) theory to the topic of inquiry was reflected on by discussing the key features in relation to the subject of inquiry. A justification for its inclusion is provided in a conceptual map which represents Kanter's (1977) theory of organisational

power as a modernist paradigm used to underpin understanding of the essence of working as an OTCL.

2.1 Identification of literature and modes of access

The literature was reviewed by searching national and international sources utilising multiple approaches such as the UNE Library catalogue, the UNE electronic library, public hospitals' libraries linked to the researcher, the University of Sunshine Coast Library catalogue and computer search of the Medical Literature Analysis and Retrieval System online (MEDLINE), ProQuest, Cochrane Library, PubMed Online Library, Evidence-Based Medicine Reviews (EBMR), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Occupational Therapy Systematic Evaluation of Evidence (OTSeeker), and Google Scholar available in English was included. ABS data was obtained directly. Key words and a combination of key words utilised in searches included occupational therapy, clinical leadership, health care workforce, change management theories, job satisfaction, hermeneutic phenomenology, health management, Australian Health Care System, health policy, and health reform. For the most part this search excluded articles that were not research-based to help to ensure that only relevant current research evidence was reviewed and also where relevant, policy documents have been included.

2.2 Historical overview of occupational therapy practice internationally and in Australia

Occupational therapy is a relatively young profession both in Australia and internationally. Kielhofner (2005) and Matuska (2011) associated the origin of the profession in the United States of America in 1917 with the impact of global events such as the First World War, the booming industrial revolution and the rise in work-related injuries, poliomyelitis, and tuberculosis epidemics. These events witnessed an increase in demand for rehabilitation services and this demand propelled the expansion of occupational services for those who survived war and diseases.

Matuska (2010) links the growth and expansion of occupational therapy to three key ideological and practice reforms since its inception, namely the occupation, mechanistic and science of the profession. The first reform, occupation, is concerned with the foundational beliefs that underpin occupational therapy. In view of the significance of the occupation reform phase, Kielhofner (2005) portrays it as the core foundation upon which the occupational therapy profession was established. This description underscores the important role of occupation relative to health, the mind-body link, and the significance of creating a sustainable balance between work, self-care and play. It is interesting to note that during this inception phase of the profession, a psychiatrist, Adolf Meyer, was the first person to use the term occupational therapy late in the 19th century. During this time occupational therapy practice had a bias towards the use of leisure, work, and self-care activity programs for the mentally ill (Hocking 2004).

The first definition of occupational therapy was developed by a medical doctor who referred to it as a profession that included 'any activity, mental or physical, definitely prescribed and guided for the distinct purposes of contributing and hastening recovery from disease or injury' (Pattison 1922:19). The World Federation of Occupational Therapy (WFOT) (2011) currently views it as a profession that is concerned with promoting health and wellbeing through engagement in occupation. The first Professional Association in this country, the Australian Association of Occupational Therapists (AAOT) was formerly established in 1945 (Anderson & Bell 1988:28). The first presidency was held by a British-trained medical doctor, Dr Dennis Glissan, whose appointment assisted occupational therapy to establish a profession status (Anderson & Bell (1988). 'The constitution of the Queensland Division was signed on the 14th October 1948, with Dr. A.R. Murray elected as the first president' (Occupational Therapists' Board of Queensland 2012).

The second shift in the professional ideological and practice paradigm, the mechanistic paradigm, was characterised by an explosion in research, legislative changes to the rehabilitation and education of handicapped children in the United States of America (USA), and advances in scientific knowledge about the human body were expressed by the use of clinical reasoning to deal with various diseases (Mattingly & Fleming 1994). During this period, occupational therapy practice responded to global shifts in health care practice prompted by advances in technology and diagnostic measures that demanded proof of effectiveness (Matuska 2010). In Australia, the AAOT was incorporated as a company in NSW in 1948 and under the constitution the Association

became responsible for its own affairs and training of occupational therapists. The first course of occupational therapy training was developed and implemented by the NSW Physiotherapy Association in the 1940s (Anderson & Bell 1988:16; Occupational Therapists Board of Queensland 2012). It was a two-year course, in which students learned craft skills and attended lectures in anatomy, physiotherapy, pathology, muscle movement, psychology and psychiatry (Anderson & Bell 1988:245). The first Occupational Therapy diploma course was commenced in 1955 at the University of Queensland. In 1968 the course was upgraded to degree status.

The current Australian professional-entry courses in Occupational Therapy are all now based in universities. Many offer three-year to four-year programs with additional postgraduate studies at honours, masters, and doctorate levels, with a re-emphasis on human occupation and occupational science research. The World Federation of Occupational Therapy in accordance with internationally-set standards accredits all the above courses. According to Morley, Atwal and Spiliotopoulou (2011), the science of occupation paradigm requires occupational therapy practitioners to demonstrate evidence-based clinical outcomes and efficiency by integrating scientific knowledge and professional values of holism and meaningful occupation.

It is important at this stage in the context of this study to revisit the historical changes that occurred to occupational therapy management and the subsequent effects of the changes to gain insight into the current Queensland OTCL role. Briggs (2010) attributes the struggle over the control of the work of professionals in organisations as typically

characterised as a clash between bureaucratic hierarchical control and professional colleague control. At issue in the Queensland OTC leadership role described in Appendix G, is whether the autonomy accorded to professionals by virtue of their expert knowledge is sufficient to meaningfully drive organisational reforms or becomes subordinated to the demands of organisational bureaucracy.

Historically, occupational therapists have over the years sought recognition as professionals within the bureaucratic structure of hospitals (Matuska 2010). For example, occupational therapists who participated in a longitudinal survey carried out by Matuska (2010) to explore their perspectives on the value of historical practice changes that happened to occupational therapy, regarded themselves as occupying a central role in patient care and any health care sector restructuring to determine the conditions of their work. Another related study by Morley, Atwal & Spiliotopoulou (2011) on global occupational therapy reforms shows that the profession has gained significant control over its work over time through its efforts to increase managerial responsibility of the senior occupational therapy clinicians. These occupational therapists have also participated in the implementation of shared governance activities. The key conclusion from the Morley et al. (2011) study resonates with findings from an investigation involving NSW NUMs about their experiences in first-line management (Paliadelis 2008). A key conclusion from this nursing investigation revealed that efforts by the profession to increase managerial responsibility led to the establishment of a dual NUM role that was marked by expanded responsibilities that lacked adequate power to execute the tasks.

Matuska (2010) links the initial senior occupational therapist role with professional role modelling for junior staff, and as a custodian one of quality professional practice standards. In this practice framework, the initial senior occupational therapy role was designed to provide support, nurturing and mentorship to their new graduates. These structural changes to the senior occupational therapy role resulted in an expansion of occupational therapy management responsibilities, which meant that less time is now spent on carrying out direct patient care responsibilities. Gamble, Lincoln and Adamson (2009) in a research study that explored NSW occupational therapy managers' perspectives on their experiences in terms of roles, responsibilities and work satisfaction, revealed that there are unmet workload demands in the occupational therapy management role because of these expanded responsibilities. In this study, occupational therapy managers were mainly drawn from the available senior clinical staff to occupy managerial positions. They practised as clinician-managers and manager-administrators with restricted direct patient care responsibilities. Furthermore, their newly-expanded role involved other responsibilities such as human, financial and resource management.

Public occupational therapy services exist within the broader Australian public health care system as a subsystem, which has been structurally and ideologically subjected to constant health reforms. It is important to note that occupational therapy exists as part of the division of allied health in the public hospital system according to the Services

for Australian Rural and Remote Allied Health (SARRAH) definition. SARRAH
(2006:3) defines allied health as:

> "Tertiary qualified health professionals who apply their skills to diagnose,
> restore and maintain optimal physical, sensory, psychological, cognitive and
> social function. They are aligned to each other and their clients. Professions
> may include but are not limited to: Audiology, Nutrition & Dietetics,
> Occupational Therapy, Optometry, Orthotics, Pharmacy, Physiotherapists,
> Podiatry, Psychology, Radiography, Social Worker and Speech Language
> Therapist".

A key example of the economic impact of these constant health policy reforms has

been an increasing intertwining between managerial and clinical domains of health care

services imposed by the demand for health professionals to demonstrate cost-

effectiveness, efficiency and the need to embrace evidence-based practice (Briggs

2010; Butler, College of Occupational Therapists 2005; Cronin-Davis & Mayers 2009;

East 2000; Finlay 2001; Godfrey 2000; Hunter 1996; Lloyd & King 2002; Marsh et al.

2005; White 2003). Palmer & Short (2010) describe the Australian health system in the

form of three operational levels: the Commonwealth, State/Territory and Local

Government. Furthermore, the health system incorporates both the public and private

sectors in terms of funding and health services delivery systems. Palmer & Short (2010)

identify a key dominant feature of the Australian health systems as the separation of

powers and responsibilities between the Commonwealth and State/Territory

governments. Briefly, the Commonwealth government is responsible for the funding of

health services while the State or Territory governments have principal responsibility

for the direct provision of services. Local governments' responsibilities lie in carrying

out environmental control measures, and a broad range of community-based and home

care services. Public occupational therapy services in Australia operate at Commonwealth, state/territory and local government levels.

The significant feature that marked the impact of economic reforms on allied health in the past decade in Australia has been the devolution of centralised professional hierarchical structures to divisional clinical unit models. This devolution created a dual role of a clinician-manager centred on effective clinical resource management, service efficiency and increased accountability. According to Hunter (1996) the focus was on the resource management and service management domain whilst incorporating cost minimisation, greater provider accountability for service quality, and cost and flexible client-oriented service delivery.

There is a plethora of occupational therapy research discussing the impact of repeated health reforms on the general delivery of occupational therapy services, in which practitioners were more inclined to seek and gain status and power through asserting their professional voice and protecting professional practice boundaries, rather than collaborating in inter-professional ways (Craig, Michigan & Robertson 2004; Griffin 2002; Matuska 2012; Occupational Therapists Board of Queensland 2012; Shiri 2006; Whiteford & Wright-St. Clair 2005). Shiri (2006) found from an investigation of New Zealand physical acute care OT positions that promoting occupational therapy on a case-by-case basis by educating various stakeholders was effective in enhancing understanding of the value of this profession. Despite an existing disparate and tangled viewpoint over the description of occupational therapy status, historical observations

(Wallis 1987) suggest it as a semi-profession that is yet to emerge as a fully mature profession on the basis of the Australian Standard Classification of Occupations. These historical and practice changes justify the fact that the phenomenon of practising as an occupational therapist in Australia is challenging, incomplete, and still elusive to both practitioners and policy-makers. This gap in the body of published literature underscores the importance of a further investigation into this specific domain of OTC leadership roles.

2.3   Contemporary power issues for the occupational therapy profession

This section reflects on the issue of power dynamics within health care professions such as occupational therapy as expressed in terms of professional status to extrapolate on the existing practice challenges. Shortell & Kaluzny (2006) describe professional status in health care teams as a process that confers a measure of worth to individual professions during the process of negotiating roles within health care teams. In this manner, professional status in health care teams is linked to organisational power issues. Kanter (1977) expresses the issue of organisational power in a positive sense by stating that first-line managers who enjoy high professional status in teams feel valued as members of the organisation and are more likely to get the job done. For Williams and Paterson (2009) and Zweck (2004) development of professional artistry is an essential component of building expertise and mastery within the occupational therapy profession to reflect professional status. This viewpoint underscores the importance of understanding and articulating the art of practice into the existing research evidence in a manner that is meaningful and accessible to others within and outside the profession.

To that end, Higgs, Titchen & Neville (2001) stress the value of maintaining professional status and the rights and privileges that come with that responsibility in a way that permits excellence within the profession and establishes a comprehensive body of knowledge. In doing so, Parry (2001) links evidence-based decision-making as a sign of utilisation of scientific research evidence to influence other team members' work within teams.

Previous research undertaken with occupational therapists, both overseas and in Australia, indicate that they are struggling to embrace the biomedical influence imposed on their practice by medical practitioners (Atwal 2002; Craig, Michigan & Robertson 2004; Freidson 2007; Gamble, Lincoln & Adamson 2009; Klein 2006; Lloyd & King 2002; Meade et al. 2005; Moore et al. 2006; Shiri 2006). Atwal (2002) linked working alongside nurses in a multidisciplinary team context as a threat to occupational therapy's authority over practice boundaries because of role overlaps. Craig et al. (2004), Klein (2006), Meade et al. (2005) and Shiri (2006) all suggest that doctors who worked in health teams have significant status in these teams and supervised other health professionals' work. From this perspective, medical dominance and the subservient position of other health professionals is an accepted organisation norm for many allied health professionals. Freidson (2007) and Lloyd and King (2002) associate the influence of limited power and status for any professional group with existing challenges to its professional identity, strengths and weaknesses.

Gamble et al. (2009), in a case-study investigation of the experiences of the NSW occupational therapy management role, describes the essence of working as an OTCL as a clinician-manager or manager-administrator role. This was based on the nature of roles and responsibilities that a leader undertakes in an organisation and the size of the occupational therapy team. In these competing work contexts, the managers' role was described as a unique dual position that was constantly exposed to health policy shifts and was blurred by competing priorities of roles and responsibilities. As Braithwaite and Goulston (2004) show, policy analysis is a diluted concept for clinicians moving into first-line positions that have dual roles and responsibilities. Inherent power issues are expressed in terms of challenges involving interpreting and implementing health policies. Also, research into job satisfaction by Hom & Kinichi (2001); Shaw, Gupta & Delery (2005); and Shiri (2006), negatively identified multidisciplinary teams as professional battlegrounds characterised by inter- and intra-professional rivalry, jostling between members for resources, supremacy of individual professions, and professional recognition by the medical profession. These disagreements between team members had an adverse influence on organisational effectiveness, performance and productivity.

Expanding the debate on the issue of medical professional dominance in health care teams, Kielhofner (2005) analysed the influence of the medical model on delivery of patient services. Kielhofner (2005) stated that the medical model put emphasis on the human need for biological wellness and survival, with doctors focussing on solving problems that threaten survival and wellbeing. In a similar research investigation, Hanschu & McFadden (1981, cited by Sutton 1998) found that 'the primary orientation

in hospitals is to relieve pathology, which may preclude the occupational therapy perspective of occupational performance' (p. 1087). Affirming the issue of medical dominance and health system reforms' forced changes in the nature of occupational therapy practice, previous studies done both in Australia and New Zealand (Craig et al. 2004; Griffin & McConnell 2001) on occupational therapy practice indicate the increasing importance for occupational therapists to understand the new public management practice expectations that underscore the value of clinical and managerial competencies over health care resource allocations and shifts in public health care funding. These therapists relied on the patients' medical diagnosis and subsequent dysfunction as a key that orientated them in their clinical reasoning. In these qualitative investigations, the patients' medical diagnosis was the most critical factor that influenced how therapists assessed their patients and organised their treatments. The medical diagnosis further provided therapists with an initial shortcut to patient management, especially in fields where time was limited.

As a remedial approach to the biomedical influence on occupational therapy practice, Cameron and Masterson (1998) in an investigation of British occupational therapy practice across several health care teams asserted that jostling for supremacy in teams is not enough for occupational therapy clinicians and managers. Rather, these researchers urged the profession to gain a greater understanding of the processes through which policies are developed and implemented, as well as being represented at the executive decision-making level of an organisation in order to mitigate the biomedical model impacting too heavily on occupational therapy practice. However these researchers did

not elaborate on how occupational therapists could become better engaged in the decision- and policy-making processes within organisations. Shortell and Kaluzny (2006) take a more passive approach to the analysis of tensions in teams by suggesting that they are natural and cannot be avoided, but identify that problems can have a negative impact on organisational performance if not addressed.

In addition, Dickson (2003) advised occupational therapists to raise the profession's credibility and relative priority for resource allocation, with decision-makers and consumers. He suggested using media exposure to inform the public that the profession holds great mastery in functional activities of daily living, undertaking outcome-based research and generating objective data.

Pringle (1996) explored British occupational therapists' and their managers' experiences with the introduction of trusts in the National Health Service (NHS). Study findings revealed a pattern of the increasing scrutiny of work practices and greater pressure on the profession to articulate and justify its contribution to health care outcomes. This move to become more effective and efficient in the use and management of resources and service delivery was perceived as impacting on traditionally-held practice flexibility of occupational therapists. Occupational therapy managers expressed feelings of frustration, detachment and powerlessness because they are largely restricted to implementing decisions made by others. In particular, the study identified a lack of professional autonomy, supervision, support, and a flattened career structure. In addition, loss of work flexibility in terms of the ability to organise and

structure workload issues, which was constrained by changes in job description and the imposed demands of non-contact responsibilities, was identified by these participants as a huge concern. In this study context, occupational therapists and managers perceived the effect of health care reforms of the National Health Service as a threat to professional authority over their practice jurisdictions, roles and responsibilities.

Clouston (2012) based an exploration of the influence of organisational workplace cultures on the lived experience of work-life balance for 29 occupational therapists using an interpretive phenomenological analysis approach. She identified links between organisational workplace cultures of power and performance on individual employees to positive organisational outcomes. These participants expressed little autonomy over their own workloads and work-life balance, showed high levels of job stress and low self-esteem, and revealed a disenfranchised professional identity. In this context, employee work-life balance was directly linked to the organisation's professional sub-culture's power dynamics.

Furthermore, in the USA, Brayman (1996) using the occupational adaptation frame of reference to investigate the demands that the work environment placed on occupational therapists during a period of rapid change, found they were concerned about the relationship between the organisation and its employees, the changing nature of the work itself, and the pace of change and its effect on practice. The study identified a conflict between individual and organisational values as reflected in terms of

professional issues such as cross-training, de-professionalization, and changing professional values as a requisite for their continued employment.

Duckett (2007) points out that allied health professions have traditionally been relatively weak in hospital power structures, as they do not have the status and role in attracting and treating patients directly as is the case with medical professionals. More so, allied health is largely female-dominated and lacks the numerical dominance that is enjoyed by nurses, although this does not necessarily translate into higher status and power. Also, the overall pattern is that groups with a larger proportion of women tend to have lower earnings. According to Duckett (2007), it is against the above context that allied health professionals felt excluded from the decision-making processes of hospitals and responded in the 1980s by creating an Allied Health Division so that they have some representation in senior hospital corporate structure.

Whilst there is a concerted media focus on health issues, the public debate has failed to focus on occupational therapy services given the critical role it plays during effective discharge planning of patients from hospitals, the latter a cost saving measure for governments. The focus is on hospital waiting lists and a shortage of doctors and nurses. According to Craig, Michigan and Robertson (2004), curative medicine based on scientific principles is valued more highly than the alleviative, pragmatic function of occupational therapy within western health care settings. In other words, assisting a client to regain independence with activities of daily living is a low status activity when compared with diagnosing and curing disease. Competition to access limited health

care resources requires objective and scientific justification. On the other hand, occupational therapy practice as described above employs a humanistic approach and relies mainly on the subjective information from patients during treatment, which is relatively difficult to justify in terms of budget allocations. Despite the lack of public awareness, previously cited research literature from overseas and Australia suggests that the recent global health care changes have directly influenced both the delivery and management of occupational therapy, as well as the allocation of human, fiscal and physical resources to these services (Godfrey 2002; Griffin 2002; Lloyd & King 2002).

Whilst the above is true in one sense, what is needed is a balance between use of curative medicine based on scientific medicine and the pragmatic function of occupational therapy based on activities of daily living. For Marriott (1997), professional power issues in a British occupational therapy practice are best examined by evaluating the meaning and contribution of occupational therapy to the effective management of the health service. Using a power dimension to examine the organisational life of a health service, Marriott (1997) proposed a link between the occupational therapy philosophy and a participative approach to management, whilst highlighting the associated challenges and benefits of this management style. This article concludes by advocating the positive use of power within the political arena and by encouraging all occupational therapists to participate fully in the management of their services.

Paliadelis (2008), found from an eclectic feminist investigation of the experiences of the NSW NUMs in their role, that first-line managers' opinions and ideas are rarely heard in health care organisations as they lack the authority or status of other health care professionals. Clouston's (2012) findings from an investigation of the influence of organisational cultures on the lived experiences of British occupational therapists' work-life balance, portray these employees as having little autonomy over their work-life balances because of high job stress, high workloads, and low professional status in their workplaces. In this study, occupational therapy is shown as having a notable disenfranchised professional identity because of lack of access to lines of organisational power structures. Similarly, Matuska (2011) concludes from a longitudinal case study survey of historical role changes for occupational therapy that it remains a subservient profession in health care teams because of an entrenched powerless image that is a by-product of its use of art and craft, and as a female dominated profession. Likewise, Clouston (2012), Kanter (2003) and Paliadelis (2008) associate female dominated professions with powerless groups in health care teams on the basis of a traditional view of themselves as caring and obedient employees.

Research into lack of professional status in occupational therapy has been linked to studies that reviewed job satisfaction (Albion, Fogarty, Machin & Patrick 2008; Craig et al. 2004; Griffin 2002; Meade, Trevan-Hawke & Brown 2005; Mills & Millstead 2001). In a phenomenological investigation of an Australian neurology ward-based group of occupational therapists, the findings reported a lack of team member contributions on issues pertaining to discharge planning because of a perceived lack of

professional status (Griffin 2002). In addition, it was found that this perception directly contributed to the participants' job dissatisfaction. Similar experiences were also shared by occupational therapists who practised in a rural and remote setting in Australia, which contributed to their desire to leave employment (Mills & Millstead 2001).

According to Mullins (2002), the debate on the issue of power within health care teams relevant to occupational therapy leadership is complex because of contrasting and incompatible theoretical perspectives. In view of this situation, Martin (2002) advises researchers to approach this discussion based on multiple paradigms in order to gain an in-depth awareness of power and potential implications on leadership. Mandy (1996) suggests reviewing key features of interdisciplinary and multidisciplinary teams. This is vital because the majority of occupational therapists work in either multidisciplinary or interdisciplinary team structures (Griffin 2002). In this scenario, Jessup (2007) shares a perspective of an interdisciplinary team approach as a health delivery model that integrates varying discipline approaches to patient care into a single consultation. Within this team structure, as Korner (2010) argues, discipline specific boundaries are relaxed and there is easy transference of knowledge thereby facilitating a positive contribution towards the creation of new team knowledge. Interdisciplinary team members need to understand each other's role and recognise areas of overlap. Korner (2010) underscores the value of understanding of each team member's role by suggesting that it helps individual members to consider different perspectives. In doing so, Korner (2010) suggests resolution is achieved through role negotiation whenever conflict arises between team members. A close analysis of the multidisciplinary team

concept reveals that it is flawed because each individual remains discipline-specific and team members may therefore fail to see important synergies and efficiencies through cooperation with different disciplines. The different professions operate in parallel lines rather than intersecting points where there is a transfer of knowledge (Korner 2010). Notwithstanding the value of collaborative interprofessional teamwork to enhance person-centred care, Joshi and Jackson (2003) and Mickan & Rodger (2010) identify one of the risks of interdisciplinary teams as one in which traditional hierarchies or dominant personality types may interfere with the teamwork process because of multiple team member characteristics such as gender, knowledge, and skills on the subject of team working.

Joshi and Jackson (2003); Korner (2010); and Opie (2002) perceive teamwork as a desirable and efficient way to deliver cost-effective health care services by reducing duplication, cost-effective resource utilisation and enhancing professional collaboration towards delivering holistic patient management approaches. Joshi & Jackson (2003) and Jackson, Joshi & Erhardt (2003) link diversity in a team with an employee's ability to access a diverse array of external networks, which in turn become a source of diverse perspectives, knowledge, and information. In addition, teamwork also creates a positive work experience for team members and better outcomes for patients, thereby providing a source of meaning, value, identity, learning opportunities, and internal support crucial for the economically-rationed health care sector. However, by definition, the concept of a team entails difference (Korner 2010). From this perspective, organisational context plays a vital role in facilitating or constraining the effectiveness of teamwork. Korner

(2010) described this difference in terms of power, understandings, priorities, ways of working, and status, characterised by collaborative working challenges and inevitable conflicts. An example from this study shows that political decision-making often takes precedence over clinical decision-making, thereby causing teams to become dysfunctional in the process.

There is extensive literature in the field of occupational therapy of both inter- and intra-professional rivalry, for example, conflict of jurisdiction, unequal power– relationships, communication barriers, differences in professional status, and role ambiguity (Atwal 2002; Korner 2010; Meade et al. 2005; Mickan & Rodger 2005; Moore et al. 2006; Shiri 2006). Within health care environments, inter-professional working can be constrained by unequal power relations between professions, which can have a direct effect on service delivery. On one hand, Opie (2002) described teams as possible sites of disciplinary contests and power struggles conducted across personal and professional planes. She stated that teams are divided and fragmented by disciplinary power, knowledge claims and the desire to protect their professions.

Another viewpoint expressed by Caldwell and Atwal (2003) associates the predominance of interdisciplinary teams in Australian health care settings with high quality health care. This links individual health professionals across several teams to help ensure a holistic continuum of care provision that is consistent with the Australian Health Care Standards (EQuIP 4 2008). Study conclusions from an investigation of both Australian (Griffin & McConnell 2001; Griffin 2002) and New Zealand physical

acute care occupational therapy practice (Craig et al. 2004; Shiri 2006) suggest that the majority of therapists work in multidisciplinary teams as single representatives of their professions. Shiri (2006) reported that several occupational therapists who worked as individuals in their professional teams within physical acute care settings, stated that it was an intimidating experience because of differences in their professional orientation and training, compared with other health professions.

2.4   Job morale issues in occupational therapy

Levels of job satisfaction have been the subject of debate in determining the reasons for attrition within the general occupational therapy profession. Research into occupational therapists' job satisfaction has largely been driven by concerns regarding their recruitment and retention (Meade, Brown & Trevan-Hawke 2005; Moore et al. 2006; Pinnock, Hubby, Tierney, Hamilton, Powell, Kielmann & Sheikh 2009; Riley 2006; Tariah, Hamed, AlHeresh, Abu-Dahab & Al-Oraibi 2011; Wielandt & Taylor 2010). According to Tariah et al. (2011), staff satisfaction across professions is an issue of concern for health organisations nationally and internationally. It affects service provision, quality of patient care, and professional growth. In reality, job satisfaction greatly influences an individual's decision to remain in his or her work situation. It is therefore essential for this literature review to include the job satisfaction and retention literature in order to inform this study of the lived experiences of the newly-established OTCL role.

In Australia and overseas, retention and productivity levels of a workforce are one of the essential ingredients for organisations to prosper in today's competitive business environment (Riley 2006). It is also vital to understand the critical management and leadership role first-line managers play in health care organisations when implementing health care reforms and increasing health care staff recruitment and retention. This study seeks to explore the role of OTCLs in an effort to understand the role they play in relation to these factors. Furthermore, ABS (2008) shows that health sector workforce issues, in terms of recruitment and retention, remain significant expenditure factors for health care budgets in Australia.

According to the ABS (2008) and Mason and Griffin (2003), the Australian health industry is the fastest expanding sector of the economy. It is characterised by constant growth in workforce numbers and gross domestic product (GDP) health services expenditure. Briggs (2010) attributes this expansion in the health industry to demographic factors such as an increasingly ageing population, public demand for health services, rising demand for efficiently-managed health services to ensure cost management, and improvements in technological and biological innovations. The resultant impact of the simultaneous expansion of the health sector and structural reforms was the 'permanent white water'. Braithwaite, Westbrook, Hindle, Iedema & Black (2006) suggest this exists, based on an investigation of the role of hospitals restructuring towards achieving efficiency. The study described a period in the Australian health system that was characterised by unpredictable reforms that presented health managers with unique problems. These health management problems demanded

managers to constantly justify health care costs, in the context of overregulation and constant monitoring of health care standards, health workforce rationing, amalgamations, and expanding and diverse provider population. In these work contexts, there is marked escalating consumer demand and spiralling labour-related costs (Duckett 2006). These labour related costs continue to be the largest proportion of total costs in the Australian health industry in order to meet service delivery needs.

The constantly increasing health care labour costs underscore the importance of investigating turnover intentions of the workforce for organisations, employees and clients in order to curtail escalating costs. Given the size of this problem in Australia and its impact on the health care budgets (ABS 2008), it is vital to gain insight into the lived experiences of the newly-established OTCLs' role by investigating the scope and responsibilities of this role in terms of both the clinical and managerial functions. This information is critical to influence understandings on the study population's recruitment, retention and professional development strategies, which in turn informs policy makers about workforce labour costs.

Traditionally, as Sutton and Griffin (2000) argue, within Australian health care organisations, research into staff retention with a specific aim of containing labour-related costs is favoured for implementation ahead of other staff development initiatives. This is the case because of the negative impact of staff attrition on budgets. However, there is limited research evidence available that directly relates to the retention of the occupational therapy management workforce in Australia. So while

research evidence indicates that staff shortages are a major international problem for the occupational therapy profession, there is no clear understanding of factors that will enhance their retention, particularly in relation to those in newly-created first-line management positions (Gamble, Lincoln & Adamson 2009; Moore et al. 2006; Tariah, Hamed, AlHeresh, Abu-Dahab & Al-Oraibi 2011; Wielandt & Taylor 2010).

A number of study findings reveal that communication, teamwork, good staff relationships and access to organisational information, support and resources, and opportunity for career progression, are important factors for consideration by first-line managers generally, and this can be applied to occupational therapy clinicians and team leaders (Anderson, Spataro & Flynn 2008; Gilham & Ristevski 2007; Meade, Trevan-Hawke & Brown 2005; Moore et al. 2006; Samiento, Laschinger & Iwasiw 2004; Tariah, Hamed, AlHeresh, Abu-Dahab & Al-Oraibi 2011; Upenieks 2002). It is also interesting to note that remuneration, nature of work, and supervision were rated highly as factors that contributed to work satisfaction by occupational therapists, who either occupy a management or a clinical-based role (Boshoff, Alant & May 2005; Moore et al. 2006; Wielandt & Taylor 2010).

Elsewhere, job satisfaction studies investigating occupational therapy practice in general, job security, high status, effective commitment, team member relationships, unrealistic workloads, gender, career self-efficacy, stress, professional support, management structure, and family-to-work balance, were closely correlated to turnover intentions for occupational therapists (Albion, Fogarty, Machin & Patrick 2008; Clarke,

Lewchuk, de Wolff & King 2007; Clouston 2012; Pinnock, Hubby, Tierney, Hamilton, Powell, Kielmann & Sheikh 2009; Smith Randolph 2005; Stagnitti, Schoo, Reid & Dunbar 2005). People management and mediating between staff and senior managers, including the autonomy to make management decisions, was identified in one of the only studies that explored the occupational therapy manager role in NSW, as both a source of joy and frustration (Gamble et al. 2009).

In summarising, research studies that investigated managers' perspectives on their experiences of first-line management roles within the health industry rated highly the need for greater access to structural lines of power such as information, resources, support and opportunities (Kluska, Laschinger & Kerr 2004; Laschinger, Sabiston, Finegan & Shamian 2001; Upenieks 2002), budget control, autonomy to make decisions, flexibility and effectiveness (Braithwaite 2004; Gamble et al. 2009; Smith Randolph 2005). Briefly, these factors were highly regarded as key aspects of a manager's work. Specifically, Gamble et al. (2009) discovered that occupational therapy managers assumed responsibilities that were consistent with manager administrators. Nevertheless, as Gamble et al. (2009) concludes, there is sparse published research about the experiences of occupational therapists working in dual management and clinical roles in Australia.

2.5   Recent reforms in occupational therapy services in Australia

This section explores recent reforms to the Australian occupational therapy services, which comes as a result of broad ongoing health reforms. It begins with a brief

overview of Australian health reforms generally and then contextualises the impact of these reforms to occupational therapy services. Given the paucity of published research literature on the experiences of those practising in the OTCL role, this section reviews relevant contemporary research evidence that is applicable to occupational therapy services in Australia.

The structural and policy environment where OTCLs practise is constantly changing. It could be anticipated that changes will continue as Palmer & Short (2010:20) allude; the Australian health care system is in a period of transition and continued change will remain a significant political issue in the immediate future. However, health sector reform is a complex and jumbled phenomenon for both OTCLs and health organisations generally in relation to selecting the most cost-effective and efficient model to deliver and manage health services (Braithwaite & Goulston 2004; Liang & Shortell 2005; McKee & Healy 2000). In Australia, the reforms have resulted in decentralisation of some allied health departmental services into clinical streaming with accompanying loss in autonomy, budgets, and professional recognition (Griffin 2000; Griffin & McConnell 2001; Robinson & Compton 1996). However, as Briggs (2010); Gray (2006) and Palmer & Short (2010) demonstrate, there is evidence describing the success of the Australian health system's reforms because it is perpetually evolving.

According to Clinton (2004), the rationalisation of health services as a result of financial pressures and cost-cutting measures introduced in the health sector has affected the provision of public hospital services such as occupational therapy services

and reduced workforce levels. Harris and associates (2002); Pilling and Stacey (2004) and Reedy and Learmonth (2000) portray an overarching image of health managers as a product of a career shift from clinical positions. This career transition process is associated with professional and management ideological conflicts that require a mental shift in order to enhance and acquire new competencies.

Anderson, Spataro and Flynn (2008); Cable and Judge (2003); Enns and McFarlin (2003) and Kristof-Brown, Zimmerman and Johnson (2005) associate and emphasise the best approaches to management, power to influence co-workers, complementary organisational fitness, role flexibility, and effective clinical leadership of structural organisational reforms, with the ability to deliver and lead efficient world-class health care systems. One key challenge, as identified by Farrell (2003) and Humphries (2002), is a shift from maintaining strict professional boundaries to interdisciplinary team practice demanding enhanced skills in communication, human resource management, cost-effectiveness, work flexibility, and collaborative practice as cornerstones for improvements in health care delivery and efficient cost savings. Similarly, Hartman and Crow (2002) singled out financial management as a new requirement for first-line managers among other skills such as communication, accountability, decision-making and conflict management.

Consistent with global trends, renovation of public health systems for developed nations has been on the international agenda for several years. In Australia, the health care sector has undergone significant structural and policy reforms for several years in

response to political debates characterised by far-reaching implications on the structure of health workforce systems (Duckett 2007; Gauld 2003; Gray 2006; Palmer & Short 2010). Furthermore the Australian health system has encountered constant significant public criticism that has been the impetus for repetitive structural and ideological reforms (Briggs 2010; Gray 2002; Menadue 2003; Van Der Weyden 2003). The growing public disenchantment with the quality, lack of provider accountability, and models of health care delivery has been a central feature of these constant Australian health system reforms (Mackersy, Robertson & McKay 2003; McKernan 2007; Walsh 2002). Specifically these reforms have reflected a tension between two competing policy paradigms, namely those in favour of health services integration and those who desire decentralisation of health services depending on the prevailing political and economic context at federal or state government levels (Clinton 2004).

In the context of these ongoing reforms, there is limited published research investigating how the changes may impact on those working in a first-line management role in Australia. To date, Gamble et al. (2009) published an investigation of NSW Occupational Therapy Managers' roles and responsibilities based on a range of tasks performed by these managers. While in the nursing profession, Paliadelis (2008) investigated the experiences of working as a NSW Nurse Unit Manager, suggesting that as a first-line management role, the participants had limited organisational power to get the job done. It is in this context of a lack of published research on the lived experiences in an OTC leadership role, that this study seeks to gain insight.

According to McDaniel and Driebe (2001), an unusual interdependent relationship among multiple stakeholders is a key result of complex and rapid health reforms. This new work structure involves significant information asymmetry and a weak link between a heterogeneous professionalised provider population and typical patients. In these constantly changing practice contexts, there is a widening gap in perspectives in defining key objectives and what constitutes quality health care because of variations in professional orientation, political, social and economic factors among various stakeholders. The ideal solution to this complexity, according to Baum (2002); Beer and Nohria (2000); Clouston (2012); Firth-Cozens and Mowbray (2010); and Outwaithe (2003), is to have clinical leaders working in strategic roles in terms of positional authority within health care settings in order to deliver effective integrated health care services. By doing so, as Griffiths (2005) argues, it narrows the gap of existing tensions between economic values and non-economic professional values in health care institutions, establishes organisational performance management systems, and promotes multiple stakeholder collaboration. One way to achieve this, according to Liang and Shortell (2006) and Touati et al. (2006), is to establish synergies between various clinical leaders as a way to access strategic organisation information that will be communicated to other employees in order to coordinate patient service delivery.

However, to date there is scant published research evidence from participants' viewpoints in Australia, attesting to the progress of this health reform strategy. Therefore, this study is timely, as it will explore the experiences of OTCLs to assist in understanding the role of one group of clinical leaders.

As already stated, occupational therapy services exist within the broader Australian public health care system as a subsystem and have been directly or indirectly subjected to the above changes. Godfrey (2000) argues that the reforms were driven by the need to increase efficiency, become more cost-effective, reflect new government policies, increases in new technology, public knowledge and expectations. First-line managers are key actors in quality improvement processes, so they are a targeted group for the structural reforms in the state of Queensland to improve clinical accountability, patient satisfaction and financial management through leadership development and cultural change practices (Beer and Nohria 2000; Duckett 2007; Ginsburg 2003). These reforms, following similar trends in the rest of the Australian health system, as Gamble et al (2009) and Meade et al (2005) argue, have markedly altered the structure of service delivery systems, staff job satisfaction, organisational structures, and work practices in pursuant of health service integration.

To summarise, in Australia, constant public health sector restructuring has attracted international and local media, political, and professional attention to such issues as patient safety, staffing levels, and the loss of expensively educated health professionals either to the international market or from the health sector entirely (Palmer & Short 2010). Simply put, health care delivery and management practice contexts have changed substantially because of the pressure to provide a cost-effective service in budget-constrained systems. These constantly changing practice environments have imposed further demands on health care professionals, such as occupational therapists

and managers, to base their decisions regarding their practices and resource allocation on sound evidence (Addy 2006; Blair & Robertson 2005; Law, Pollock & Stewart 2004; Morrison & Robertson 2011). However, a significant gap in published research evidence that explores this particular study population underscores the importance of this investigation.

Part 2: The Theoretical Framework for this study

2.6   Kanter's (1977) theory of organisational power

According to Kanter (1977) organisational power is defined as the ability to get things done in an organisation. Power is therefore drawn from structural conditions in the work environment rather than an individual's personal characteristics or socialisation effects (Kanter 1993:166). In this respect, as Kanter argues, the theory perceives power as a reflection of the organisational position held by an employee within an organisation and the employee's ability to manage all the resources that are needed in order to meet the organisational objectives of the position.

Therefore Kanter (1977) identifies that power has a formal and informal component. According to Kanter (1979) formal and informal systemic structures reflect sources of workplace empowerment. Formal power is interpreted as positional authority or power that is embedded within job positions as part of the organisational structure that allow independence in decision-making. From this perspective of formal power, Kanter attributes job discretion, recognition, and relevance to organisational goals as important constituents of formal power. High job discretion ensures that work is non-routine and allows flexibility, creativity and adaptability; whereas an employee is visible in the organisation if job responsibilities and accomplishments are relevant and recognisable in terms of the organisation's strategic plan (Kanter 1979). In this manner, Kanter (1977) views the organisational structure in the form of decision-making processes and as a system that is consistent with the purpose of the organisation. In other words, there

is need for legitimacy of the role that resonates with the job profile activities in order for the employee to be credible, valued, and recognised in that role.

Kanter (1979) described informal power as another source of power obtained from interpersonal alliances or relationships an employee constructs within and beyond the organisation with co-workers, superiors, and subordinates in order to get the job done. Kanter (1979) links these relationships with approval, prestige, and backing, as sources of informal power. In addition, peer networks provide reputation and informal information about the organisation (Kanter 1979). Kanter (1977) theorises that employees with high formal and informal power have greater access to structural lines of power and opportunity. The structure of power reflects an employee's ability to access lines of information, support and resources in the organisation. This situation implies that employees require knowledge and information to carry out their jobs.

While Kanter's theory was originally published in the 1970s, it is still relevant in understanding organisational power in contemporary organisations. A number of recent studies have drawn on this theory to explore power issues. For example, this theory of organisational power has been used to underpin an exploration of first-line management roles in health care. Paliadelis (2008) conducted an investigation of the working world of NSW NUMs. She argued that individuals with organisational power and opportunity are happy and productive at work and able to positively contribute to meeting organisational goals. From this structural viewpoint of organisational power, Kanter (1977) describes the notion of power in a positive sense by expressing it as one that

influences managers to feel valued members of the organisation. In turn this means that empowered first-line managers are more likely to empower their staff, which leads to improvements in staff morale and work effectiveness. Another recent study by Kluska, Laschinger and Kerr (2004) put forward the notion of organisational power in terms of job accomplishments. In this viewpoint, conditions in the workplace influence how much productive power is available to employees.

Kanter's (1977) theory identified four organisational structural determinants that influence employees' access to power: strategic access to opportunity; information; support; and resources. Using this framework, Miller, Goddard and Laschinger (2001) defined opportunity as relating to job conditions that provide individuals with the chance to advance within the organisation and to upgrade their knowledge and skills. In other words, opportunity relates to an employee's expectations and future hope for career advancement and personal growth within an organisation. According to Paliadelis (2008), employees with low opportunities experience low self-esteem, limited aspirations, and limited upward influence. As Paliadelis found, they are also less likely to seek or accept change. Opportunity is described by Kanter (1977) as pivotal to employee job satisfaction and productivity. Therefore it is vital for managers to have access to career pathways and professional development as a form of empowerment in order to function effectively in organisations. The next structural determinant of power described by Kanter (1977) is information: this includes open channels of information that are directly work related about the whole organisation

such as budgets, salaries and operational data. Access to timely and relevant information is vital to first-line managers, if they are to perform their role effectively.

Ledewell, Andrusyzyn & Iwasiw (2006) indicate that access to resources for employees implies that they are able to obtain material, financial, and other rewards necessary to successfully achieve job demands. In other words these resources have to be adequate and appropriate in order to be able to meet the job's demands.

Lastly, organisational support is interpreted by Kanter (1977) as the feedback and coaching an employee receives from superiors, peers, and subordinates. Support may take the form of supervision, coaching, team-building processes, and performance management. In summary, employees who do not have access to organisational information, support, resources, and opportunities are less likely to succeed in their roles. It has been suggested that without sufficient power, as defined by Kanter (1977), first-line managers will experience significant challenges in meeting organisational goals. Conversely, if employees have access to the four structural determinants of organisational power, they are more likely to feel empowered to succeed in the role and to support their subordinates to carry out their responsibilities effectively.

Kanter (1977) expresses strong views that organisational structures are a reflection of organisational power. This viewpoint describes lack of power as a feature that characterises role creation instead of an indication of personal qualities. Kanter's (2003:8) viewpoint is that powerless behaviours are a 'universal human response to

blocked opportunities'. Thus, employees who experience blocked opportunities at their workplace express their frustrations by demonstrating powerless behaviours. Several recent research studies that have investigated various aspects of health services managers' roles have also highlighted the significance of focusing on the role construction and the determinants of organisational power embedded in these roles (Briggs 2010; Brightman & Moran 2001; Dennis; Lamothe & Langley 2001; Paliadelis 2008). To add to this body of knowledge, this study seeks to gain an insight into the OTCL role specifically.

Several schools of thought have compared and contrasted the issue of organisational power as part of organisational culture within organisational politics and power dynamics systems (Anderson, Spataro and Flynn 2008; Lewis and Taylor 2004; Osborne & Gardner 2005; Paliadelis 2008). For example, Anderson, Spataro and Flynn's (2008) and Paliadelis' (2008) perspective of power, underscores the importance of employees' ability to influence others in organisations which is critical to each person's work effectiveness. Likewise, initiating change, obtaining assistance, and implementing new ideas require the capacity to influence, direct, and change other's behaviour (Lewis & Taylor 2004). This perspective views organisational culture as an accepted social phenomenon of life, which is difficult to recognise, challenge, and change because it is immersed in strong beliefs about the nature of work, role definitions and the ideal employee. By definition, organisational culture is:

> "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and therefore, to be taught to new members as

the correct way to perceive, think, and feel in relation to those problems (Schein 1992: 373-374)".

Yet Osborne and Gardner (2005) perceive work-based relationships as a reflection of organisational culture in terms of structures such as hierarchies, rituals, routines and stories that form the day-to-day working environment of an organisation. From this viewpoint, organisational culture includes the structural levers that determine where power is located in the organisation such as values, beliefs, mission, information systems, local politics, routines, and the operating systems. Therefore first-line managers' roles are influenced by organisational structures and culture. However, this chapter briefly compared and contrasted organisational power as part of organisational culture as it was outside the parameters of the philosophical framework of the study. So while it is clear that organisational power is linked to organisational culture, this study draws only on Kanter's theory of organisational power to assist in understanding the experiences of the participants.

2.7   Justification for the theoretical framework

The health policy reform agenda in Australia has repeatedly been on the political and public radar at every federal election (Gray 2006; Lewis 2005). According to Briggs (2010) and Palmer & Short (2010), health sector reform was principally driven by successive governments' demands for greater efficiency and effectiveness, improved access to health care, and flexibility made in an environment that is characterised by budgetary constraints. These rapid health sector changes create challenges for public

health managers such as OTCLs, who have to operationalize their role in such a way that they can meet these challenges.

This study will explore the working world of OTCLs to gain insights into the dual clinical and managerial components of the role. It is important to note that OTCLs occupy a first-line management role, a leadership role described by Kanter (1977) as one with limited access to organisational power, organisationally invisible and unrewarded. Based on a number of studies, Kanter (1977) described in her book *Men and Women of Corporation,* both male and female first-line managers are often functionally powerless because they are frequently responsible for getting the job done without access to adequate resources. This theory is congruent with the aims of this study, which seeks to understand how a group of OTCLs experience their role in the context of constant role re-definition and organisational change.

Kanter's (1977) theory is ideally suited to provide a framework to examine the relationship between the OTCL role and the power relations in the relevant health care organisation. Statistics from the 2010 Queensland Occupational Therapy Board workforce survey showed that 90% of practising occupational therapists are female, a situation that resonated with the use of Kanter's (1977) theory. An additional vital point to note is that Kanter's (1977) work was based on female groups within large public organisations primarily concerned with the participation of women. Similarly, Paliadelis (2008) employed Kanter's (1977) theory to examine the concept of organisational power among predominantly female NSW NUMs and found

organisational power as being closely linked to the overall state of the system and invested within organisational structures. The author found a nurse unit manager's organisational power to be manifested by the manager's credibility as a leader, implying that power was not a personal feature but reflected the role.

While there are many theories that explore the use of power in organisations such as Marxist perspective (Luke's 1974) and Postmodernist perspective (Foucault 1969), Kanter's (1977) theory has been selected as the most appropriate for this study because it identified organisational role constructs instead of individual qualities as key factors influencing participants' access to organisational power. In the same manner, Kanter's (1977) theory of organisational power was chosen to facilitate understandings as expressed by the OTCLs who participated in this study and who occupied a first-line management role.

Kanter's (1977) theory of organisational power also provides a framework to examine organisational structures as determinants of power. In this way power is situated within organisational job positions, manifested as working relationships between managers and their subordinates. Research evidence suggests empowerment as an emerging construct used by theorists to explain organisational effectiveness (Kluska et al. 2004; Sarmiento, Laschinger and Iwasiw 2004). It is also associated with issues of powerlessness of disempowered groups (Shamian, Kerr, Laschinger, & Thomson 2002). The act of empowering subordinates is a principal component of managerial and organisational effectiveness as viewed by Sarmiento, Laschinger & Iwasiw (2004), and

Upenieks (2002). Therefore it is vital to identify conditions within organisations that may influence the power of first-line managers. In the process of employee empowerment the focus is firmly on the actions of the power holders to transfer power to the less powerful, whilst enabling employees to significantly affect organisational outcomes. Likewise the purpose of this study seeks to gain insight into the lived experiences of a group of occupational therapists, who occupy a first-line management position that has not previously been the subject of research in Australia.

2.8   An overview of research that conceptualised Kanter's (1977) theory

This section examines existing research literature that has drawn on Kanter's theory of organisational power, to demonstrate that while this theory was developed in 1977, it is still contemporary and relevant to the health care industry today. Kanter's (1977) viewpoint on organisational power, which can be applied to clinical leadership roles, as first-line management roles, are that power is structurally embedded within organisational structures and relationships and is based on the manager's ability to access formal and informal power.

Relevant contemporary research literature will be reviewed in this section to demonstrate the applicability of Kanter's (1977) theory of organisational power to this study, by discussing both international and Australian research literature on leadership roles that are relevant to the health care sector. In doing so this section underscores the relevance of Kanter's (1977) theory and the value of good leadership to health care contexts which has been portrayed in previous research studies as a consistent theme

within Australian and international health care settings reforms (Anderson, Spataro and Flynn 2008; Braithwaite 2005; Braithwaite, Hindle, Westbrook, Iedema & Black 2006; Braynion 2004; Briggs 2009; Duckett 2009; Dwyer 2004; Olsen & Neale 2005; Touati et al. 2006). Adamson et al. (2008) associates the ability to initiate change with the capacity to influence, direct and modify other employees' behaviours in order to achieve organisational effectiveness. Briefly, these study findings show that clinical leadership is based on organisational power as a requirement to influence organisational change, quality of patient care and safety, and the utilisation of health care resources. Correspondingly, in Kanter's (1977) theory, employees with high levels of formal and informal power have access to structures of productive power within an organisation such as information, lines of support, opportunities, and resources.

Kluska, Laschinger and Kerr (2004) directly link moderate empowerment and rewards for perceived work efforts in an investigation that surveyed staff nurses' empowerment and effort-reward imbalances. Staff nurses who participated in this study's responses were measured by five self-report instruments: the conditions of work effectiveness, job activities, organisational relationships, the effort-reward imbalance, and a demographic questionnaire. Prior research by Laschinger, Finegan, Shamian & Wilk (2001) found staff nurses to be moderately empowered with varying levels of access to information, support, opportunity and resources. These participating nurses showed dissatisfaction with increased workloads, uncertainty about the future, and managers' focus on financial bottom line, lack of resources to support high-quality patient care, and diminished learning opportunities. Study findings portrayed Kanter's (1977)

explanation of outcomes of powerlessness such as job dissatisfaction, burnout, tension, worry, stress, reduced morale and organisational commitment.

Other previous investigations associated staff nurses' greater levels of organisational commitment with greater participation in organisational decision-making (Kutzcher 1994), higher levels of structural empowerment (Laschinger et al. 2000), higher levels of job autonomy (Sabiston and Laschinger 1995), higher levels of job satisfaction (Laschinger, Finegan & Shamian 2001) and greater organisational trust (Laschinger et al. 2001). All these studies support Kanter's (1977) theory that proposes that structures in the workplace can empower employees to accomplish their work in meaningful ways, thereby reducing the likelihood of occupational stress.

Informal power is a useful determinant of job satisfaction that supports Kanter's (1977) theory. This theory proposes that positional power is not sufficient for effective performance in organisations. Based on findings from an investigation of college educators' experiences of their jobs in a diploma nursing program, Krahn (2000) underscores the value of informal working relationships as pivotal towards effective performance. Study findings revealed that college educators' empowerment and job satisfaction were negatively related to the number of students taught in a classroom and hours worked per week. Furthermore, findings showed that participants had insufficient student contact time because of unreasonable workloads. This study concluded that student contact was an important job satisfaction factor for college educators. Similarly, Kanter (1977) theorises that work structures such as teams empower employees by

fostering opportunities to learn and grow, and provide access to work satisfaction and effectiveness. Linking findings to Kanter's (1977) theory, the number of students taught and hours worked was an important determinant of power in terms of it being a useful empowerment resource. Conversely, by addressing these concerns, the organisation creates increased opportunities that would become sources of job satisfaction and empowerment for the study participants.

2.9   Summary

This section has demonstrated the relevance and applicability of Kanter's (1977) theory to contemporary research. The studies cited in this section support the applicability of Kanter's (1977) theory of organisational power. This was achieved by firstly demonstrating the relevance of Kanter's (1977) viewpoint of organisational power as a positive resource for use by both organisations and employees to achieve work effectiveness. Secondly, both formal and informal powers have been linked to structures in the workplace that empowered employees to accomplish their work in meaningful ways, thereby reducing the likelihood of work-related stress. This section concludes that Kanter's (1977) theory is still contemporary and relevant to today's health care industry.

2.10   Conclusion

This chapter has critically reviewed relevant research literature to provide a background and context to the phenomenon of the Australian OTCL role in terms of its dual clinical

and management domains. This chapter has set the scene of this study by reviewing literature within the context of the Australian health care system and occupational therapy services, the historical perspectives, and the impact of health reforms on the OTCL role and health workforce in terms of job satisfaction issues. Section 2 presents and justifies the use of Kanter's (1977) structural theory of organisational power as a theoretical framework for this study. The next chapter discusses the study's methodology and research methods.

Chapter Three

Methodology and Research Design

3.0   Introduction

In this chapter I present hermeneutic phenomenology informed by Martin Heidegger (1962) and Gadamer (1975) as the philosophical and methodological paradigm I chose for this study. This abstract philosophy provided the foundation for the selection and discussion of van Manen's (2001) hermeneutic phenomenology as a practical guide to the research method and design and the Interpretive Phenomenological Analysis (IPA) (Smith 2004) to interpret study findings. Firstly, I examined important concepts underpinning Martin Heidegger's (1962) and Gadamer's (1975) hermeneutic phenomenology as a rationale for the inclusion and use of this philosophy in its abstract state to this study.

Secondly, as is the case with all research inquiries that employ the qualitative interpretive paradigm as put forward by Denzin (2005), I faced a challenge of identifying a practical research method that was consistent with the chosen philosophical framework. In this phenomenological inquiry, I encountered a dilemma of choosing a feasible and practical research method that was hermeneutic because phenomenology is primarily a philosophy that is abstract in nature. Therefore it was my responsibility to discuss and articulate the chosen phenomenological method on the basis of the selected philosophical framework in order to justify it within the context of the study phenomenon under investigation. Furthermore, debates on the use of

interpretive phenomenological analysis in occupational therapy research provided a foundation for identifying a practical and acceptable guide to the research method and design that was selected. In response to the need to utilise an acceptable method, in the second section of this chapter I described van Manen's (2001) hermeneutic phenomenology as guide to the research method and design, and the Interpretive Phenomenological Analysis (Smith 2004; 2010; 2011) to interpret findings.

The data triangulation approach, as Smith, Flowers and Larkin (2009) and Yardley (2008) attest is an in-depth interpretive pathway which shows sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance of the study phenomenon. This was a fitting methodological approach because IPA is concerned with detailed examination of personal lived experience, the meaning of experience to participants, and how participants make sense of that experience (Smith 2011). Hefferon & Gil-Rodriguez (2011) and Smith (2010) point to the dominant position IPA, primarily an interpretive approach, holds in qualitative research, as a substantial or detailed form of thematic analysis. In this context, IPA allows a double hermeneutic data analysis process that has roots in the abstract hermeneutic phenomenology (Heidegger 1962; Gadamer 1975) and ideography, which is consistent with symbolic interactionism that involves use of symbols or phrases to represent ideas (Bramley & Eatough 2005; De Visser & Smith 2006). During the IPA process, I sought to make sense of the world of the participants who were also trying to make sense of their lived experiences. In doing so I demonstrated IPA's conformity to key concepts of hermeneutic practice, which include hermeneutic circle and fusion of horizons. These

concepts will later on be discussed in detail. I then examined the study rigour and considered ethical issues including their mitigation in the context of the subject of investigation to explicate the trustworthiness of study findings. A brief summary of key points from this chapter provides a conclusion to the entire chapter.

3.1   An introduction to phenomenology

Phenomenology, as an interpretive paradigm, reflects an attempt to obtain an in-depth understanding and interpretation of meanings that people personally attach to everyday events. According to Parry (2001:203) and van Manen (2001: 7), phenomenology seeks 'to gain a deeper understanding and interpretation of the nature or meaning of our everyday experience'. Whilst Crotty (1999) explains a phenomenological method as one that seeks to uncover the meaning of humanly experienced phenomena through the analysis of subjects' descriptions, Garza (2007: 338) perceives it in terms of 'the flexibility of phenomenological research and the adaptability of its methods to ever-widening arcs of inquiry as one of its greatest strengths'. There are various ways of undertaking this phenomenological research. Finlay (2008), during an exploration of the British occupational therapists' life worlds, portrays phenomenology as a movement that has no strict guiding rules or uniform beliefs. Butler, Cronin-Davis & Mayers (2009) and Ballinger (2004) associate interpretive phenomenological analysis as a study methodology with complex occupational therapy practice research. This is the case because it acknowledges the influence of the researcher in the research process and resonates with the person-centered nature of the profession. Therefore, phenomenology

is concerned with how human beings understand their world through direct experiences.

Based on the philosophical values, theoretical preferences, and variations in research methods employed in response to the research question, I utilised hermeneutic phenomenology to identify research methods based on core tenets in Heidegger (1962); Gadamer (1975); van Manen (2001); and Smith's (2004) IPA to understand and interpret participants' perspectives of the study phenomenon. Heidegger's (1962) and Gadamer's (1975) ontological hermeneutic phenomenology was a counter-response, in its abstract state, to Hurssel's transcendental phenomenology. From this perspective, I chose to provide a reflective account of the key concepts that underpin the study's philosophical paradigm by examining key features as shown in the following section.

3.2 A critique of transcendental phenomenology and ontological hermeneutic phenomenology

Crotty (1999) and Finlay (2008) describe two major types of phenomenology, namely Husserl's transcendental phenomenology and Heidegger's hermeneutic phenomenology. Both scholars were German and used dense German language, marked with variances in translation. Husserl's transcendental phenomenology was further developed by several other scholars such as Colaizzi (1978); Giorgi (1989); van Kaam (1969); and Spiegelberg (1978). These scholars have developed phenomenological research methods that provide broad approaches rather than positivist, objective guidelines based on Husserlian phenomenology with an emphasis on bracketing.

According to Luft (2004), Edmund Husserl, both as the founder of phenomenology and a mathematician, aspired to preserve some semblance of objectivity as a way to gain credibility of his methodology and was keen to prove human consciousness. He believed the mind and body to be mutually exclusive, suggesting that the mind was directed towards objects with the aim to provide a philosophy of science that provided a foundation of all sciences. Husserl (1870) believed in scientific methods of understanding everyday life experiences and advocated for bracketing of pre-existing prejudices as a way to view the life world in its original state. Furthermore Husserl (1870) proposed transcendental phenomenology as a pure thought explanation of the relationship between consciousness and objects of understanding. Barnacle (2001) also described Husserl's view of pure thought as a cognitive activity that refers to being free from pre-assumptions and prejudice and remaining neutral. In this situation, as Velarde-Mayol (2000) and Wrathall (2005) suggest, Husserl's transcendental phenomenology seeks to investigate the process of acquiring knowledge (epistemology) and expressing absolute truth via thick description. Therefore epistemology is concerned with the process of acquiring knowledge.

Husserlian phenomenology is descriptive, with the intention of raising awareness about human experience. Husserl concentrated on knowledge and consciousness and as a mathematician was motivated to offer objective data. According to Husserl (1870), knowledge stems from conscious awareness and the human mind is directed towards objects (intentionality). In doing so, he examined the world pre-reflectively and

therefore advocated for phenomenological epoche (bracketing). According to Stumpf & Frieser (2008), Husserl believed that it was first necessary for any pre-conceived ideas to be put aside in order to expose the true essence of the 'lived experience'. By employing bracketing Husserl advanced the notion of jointly allowing reflection on the research subject whilst neutralising the existing residue of consciousness in order to ensure that findings were not vulnerable to the researcher's agenda.

On the other hand Heidegger (1962), who was Husserl's university assistant, derived inspiration from his mentor's concept of phenomenology and developed his own opposing approach called hermeneutic phenomenology. Martin Heidegger was born in south-west Germany in 1889 to a Catholic family that wanted him to become a priest, but he left a theology course due to a combination of ill-health and a lack of passion (Wolin 1993). According to Heidegger (1962), at the core of his hermeneutic phenomenology is ontology, which is the study of Being or study of human existence. His philosophy was based on previous philosophies such as historical hermeneutic and Husserl's transcendental phenomenology. Heidegger (1962) combined key features from the two philosophies into hermeneutic phenomenology. In doing so he moved the debate beyond the epistemology approach, concerned with the process of acquiring knowledge, to an ontological one with added existential flavour (Dreyfus & Hall 1992). Heidegger (1962) dedicated his book, *Being and Time* to Husserl who supported his career to the very end, but it was a radical contrast from Husserl's phenomenology of conscious activities to that of *Being*.

In addition, Martin Heidegger contributed to the development of other philosophical ideas including phenomenology (Merleau-Ponty), existentialism (Sartre), hermeneutics (Gadamer), postmodernism (Derrida) and other fields such as political theory, psychology and theology (Wolin 1993). Heidegger (1962; 1982) developed hermeneutic phenomenology as a reaction to Husserl's transcendental phenomenology, and as a consequence his central ideas are contrasted with those of Husserl in order to gain a clear understanding of his core ideas. Overall Martin Heidegger (1962) believed that people are situated in the world and that all understanding of the world occurs through human experiences. Based on this viewpoint, Cohen (2000) and Thompson (1990) advised Heideggerian researchers to undertake an in-depth exploration in search for clues about hidden meanings pertaining to everyday experiences.

Contrary to Husserl's ideas, Heidegger (1962; 1982) was interested in moving the debate from description to interpretation with an emphasis on deriving meaning from being. The outcome of a hermeneutic inquiry entails understanding and meaning through interpretation. Furthermore Heidegger rejects the mind-body duality of human existence underpinning Cartesian thought. Johnson (2000) and Rice and Ezzy (1999) elaborate that Heidegger instead advocates for *Dasein*, a German concept meaning human existence with the entity to ask what it means to be, their being, or being in the world. *Dasein* is the concept upon which Heidegger built up the entirety of his thinking. Commenting in his book *Time and Being* on the concept of *Dasein,* Heidegger (1962:27) stated:

> "Thus to work out the question of Being adequately, we must make an entity the inquirer-transparent in his own Being. The very asking of this entity's mode of

Being; and as such gets its essential character from what is enquired about namely, Being. This entity which each one of us is himself and which includes enquiring and the possibilities of its Being, we shall denote by the term Dasein".

In other words, *Dasein* is the inherent thing that allows humans to wonder about their own existence and to question the meaning of their being in the world.

As McConnell-Henry, Chapman and Francis (2009) suggest, Heidegger vehemently rejects bracketing and advocates for prior understanding or fore-structure and time context augmented interpretation. Heidegger asked questions that he thought would ultimately result in uncovering the meaning of being. Pringle, Drummond, McLafferty & Hendry (2011) and Kelle (2005) underscore the importance of the researchers' prior knowledge and fore-structure as the only true way to conduct a hermeneutic inquiry, to ensure that the questions asked are relevant. From this viewpoint, I selected Heidegger's (1962) ontology, which is concerned with the desire to uncover and unravel the meaning of being. For Heidegger, knowing only came through interpretation and understanding. In doing so, Heidegger (1962) stressed that it is not possible to live devoid of interpretation and that there is a multiplicity of truth.

Time (temporality) and space (spaciality) are pivotal in Heidegger's thinking. According to McManus-Holroyd (2005), Heidegger believed that humans are at all times immersed in their world, and that context impacts heavily on both existence and experience. Time refers to the contextual nature of experience in that past experiences influence both present and future dealings. Heidegger (1962) argues that temporality is

central to the concept of Being in that neither knowledge nor experience is gained statically.

Van der Zalm & Bergum (2000) describe the hermeneutic circle as the back and forth movement, of questioning and then re-examining the text that results in an ever expanding circle of ideas. The hermeneutic circle relies on the circular movement from the whole to the parts, incorporating the contributions of all by de-constructing and then re-constructing, resulting in a shared understanding. Kincheloe & McLaren (2003) links the hermeneutic circle with symbolic interactionism. For Kincheloe & McLaren the hermeneutic circle is a metaphor for the dialectic movement between parts and the whole that is reflexive and ongoing, in which people come to develop an understanding of a phenomenon. By utilising the hermeneutic circle, I attempted to 'read between the lines' and uncover the true essence of the experience (Heidegger 1962). In doing so, I therefore became a legitimate part of the research process. I was already immersed in the research process. I was being-in-the-world of the participant and the research question. This viewpoint is supported by Clouston (2012) and Dowling (2004) who assert that the researcher is as much a part of the research as the participants, and that the researcher's ability to interpret the data is reliant on previous knowledge and understanding. Furthermore Dowling (2004:32) argues that there is no interpretative research that is free of judgment or influence of the researcher without presuppositions as follows:

> "We do not, and cannot, understand anything from a purely objective position. We always understand from within the context of our disposition and involvement in the world".

In addition, McConnell-Henry et al. (2009) and Smith & Osborn (2005) recommend that it is vital for any researcher who subscribes to the philosophical standpoint of Being–in-the-world attested to by Heidegger to be open and upfront with this viewpoint.

Whilst expanding the debate on hermeneutic phenomenology an assistant to Heidegger, Gadamer (1975), through his work *Truth and Method*, adopted and extended an understanding of the concept of hermeneutic phenomenology developed by Heidegger (1962). Gadamer (1975) viewed Heideggarian phenomenology as hermeneutics, implying a process that involves the interpretation of the transcribed text whereby the meanings between the researcher and text become clear. Gadamer (1975) re-interpreted the word pre-judgment positively as an inevitable aspect of understanding. Like Heidegger's idea of fore-structure, Gadamer's prejudice involves the process of understanding. According to Gadamer, pre-judgment or pre-suppositions are something one brings into an understanding but it does not restrict our understanding, instead, by our pre-suppositions or prejudice, the world opens up to us. In other words all truth or perception is influenced by the pre-existing knowledge possessed on the subject.

Elaborating, Pillay (2002) described Gadamer's view of truth as contextually determined and that everything is understood through interpretation. In this situation the act of interpretation is an act of encounter (dialogue) between the interpreter and the 'being of the thing' such that the latter discloses itself. All understanding, as Gadamer

(1975:432) perceives it, is therefore 'trapped' in the hermeneutic circle where everything is 'interpretation, contextual and circular':

> "Everything that is language has a speculative unity, it contains a distinction, that between its being and the way in which it presents itself, but this is a distinction that really is not a distinction at all".

In Gadamer's view, language is a central concern of hermeneutic understanding that is both an instrument and a vehicle of thought, tradition and Being. The concept of fusing of horizons was introduced by Gadamer (1975), who suggested that each person has a horizon of understanding. By suggesting horizon, Gadamer implied the sum total of all influences that make individuals who they are, including the social, political, and historical contexts in which they live. This horizon is then the focal point from which one perceives the world and all its possibilities and performs any interpretation. Based on this viewpoint I contextualised the concept of understanding and interpretations within my pre-existing knowledge and prior involvement as an OTCL. In this manner my understanding of the phenomenon was therefore shaped by my professional and working history. Also, interpretation occurred within a particular horizon that was defined by my prior situated experiences that I conveyed through the art of writing.

3.3   Justification for the selection of Heidegger's (1962) and Gadamer's (1975) philosophy of hermeneutic phenomenology

In this chapter, central ideas of Heidegger (1962) and Gadamer's (1975) hermeneutic phenomenology in relation to the understanding of human experience underpin the philosophical and interpretive standpoint of this study. Briefly, Heidegger (1962)

shifted Husserl's epistemological view of human experience based on human consciousness and phenomenological reduction to an ontological perspective of understanding the notion of Being. Heidegger's approach is based on the meanings attributed to the existential aspects of Being (*Dasein*), which is concerned with human existence and the manner in which people organise and make sense of their own existence. From a methodological perspective, this philosophical paradigm was a suitably appropriate framework because Heidegger rejects conventional methodological assumptions when investigating human phenomenon. For Heidegger, it is impossible to use objective scientific data to understand human phenomenon. Pursuant to Heidegger's viewpoints, participants' ontological viewpoints (interpretation) in this study regarding the OTCL role are informed by past experiences (historicality), fore-structure (pre-understandings), (temporality) and context (time and space/environment). In doing so, this research views each story as interpreted work that is being communicated through writing as the final thesis. Consistent with this perspective, Wrathall (2005) pointed out that our understanding is rooted in our definitions. Similarly, in this thesis I sought to gain knowledge and understanding of the life world of OTCLs through the use of individual semi-structured interviews, observations, and a reflective journal about my personal experiences during the research process. As stated previously, I was practising as a clinical leader and therefore was in the same world as the participants, which allowed me to bring previous personal experiences to the study.

Heidegger also addresses temporality as a central feature of *Dasein* by arguing that human values and culture exist in the process of understanding the idea of *Being*. In this

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study, previous experiences of working in the OTCL role informed study participants' viewpoints regarding the essence of working in that role during individual semi-structured interviews. In addition, contextual factors such as work setting, knowledge, and motivation influenced participants' views on the study phenomenon and were recorded in the form of field notes. On the other hand, Gadamer (1975) extended Heidegger's views by introducing the aspect of language as a vehicle for articulating understanding and underscoring the importance of history in shaping the process of understanding human phenomenon.

However, research by Bondoc and Burkhardt (2004) and Unsworth (2011) demonstrate that occupational therapy practitioners now have an excellent grasp of evidence-based practice to guide both the clinical and managerial domains of their roles. Nevertheless, McConnell-Henry et al. (2009) and Wilding & Whiteford (2005) identified that neither Husserl nor Heidegger aimed to produce methodologies but offered two abstract theoretical philosophical frameworks that have been used to underpin methodologies and research. In this context, researchers employing the philosophy of phenomenology face a dual challenge of embracing very distinct concepts, involving employing both a pure practical research method and one that adheres to the original abstract philosophy of phenomenology.

Brocki and Weardon (2006); Caelli (2000); Patton (2002); Smith (2004; 2007); Smith & Osborn (2003; 2008); Reynolds (2003) and Starks and Trinidad Brown (2007) stress the importance of a flexible and adaptable methodology that exhibits strong theoretical

connections and purpose, combined with a uniform approach to analysis. In essence, there is need for the approach to be utilised to pursue a particular study that originates from the philosophical implications inherent in the research question. From this perspective, I employed a methodological conceptual triangulation by adopting some core ideas of van Manen's (2001) hermeneutic phenomenology to guide my choice of the research method and design, and Smith's (2004) IPA to understand and interpret participants' perspectives regarding the study phenomenon. In the following section, I explicate the mixed approach to my research methodology to allow a pathway for the reader to follow.

Smith & Osborn (2008) and van Manen (1997) advise interpretive phenomenological researchers to employ research method approaches that originate from the philosophical implications contained in the research question. Wertz (2005) associates quality of phenomenological research to its relative power to draw the reader into the researcher's discoveries, allowing the reader to see the worlds of others in new and deeper ways. In other terms, research reports need to accommodate raw data such as participants' verbatim extracts, to provide a chance for readers to draw conclusions about the soundness of the researcher's analysis. To that end, I reflected on existing debates on the use of interpretive phenomenology in occupational therapy research in the following section to ascertain its applicability, popularity, and relevance in this area of study and profession. In doing so, the process enabled me to set the groundwork needed to identify van Manen's (2001) hermeneutic phenomenology as the practical paradigm

to guide the identification and presentation of research methods and Smith's (2004) IPA to understand and interpret participants' perspectives of their lived experiences.

3.4   Debates on the use of phenomenology in occupational therapy research

Ballinger (2004); Butler, Cronin-Davis and Mayers (2009); Finlay (2003) and Wilding & Whiteford (2005) identified a growing occupational therapy interest in interpretive phenomenology research since the 1990s as an underpinning framework seeking to explain students', occupational therapists' and managers' clinical reasoning, and patients' experiences, of the service. This paradigm allows researchers to provide and interpret participants' viewpoints regarding their lived experiences. In this situation, as Smith (2011) argues, participants have the opportunity to describe the perceptions of lived experiences, and researchers have the opportunity to interpret these lived experiences. Within the phenomenological paradigm, there are many strands that focus explicitly on life world (Ashworth 2003; Dahlberg, Dahlberg, and Nystrom 2008) and lived experiences (van Manen 2001). Hermeneutic philosophies highlight the researcher's role and horizons of interpretation such as in the Reflective Life World Approach (Dahlberg et al 2008), Interpretative Phenomenological Analysis (Smith 2004; Smith & Osborn 2003), Embodied Enquiry (Todres 2007), Critical Narrative Analysis (CNA) (Langdridge 2007), and in the Dallas' approach to phenomenological research (Garza 2007). The heuristic approach adopted by Moustakas (1990) to portray the researcher's role in self-reflection towards producing a creative synthesis to explicate lived experience is brought to the fore.

Relational research approaches (Finlay & Evans 2009) pay attention to the researcher's journey and the research process by focusing on how data emerges out of embodied dialogical encounters between researchers and co-researchers. An example of relational research is the dialogue research approach (Halling & Leifer 1991). Within this framework, several phenomenologists investigate a phenomenon by dwelling in and negotiating layered meanings together. Ballinger (2004) and Smith (2004) postulate that IPA approach is the method of analysis that is suitable for capturing the complexity of occupational therapy practice. According to Matuska (2010) and Turpin and Iwama (2011), early occupational therapy phenomenological research has generally coined the term clinical reasoning, to explain the process of thinking and making judgements in tandem with demands imposed by early global industrialisation and technology evolution. These historical milestones required health care practitioners to provide a scientific justification of their professional input as a way to allocate health care resources.

Marsh, Fisher, Marthers and Fish (2005) point to the prevailing concerns in health and social care regarding the need to prove the effectiveness and value of interventions. In addittion, White (2003) and College of Occupational Therapists (2005) specifically link these concerns to the occupational therapy profession, which is expected to provide robust, research-driven evidence-based interventions in order to ensure solid foundations and professional credibility in the area of research. Taylor (2007) identifies an existing tension within health care practice settings for professions such as occupational therapy that have humanistic foundations in defining and applying

evidence-based practice because of a perceived incompatibility with client-centred practice. Furthermore, Butler et al. (2009) underscores the importance of finding a research method that is consistent with the values and underpinnings of occupational therapy, which acknowledges the researcher's influence within the research process and is consistent with the person-centred nature of occupational therapy. Starks and Brown Trinidad (2007) extrapolate that such a methodology, as is the case with interpretive paradigms, is one that allows data to speak for itself, with rich description and an authoritative perspective without precluding the participants' viewpoints and the researcher's prior knowledge on the subject.

Another challenge to the use of evidence-based practice, as Morrison and Robertson (2011) point out, regards the slow pace at which evidence-based practice was integrated into occupational therapy because of its humanistic focus. In the Australian context, evidence-based practice utilises clients' knowledge of their occupational concerns and circumstances, insights drawn from experience and reflection, and critical appraisal of best available evidence drawn from research, experts and theory, to inform practice decisions (Bennett et al 2003).

In these practice contexts, as Addy (2006) argues, best practice has to be combined with clinical expertise which could be problematic for both new graduates and consumers because of lack of experience and knowledge regarding what constitutes best practice. As shown from conclusions drawn from phenomenological research studies that investigated occupational therapy practice in various settings,

inexperienced practitioners mainly adhere to standard procedures to guide their assessment of events in a specific area (Dawkins & May 2002; Finlay 2001; Shanahan 2000; Udell & Chandler 2000; Velde 2000; Ward 2003). Research findings reveal that these new professional entrants struggled with professional identity issues due to a perceived mismatch in expectations and realities of practice. Resonating phenomenological inquiry findings support the notion that by adhering to set protocols, participating new occupational therapy graduates missed important information that showed their inability to fully comprehend the nature and meaning of occupational therapy practice within specific practice environments (Shiri 2006; Tryssenaar & Perkins 2001; Velde 2000).

Mattingly & Fleming (1994 cited in Turpin & Iwama 2011) based on phenomenological investigation of various occupational therapists' clinical reasoning processes when managing clinical problems, portrays experienced practitioners as being in a situation to be able to employ four different modes of scientific thinking when discharging occupational therapy services. These thinking modes were identified as the 'three-track mind' in reference to different purposes or in response to particular features of a clinical problem. Based on Mattingly & Fleming's observations of occupational therapists in practice, experienced practitioners were able to switch between the first three of the four types of thinking modes, the 'Three-track Mind' in a rapid fashion, which appeared as if they were simultaneously employing them. These four thinking modes refer to procedural, interactive, conditional, and narrative. In this study context procedural reasoning, according to Mattingly & Fleming (1994), is

baseline reasoning that guides a practitioner when deciding about the patient's physical performance problems, whereas interactive reasoning is used when a practitioner is concerned with understanding the patient as a person. Interactive reasoning is arguably the most complex conditional reasoning because it integrates the other two reasoning styles whilst projecting an objective assessment of the future solutions (Mattingly & Fleming 1994).

On the other hand, narrative reasoning or storytelling is a form of reasoning Mattingly & Fleming suggested for use in practice contexts when occupational therapists swap stories and engage others in discussing puzzling situations to enlarge each other's practical knowledge base indirectly (Mattingly & Fleming 1994). In this study context, Mattingly & Fleming (1994) perceived the different reasoning styles as dynamic and nonlinear in their application. Also, prior clinical reasoning phenomenological occupational therapy research studies by Schell and Cervero (1993) provide an additional dimension of reasoning termed pragmatic reasoning or ethical reasoning. According to Schell and Carvero (1993), pragmatic reasoning refers to those situations when occupational therapists thought about what actually could be done, given the practice resources available in the broader work, organisational and political environment, and client's wishes.

Recently, phenomenological research in clinical reasoning has become increasingly popular in occupational therapy as a way to justify professional input within health care teams (Blair & Robertson 2005; Boucher 2005; Butler et al. 2009; Gahnstrom-

Strandqvist, Tham Josephsson & Borell 2000; Kuipers & Grice 2009; Mitchell & Unsworth 2005; Unsworth 2011). Overall, participating experienced practitioners in the studies above were found to shift smoothly from one mode of thinking to another in order to analyse and interpret various types of clinical and managerial problems.

Blair and Robertson (2005: 272); Turpin (2007) and Wilding and Whiteford (2005), whilst acknowledging the complexity of occupational therapy practice and an existence of multiple views about professional clinical reasoning, situated occupational therapy between two cultures of biomedicine and its own professional culture. Specifically, Blair and Robertson (2005: 272) described the tension caused by the dual professional cultural orientation of the occupational therapy profession as an art and a science as:

> "what might be considered to be a professional fault-line between health care and social care to which occupational therapy appears to be more oriented towards people's social and personal welfare".

Expanding this debate regarding the profession's philosophical orientation, Williams and Paterson (2009) provide further insight into the phenomenon of professional artistry and its meaning on three occupational therapists' perspectives. This phenomenological investigation sought to understand and interpret participants' perspectives about the manner professional artistry was developed and manifested in different roles. For participants in this study, artistry was linked to a combination of innate personality traits and values, fostered by professional training and personal and professional experience. These skills were gained by engaging in a constant cycle of reflective practice and further skill development. Study conclusions portrayed

professional artistry as the central focus of occupational therapy practice based on established therapeutic relationships, which in turn imparted deep role satisfaction in their practice. By explicating this knowledge and meaning about professional artistry, findings added another dimension of evidence-based practice in occupational therapy with implications for policy in terms of recruitments and for professional practice.

Similar perspectives by Turpin & Higgs (2010) reveal the complex and constant evolutionary nature of professional reasoning by exposing the existing conflicts that are embedded within decision-making cycles, the influence of broader practice contexts, and demand for collaborative decision-making. Higgs & Jones (2008) identified three core dimensions of clinical reasoning: discipline-specific knowledge, occupational therapist's cognitive abilities, and metacognition. From this perspective, discipline-specific knowledge is portrayed as both an assertion and a non-assertion. On the other hand, an occupational therapist's cognitive abilities are associated with one's ability to compare increasingly objective clinical information with the existing stock of discipline-specific and personal knowledge, and interpret it with regard to client needs and preferences, whilst metacognition relates to the occupational therapist's ability to identify existing limitations and information inconsistencies needed to enable him to monitor his reasoning and practice in view of these three interactive and contextual dimensions.

Based on occupational therapy research into the process of professional reasoning, Unsworth (2011) links the prevailing broader practice contexts (pragmatism) to the

therapist's personal philosophy in a process termed generalised reasoning, and proposed it as a subcategory of each of the other types of reasoning. From this perspective, Turpin and Iwama (2011:39) put forward a Model of Context-Specific Professional Reasoning (MCPR) in which occupational therapists integrate and synthesise the diverse and conflicting information collected in order to enable them to make sound judgements about the services they offer regardless of practice contexts. In this MCPR model, clinical reasoning is both context specific and personal and is centralised on the interaction between a professional and an ordinary patient. In this manner, the model's specific professional reasoning has an influential dynamic sociocultural approach that assumes that individuals exist within the context of both formal and informal relationships with others. In simple terms, based on Schell's (2009) viewpoint, the MCPR model refers to a situation when professionals and ordinary patients bring particular perspectives to an encounter within a therapeutic relationship in a practice context, whose perspective is also determined by existing organisational, cultural, legislative and policy factors, which in turn influence the nature of interaction.

Boucher (2005) explored the phenomenon of deciding to take up or not to accept a promotion into management roles within the organisation or apply for a management position with another organisation using 60 individual unstructured interviews in Melbourne, Australia. This phenomenological inquiry involved participants who had at least five years' of work experience in podiatry, speech therapy, occupational therapy, physiotherapy, pathology, radiology, medicine, nursing, social work, human resources,

and food services. Findings revealed themes such as 'born managers' representing a third of the participants who planned to stay in management and perceived themselves as naturally talented for the job, 'ambivalent managers' representing those participants who were undecided whether or not to take up promotions, 'former managers', and 'never have been and will not be' categories. This study conclusion showed an existence of multiple viewpoints regarding the phenomenon of working as a first-line, manager and tensions faced by senior clinicians in making decisions regarding career shifts into management.

Traditionally occupational therapists have a commitment to collaborate with their clients by taking into consideration their individual health needs and values (Kielhofner 2008). However, as shown in this section, it is the duty of the researcher to seek a phenomenological research method that is consistent with the study philosophy. In this regard, it was necessary to demonstrate some central ideas and assumptions of hermeneutic phenomenology and background information on the applicability of the philosophy to occupational therapy practice.

In the following section, I explicate the mixed approach to my research methodology to allow a pathway for the reader to follow.

3.5   An introduction to van Manen's (2001) hermeneutic phenomenology

According to van Manen (2001:28), methodology means the 'pursuit of knowledge'. As Wilding and Whiteford (2005) postulate, within interpretive phenomenology, as is

the case with all qualitative paradigms, there is no methodological orthodoxy, except for a holistic and reflective approach that allows data to guide the nature and form of study for the researcher. Nevertheless, Wilding and Whiteford (2005) specifically identify Heideggerian phenomenology as a paradigm that is loaded with features compatible with occupational therapy, which allows exploration of rich, multifaceted, dynamic, and intangible lived phenomenon.

The essence of this inquiry is to gain an understanding of the working world of Australian OTCLs in terms of the dual managerial and clinical domains of the role. As such it is a method of inquiry that supports the humanistic science that "aims at explicating the meaning of the human phenomena… and at understanding the lived structures of meanings" (van Manen 2001: 4). To accomplish this, it is important for the researcher to engage in hermeneutic practice. Simply put, hermeneutics is the practice of interpretation (Schwandt 2003). The core tenets of this approach are consistent with the underpinnings of Heidegger (1962) and Gadamer's (1975) hermeneutic phenomenology. Following Heidegger's (1962) and Gadamer's (1975) epistemological and ontological perspectives, van Manen recommends researchers to understand or interpret the research phenomenon on the basis of their assumptions and to make known their pre-understandings in bringing the phenomena into view.

3.6   The concept of pre-understanding influencing interpretation

This study employed a reflective researchers' journal in the form of daily records of my observations, experiences and key issues as they arose during the study. I began by

situating my pre-existing knowledge in accordance with van Manen's (2001) hermeneutic phenomenology, which recognises that all understanding is influenced by existing researcher prejudices regarding the phenomena. As previously discussed, Gadamer (1975) views the process of understanding as a fusion of horizons, implying that understanding is only possible in the context of previous knowledge that researchers bring into the research process. Gadamer (1975) therefore views pre-supposition in a positive manner in terms of its ability to assist interpretation and understanding. In line with Finlay's (2003) proposition, I kept a reflective journal of my pre-understandings throughout this study as a powerful strategy to constantly provoke these pre-understandings. By writing a personal reflective journal, I managed to examine my own personal views and attitudes towards the subject of research. In Chapter One, I have also included my personal and professional background in relation to the research topic in order to explicate my biography and possible influence on the research project.

3.7   van Manen's six research activities

This study sought to gain a deeper understanding of the lived experiences of Australian OTCLs by "interpreting these meanings to a certain degree of depth and richness" (van Manen 2001: 11). To this end, van Manen's (2001: 30-31) adopts six research activities to identify, understand, and interpret the experience in question. These exist simultaneously in the form of six stages as they are ontologically inter-connected, thereby precluding the very step-by-step manner. The six activities provide a sense of order and structural approach to the research project since they are consistent with the

core tenets of the philosophy of hermeneutic phenomenology as proposed by Heidegger (1962) and Gadamer (1975). Briefly the activities I utilised are:

- Turning to a phenomenon that seriously interests us and commits us to the world.

- Investigating experience as we live in it rather than as we conceptualise it.

- Reflecting on the essential themes which characterise the phenomenon.

- Describing the phenomenon through the art of writing and re-writing.

- Maintaining a strong and oriented pedagogical relation to the phenomenon.

- Balancing the research context by considering parts and whole.

In the following section I provide a discussion of these stages and the actual method that I employed in this thesis.

3.8   Turning to the phenomenon

van Manen (2001) emphasises that researchers are required to commit themselves to a phenomenon of interest. In explaining the concept of commitment, van Manen (2001: 31) states:

> "Phenomenological research is a being-given-over to some quest, a true task, a deep questing of something that restores an original sense of what it means to be a thinker, a researcher, a theorist".

According to van Manen (2001), formulation of research questions is a process that only succeeds when researchers find interest in the topic. Phenomenological research questions do not ask about relationships of variables, nor do they seek explanations.

These questions ask 'what is it like to be …?', and in the process they collect a detailed description and interpretation of phenomena under investigation.

In this study I utilised individual semi-structured interviews to collect information from participants. Burnard (2005) describes the process of interviewing as a continuum which progresses from the structured to the unstructured via the semi-structured. In this context, I employed semi-structured interviews, which involved the use of a set of both open and semi-structured interview questions as described in section 3.5.4.4.

I responded to this inquiry by setting the research questions as follows:

3.9   Research questions

- What are the experiences of working as an Australian OTCL?

- Are there any common or shared experiences among the participants? If so what are these common issues?

3.10   Investigating experience as we live in it rather than conceptualise it

In this hermeneutic phenomenological inquiry, I had a personal interest concerning the subject of investigation based on my relevant previous working experiences as an OTCL and interest in the field of study because of paucity in published research on the study phenomenon in Australia. In doing so, this study provided me with the opportunity to contribute to the body of knowledge on the subject of study. In Chapter

One I explained my presuppositions as described by Heidegger (1992) and Gadamer (1975) to justify the choice of this methodology. In this respect, I had already entered into the practice of OTCLs. Furthermore, these presuppositions assisted me to understand and interpret during stages of data collection, analysis, and presentation of study findings.

3.11   Reflecting on essential themes that characterise the phenomenon

Describing the research phenomenon

In this study, I selected and recruited participants on the basis of their ability to provide an in-depth insight into the study phenomenon. The following sections describe the pilot study that I completed as part of preparation for the data collection process. Also, I described key features of my study settings, characteristics of potential participants, and the data collection process.

a) Settings

In this study the participants contributed to the project in their private time. In this respect, the settings for the interview were chosen by participants according to their convenience. These settings included interview rooms at workplaces, the participants' homes, and individual work offices. This process helped me to reassure participants of adequate privacy, which enabled their meaningful engagement in the discussions. Overall, the selected interview setting allowed each participant to feel comfortable and relaxed enough to really tell the researcher 'how it is' as advised by Dearnley (2005:26). Briefly, the chosen setting offered study participants some personal privacy,

was informal and considerate of seating arrangements, and generally uncluttered and non-distracting, which facilitated a high quality of audio recording.

b) Recruitment of participants and their characteristics

In this study I used a purposive sampling method to identify and recruit potential study participants. During this process, as advised by Kvale (2006) and Smith & Osborn (2003) I recruited a homogenous and defined sample that reflected specific characteristics of the purpose of the study. I recruited all participating OTCLs from two QH sites. The first eligibility criterion I used was that participants had to be practising QH OTCLs who had accrued significant experience sufficient to "tell it as it is" whilst contributing to the debate on the phenomenon under investigation. Secondly, I invited all eligible 15 female practising QH OTCLs who held a dual role that comprised a clinical and managerial component to participate in the interviews. In this respect I considered Reid, Flowers and Larkin's (2005:22) recommendation on sample sizes, which stipulates that 'less is more'. I considered the need to undertake in-depth interviews and the value of establishing rapport with my participants, which became crucial to the process of collecting data. Each of the OTCLs I recruited to participate in this study was professionally responsible to a team of occupational therapists whose classification ranged from a base grade occupational therapist at Health Practitioner Level 3 to a specialist clinical occupational therapist at Health Practitioner Level 5.

I then forwarded an invitation package (see Appendix A-D), outlining details about the study and the process of consent, to two Occupational Therapy Departments requesting

potential participants to make direct contact with me if they wished to be part of my study. In addition, I sent a follow-up email three days prior to the scheduled interview date before I proceeded to the interview venue as previously negotiated with each participant. Eleven out of the 15 invited OTCLs initially agreed to participate in the study. However one participant later withdrew her consent without giving any reason. After negotiating with each participant, participation in this project took place during set times and at the participant's preferred venue. Lastly, I did not invite those occupational therapists who did not meet the above criteria to participate in the study.

c) Data collection process

Data collection took place between June 2010 and November 2011 to obtain demographic information and engage in individual semi-structured interviews. During this process I recorded field notes along with my reflective journal and gathered organisational documentation such as the OTCL position description and organisational charts. The purpose of the interviews was to explore study participants' experiences and their perspectives of working as OTCLs both in terms of the dual managerial and clinical components of the role, discuss opportunities and challenges, and identify strategies to manage these. In this research, I faced a delay period of more than a month's interval between interviews eight and nine because of participants' availability. In consultation with each participant, I was able to accommodate the ninth and 10th interviews on the same day, but separately.

Butler et al. (2009); Smith (2004) and Reid, Flowers and Larkin (2005) recommend use of smaller participant numbers ranging between 5 and 25 interviews. However I could not predetermine the actual number of interviews in this study until saturation was reached. According to Creswell (2007) and Smith (2004), the process of data collection in a phenomenological study involves primary in-depth interviews with as many as 10 subjects, purposively sampled. Reid et al. (2005) emphasised the need to describe the meaning of the phenomenon for a small homogenous and defined sample of individuals who have experienced it. In this study, data were collected until saturation was reached. In this study, the saturation process was determined by the availability of study participants and the richness of collected data in relation to the purpose of study. Creswell (2007) defines saturation as a state when further data collection does not yield any new information. I also carried out a pilot study, as detailed below, as part of preparation for the main study.

According to Patton (2002) qualitative researchers employ observation to record people's behaviours and activities as they naturally occur in a group setting. In this respect, observation is not a defined part of data collection in a hermeneutic phenomenological inquiry because it concerns personal lived experiences (Kvale 2006). However, Titchen and Ersser (2001) suggest use of observation as a reflection tool to gain access to individuals' professional craft knowledge regarding a specific phenomenon. Observation was employed in this study as a means of triangulating the data collection process. Curtin and Fossey (2007) and Harman and Clare (2006) refer to the use of two data collection methods as investigator triangulation, which enhances the

credibility of findings. Butler et al. (2009) elaborate that this multi-method triangulation is a strategy that is credible, worthy of attention, adds rigor, breadth, complexity, richness and depth, as well as a definite requirement to any inquiry. In this study, I employed observations to offset the gap between what participants stated in interviews with the actual behaviours. In addition, observations enabled me to see things first hand that participants themselves were not aware of or willing to discuss.

During interviews, I took the opportunity to record in my journal more informal data such as observations on issues such as physical setting, key issues that came up during discussions, and non-verbal communications in the form of body language. I later translated these to field notes and included them in a written database for analysis. My intention in this process was to gain a holistic perspective of the data in the form of insightful interaction patterns between myself and each participant during discussions.

After each interview I thanked each participant and reiterated the study progression stages, my contact details, and methods of accessing the final report. I consulted with my supervisors on issues pertaining to the data collection process after each interview to ensure the trustworthiness of this process. Following this process, the data I collected from the last two interviews did not provide any new information regarding the study phenomenon and I then terminated data collection at the 10th interview.

d) The pilot study

Following the human research ethical approval process by the University of New England Human Research Ethics Committee in January 2010, I completed a pilot study of the interview questions involving a physiotherapy clinical leader and the results were not included in the main study in May 2010 as part of preparation for the main study. Consistent with Roberts' (2002) and Sampson's (2004) recommendations, I carried out the pilot interview to test the appropriateness of the interview questions and to refine the interview skills of the researcher. Sampson (2004) argues that the use of a pilot project in research ascertains the demands and quality of qualitative data in terms of interview questions, time, physical, and fiscal resources. I selected this participant for the pilot study because of her appropriateness in meeting the sampling inclusion criteria and she was conveniently accessible to me. Furthermore the process was completed pursuant of Schneider (2004) and Silverman's (2001) advice regarding use of pilot studies. These authors advise researchers to employ pilot studies as a guide to identify potential problems and to improve the interviewing process's reliability through pre-testing. In doing so the process helps to ensure that study participants understood the intended meaning of the questions and the researcher understands the participants' answers. During this process, I slightly altered open-ended introductory questions to reflect the professional orientation of the participant.

At the end of this pilot interview, I asked for feedback regarding interview time allocation, appropriateness of the flow of the interview, and if the questions were relevant to the purpose of the study. The feedback I received showed that the interview

questions were relevant to the study purpose. Furthermore the interview process managed to generate rich data in terms of appropriateness and providing an in-depth discussion because of the semi-structured nature of the interview questions. In this pilot study, I sent a draft copy of the written transcript to the participant to obtain feedback. The feedback I received was consistent with the purpose of the pilot study and I made no further changes to the interviews or interviewing process.

e) Individual semi-structured interviews

In this study, I employed semi-structured in-depth individual face-to-face interviews to investigate the phenomenon of working as an OTCL. I encouraged participants to talk about their experiences through use of open-ended questions and having each participant complete the consent form (Appendix D). I ordered further questions as was determined by their responses. I utilised the same open-ended introductory questions for all interviews but changed clarifying questions according to the responses provided by individual participants. Similarly literature links use of in-depth interviews in phenomenological inquiries as data collection tools to depth, vividness and richness in data collection (Rubin and Rubin 2005). Also, Alvesson (2003) and Kuhn (2006) portray interviews as symbiotically constructed social discourses, whose data is co-produced. In this respect, both the participant and researcher are a vital part of the process.

In this study, I offered each participant the opportunity to choose their own pseudonym that was used during interviews as advised by Atsalos, O'Brien and Jackson (2007) and

Smith & Osborn (2008). In this instance, the use of self-selected pseudonyms by study participants facilitated a spirit of openness and collaboration, and enabled the reciprocal balancing of power between myself and participants. The interview lasted between 60 minutes to 120 minutes. A convenient interview schedule was negotiated with each participant. No additional follow-up interviews were needed during this process. I asked the following open-ended questions to all study participants as a guide and follow-up to seek further clarification as needed in a non-judgemental and open way. In this process, as an experienced person-centred therapist, I rephrased follow-up questions when the participant was unsure about how to answer. In addition I prompted participants to give full descriptions, with examples and repeated questions when necessary. Smith & Osborn (2008) regard the process of managing power relationships between the researcher and respondents by using constant clarification as a sound interviewing technique.

Open-ended questions:

- May I find out the reasons that have prompted you to volunteer to participate in this study?

- What have been your experiences of working both as an OTCL and an occupational therapist?

- Tell me what it means for you to be an OTCL?

- What opportunities and challenges do you encounter in your role?

Semi-structured questions:

- Have you a sense of the relative importance of the things in your workplace, which mostly contribute to the opportunities and challenges in your role?

- In the case of things that present challenges in your role, how can these be maintained and by whom?

- In the case of things that present opportunities in your role, how can these be maintained and by whom?

- What recommendations about your role do you make to: a) employers, and b): existing and future OTCLs?

- Do you have any other issues pertaining to your role that you may want to bring to the discussion?

f) Recordings

At the beginning of each scheduled interview, I gained permission from all participants for audio recording to be made and to write down some key points (see Appendix A). Wengraf (2001) advises the researcher to employ recordings during interviews to capture the data appropriately and to reduce the need to take notes. In this study I used a small, comprehensive, reliable, hardly noticeable, voice-sensitive audio-device to record interviews. This device allows 261 hours of continuous play with dual plug-in power and battery-operation, an in-built microphone and a headphone connection. Other device features include the rewind, fast forward, erase, pause, stop, volume adjustment, USB enabled, display menu and ability to divide audio-files. Common concerns from the participants with recording interviews identified by Minichiello et al.

(2000), such as nervousness, vulnerability or any other behaviour indicative of being uncomfortable, were not evident with any of the interviews. The recordings from all interviews were audible and of very high quality. I completed all the transcription of all interviews verbatim using speed-controlled playback and a set of plug-in ear-phones and power, which enabled me to produce a large high-quality written database for data analysis.

g) Field notes

During the interviews, I wrote down key points and summarised on viewpoints and personal emotions regarding the interview process using some key verbal descriptive phrases as raw data. Then I completed additional comments regarding the process immediately after each interview. Following this write-up process, I destroyed by shredding the original raw data that was collected during interviews. However, ethically there is a requirement for me to store such data at the university for five years after the study's completion. Briefly, these key points constituted the researcher's written field notes that I obtained apart from the audio recording.

h) The researcher's journal

As recommended by Burnard (2005) and Marshall and Rossman (2006), I kept a journal of events that assisted me to reflect on each interview and themes as they unfolded during the simultaneous process of data collection and analysis. In this journal I recorded observations about the process of negotiating the study in the organisation, recruiting participants, location of interviews, personal feelings, and impressions about

the interviews, interactions and observations. This journal also served as a data collection tool. In this context, the journal enabled me to re-examine previous experiences by attending to personal feelings and impressions about the study process. Also, it provided a forum for reflection on the subject under study. Furthermore, reflection on personal feelings, impressions and attitudes of the data helped to situate me in the study.

In this context, the journal examined my pre-understandings of the topic and a record of activities undertaken after each interview, field notes completed during and after each interview, personal emotions and expression of the data collection and analysis processes, and my interviewing techniques. Specifically, it was punctuated by phrases such as: 'Did any new concepts emerge?' 'Did I probe the issue adequately and appropriately?' 'Did I manage to meaningfully engage the participant?' 'I am on track!' I completed these entries immediately after each interview to enable an accurate recall of events as they transpired during interviews.

During the data analysis and interpretation of field notes and audio recorded data, I revisited initial experiences and attended to personal feelings experienced at the time. I consciously recollected good experiences and attended to pleasant aspects of the experiences. This process allowed me to situate any meanings that arose from the reflection process and kept me motivated and focussed on the study. In addition, I re-examined the study findings in conjunction with the purpose of the study, field notes and journal writings. I then integrated these findings into this study to assist me to draw

major conclusions, recommendations, implications for policy and practice, future research directions and limitations, and study limitations and their mitigation.

3.12 Balancing the research context by considering the parts and the whole

The Staged Approach of Interpretive Phenomenological Analysis

Within occupational therapy IPA paradigms, researchers are compelled to collaborate with participants in order to identify and interpret relevant meanings in a manner that resonates with the study phenomenon (Clouston 2012; Smith 2004; Smith & Osborn 2008). Consistent with Smith et al.'s (2009) suggestion regarding the fact that sample size is contextually between 4 to 10 participants for professional doctorates, I embraced IPA's idiographic commitment in terms of sample sizes, transparency and commitment, and trustworthiness, which ensured an interpretive and in-depth analysis. From this viewpoint, I utilised IPA in this research study, which was a three-stage interpretation process, to make sense of the participants' lived experiences based on their interpersonal and intrapersonal perspectives. Smith (2011:10) and Smith & Osborn (2003:51) termed it 'double hermeneutic' because the process involved a dual interpretation as shown below.

I chose to employ IPA, a primarily interpretive framework that has theoretical underpinnings in Heidegger's (1962); Gadamer's (1975) and van Manen's (2001) hermeneutic phenomenology (Smith, 2007; 2010), to understand and interpret the participants' perspectives in terms of meanings inherent in the scope of working as an OTCL in the dual role. To meet this purpose, firstly I needed to demonstrate fluency

and adeptness at some complex skills such as analysis, interpretation and writing, to meet quality control criteria in IPA to allow evaluation and an independent audit. I developed these skills by reviewing a range of research studies that employed the theoretical framework as part of data triangulation, which was monitored in supervision. Secondly, as advised by Smith (2010) there are a set of research steps that needed to be made in the appropriate order. As shown later in this section, I was flexible in adopting these steps, whilst I kept a balance between strictly following these steps and achieving flexibility. In doing so, I interrogated data collected by asking relevant questions specific to the meaning of events, participants' lived experiences and their viewpoints about the phenomenon. Smith (2004:8) portrays this as 'good enough interpretation'.

After all the data had been collected, I immersed myself first with the data by reading several times all data collected from the field and all the transcribed data in the form of transcripts 1 to 10, as well as listening to the audio-recordings. In this study, I transcribed raw data and re-read it while reflecting on the themes inherent within them. The resultant interview data and field notes were prepared into written data sheets to enable data analysis. As shown in Appendix F, I firstly moved backwards and forwards from the text, from the details of the whole and from the whole to the details, by re-immersing myself from one transcript to the next, in order to understand the subjects' lived experiences. This iterative and non-linear process was between and across participants' perspectives as described by Clouston (2012); Campbell and Morrison (2007); Fade (2004); Smith (2004), and Smith & Osborn (2003). The thrust in the

second stage of the IPA was in organising data into themes and identifying patterns or relationships among themes as suggested by Smith & Osborn (2003; 2008).

The idea of the hermeneutic circle and fusion of horizons (Heidegger 1962; Gadamer 1975) informing the initial data analysis stages, allowed me to respond to the research questions and to meet the purpose of the study. As previously stated, the research questions were: "Are there shared or common experiences among participants? If so, what are these common issues?" In doing so I was able to establish patterns across participants' rich and divergent viewpoints about the study phenomenon. In this situation I employed a double hermeneutic analysis to uncover and connect emerging themes from the data. These emerging themes were ink-coded in the written transcript to represent similar themes. Consistent with Reid, Flowers and Larkin's (2005) and Yardley's (2008) perspectives regarding IPA's commitment to ideography, I also used some key words or catch-phrases on the left-hand margin of each transcript to represent these emerging categories of themes.

In the second stage, this process was repeated for each interview to form links and connections between these different data sources. Then I constantly compared and contrasted these links and connections in search of both patterns and new emergent themes. The result of this second stage of analysis was a list made up of super-ordinate themes that I developed and collated into a working table of themes provided in Chapter Four.

As Clouston (2012); Cooksey and McDonald (2011); Newton, Larkin, Melhuish and Wykes (2007); Reid et al. (2005); Smith (2011), and Smith & Osborn (2008) suggest, the final stage of the analysis process involved translating the generated themes into narrative perspectives in order to demonstrate the analysis and interpretation. In Stage Three, as detailed in Chapter Four, I extended the second stage results to provide a systematic interpretation of these themes that were sub-divided into sub-themes supported by sufficient verbatim extracts from participants and literature reviewed in Chapter Two to illustrate both convergence and divergence in how the themes manifested. This stage of analysis was described by Dick (2003:49) as one of attempting to 'show magic and effort' by using verbatim extracts, which leaves the analysis open for evaluation and validation by readers. It was incumbent to produce an indisputable analytic report that was rigorous in terms of commitment, transparency, and was persuasive. Pursuant to the above stages and recommendations, it is my belief that I was able to produce a sustained, coherent and evidenced analytic report, which creates an avenue for the reader to follow the decision trail. This interpretive stage also assisted me to draw and discuss major study conclusions and to discuss implications for OTCLship policy and practice in the final chapter of this thesis.

3.13 Quality in the research process

I have now presented and discussed data collection and analysis tools appropriate for this study. In the next two sections I will discuss strategies needed to ensure that the research showed commitment and transparency, was credible, persuasive and trustworthy. Then I will identify and address relevant ethical issues.

a) Rigour

Rigour in interpretive phenomenology research is a controversial topic in the literature because of arguments over philosophical interpretation and a recurring discourse to express fully the criteria in use across social science disciplines and authors (Hope & Waterman 2003; LeVasseur 2003; Rolfe 2006; Sandelowski & Barroso 2002; Turner 2003; Whitehead 2004). In this discourse, Hope and Waterman (2003) seek a reconceptualization process of validity by pointing to the existence of multiple phenomenological paradigms, with each one of them requiring a unique approach to justify the validity of study findings. Yet, LeVasseur (2003); Rolfe (2006); Sandelowski and Barroso (2002); Turner (2003) and Whitehead (2004) stress the value of pedagogy in expressing quality and validity within qualitative research studies. Simply put, the process and essence of writing brings out the concept of quality and validity in qualitative research studies. The mere absence of consensus on evaluation of rigour within phenomenological research paradigms underscores the importance of defining quality, validity, and trustworthiness needed to justify the significant contribution of qualitative inquiries to sound research evidence.

In this study, the rigour of a hermeneutic phenomenology occupational therapy research is an important issue that has direct implications for the legitimacy of the literature that defines and informs occupational therapy practice, policy issues, methodological appropriateness, publication and knowledge transfer. de Witt and Ploeg (2006) and Bryman (2001) simplified the value of use of rigour in interpretive inquiries, by describing rigour as a process of assessing trustworthiness of a research study using a

set of criteria advocated by some writers for assessing its quality. As Smith (2011) suggests, there are no indisputable criteria to enhance the rigour of qualitative research but careful consideration should be taken by researchers when employing interpretive phenomenological research in order to provide new knowledge concerning people's interpretation of their experiences acceptable to the professional audience. As Creswell (2007) posits, researchers should engage in at least two methods to enhance rigour. In this research I utilised five methods to enhance the trustworthiness of the study findings based on Sandelowski and Barroso's (2002) generic framework on qualitative criteria of rigour. The criteria I used in this study reflect data credibility, fittingness and auditability.

Firstly, I employed member checking in this study to reassure participants regarding the processes of data collection and data analysis. Following Kvale (2006) and Dearnley's (2005) advice, I sent back draft interview transcripts to the participants to enable verification. This process allowed an opportunity for editing of the draft interview transcript and enabled the researcher to check on correct representation of the views of study participants. Kvale (2006) and Dearnley (2005) in their research encountered problems such as participant's distress and shock after reading one's own interviews when un-edited transcripts were sent back to participants for verification. However, this was not the case in this study. Instead, employing member checking minimised these potential problems and improved the credibility of collected data. Fleming, Gaidys & Robb (2003) and Maggs-Rapport (2001) recommend member checking as sound research practice that increases the validity of study findings.

Secondly, reflexivity was the second test I employed in this study to help ensure rigour and trustworthiness of the findings. Finlay (2006) and Olesen (2000) link reflexivity as a rigour and trustworthiness strategy that is central to every qualitative inquiry. Following this perspective, I described my pre-understandings regarding the study phenomenon in the first chapter. Jackson, Clare & Mannix (2003), based on their observations during qualitative inquiries, the process of reflecting on one's own biases, beliefs and values enables the researcher to use this self-knowledge as a resource during the study's data analysis.

Furthermore, Butler et al. (2009); Cook (2001); Finlay (2003); Kahn (2001); Koch & Harrison (1998) and Smith (2010) recommend that personal and methodological reflexivity should be included as an element of every investigation, and that without it the validity of the research could be undermined. In this study, I explained my own prejudices in relation to the study phenomenon by conceptualising it as a significant research strategy, which improved my understanding of the collected data. In addition to the process of data collection explained, I also kept a journal of personal experiences that pertained to every key stage of the research process. By doing so, I used the reflective journal as an additional data collection tool, which enabled me to re-examine my own presuppositions regarding the research inquiry.

During the stages of data analysis, I constantly reflected on these personal prejudices and explained these in the context of the study findings. The data collection process

using the journal enabled me to consciously recollect good experiences and to attend to pleasant aspects of the experiences. By doing so, the process allowed me to situate any meanings that arose from the reflection process and kept me motivated and focussed on the study. In addition, I was able to re-examine the study findings in conjunction with the purpose of study and research questions. Following the reflection process, I was able to draw major study conclusions and discuss these in relation to implications for both policy-making and practice involving OTCLs. Also areas for future research directions were identified.

Thirdly, data triangulation was employed when double-checking the data collection and analysis processes by engaging the two project supervisors to strengthen the credibility of the study as advised by Crist and Tanner (2003); Patton (2002); Turner (2003) and Whitehead (2004).

Patton (2002) and Turner (2003) identified four different types of triangulation involving: data triangulation, investigator/analyst triangulation, theory triangulation, and methodological triangulation. The process of data triangulation was further described as the use of several different evaluators. In view of Crist and Tanner's (2003) and Whitehead's (2004) recommendations on the decision-making trail, I firstly employed a methodological triangulation involving van Manen's (2001) thematic analysis to guide the identification of research methods and design, and IPA (Smith 2004) to interpret findings. This process required an intensive qualitative analysis of detailed personal perspectives derived from purposively sampled 10 participants using

in-depth semi-structured interviews. In this manner, I was able to strike a balance of convergence and divergence within this sample, presenting their shared viewpoints and analysing patterns of relationships between these perspectives. Smith (2011) associates methodological triangulation with validity, as a measure of impact and importance, trustworthiness and commitment, transparency and coherence of findings in interpretive phenomenology. To this end, I demonstrated my commitment to analyse and interpret in detail, each lived experience and patterns across participants' lived experiences as OTCLs. I then employed investigator triangulation in this study by involving the two project supervisors as part of project supervision and myself to independently analyse sampled data involving four interviews, after which the findings were compared to ensure rigour in the chosen data analysis method and that no major themes had been missed. There were no major differences in the categories that were developed from the sampled data. All those involved agreed on the themes and the transparency of the selected data analysis method.

I also purposively sampled 10 participants to take part in this study, in line with the adage less is more in interpretive phenomenological analysis (Yardley 2008), which allowed me to provide a detailed analysis and interpretation of each participant's lived experience. By following these stages, I enhanced the credibility of my study findings.

Lastly, adequacy and appropriateness of data was another strategy I used to ensure the trustworthiness of the findings as recommended by Bryman (2001); Denzin & Lincoln (2005) and Silverman (2005). Denzin and Lincoln's viewpoint on adequacy is in the

context of the amount of data collected rather than the number of participants.

According to Denzin and Lincoln (2005) adequacy is achieved when data reaches a

saturation point and variation is both accounted for and understood. On the other

hand, appropriateness refers to the selection of information that meets the purpose of

the study (Denzin & Lincoln 2005). In this study, I selected participants based upon

their professional background and work experiences as OTCLs, which helped to ensure

that they were able to contribute useful information on the study phenomenon. I

terminated the data collection process when saturation was achieved, implying that

further interviews were not generating new information.

In addition the IPA I employed to uncover and interpret participants' perspectives of

the study phenomenon that was latent in the data as compared to the use of a template,

involved an interactive and a non-linear process that resembled characteristics of the

thematic analysis and establishment of higher order themes that allowed me to make

theoretical connections. By utilising both thematic and IPA in this study, I employed

theory triangulation to improve the credibility and trustworthiness of findings. Butler et

al. (2009) described theory triangulation as a process in which more than one

framework is applied in the interpretation of the study phenomenon. This process also

ensured the trustworthiness of my study findings because it assists readers with

following the decision trail as shown in Appendix F. Finally I explicated my pre-

understandings on the study phenomenon as given in the first chapter in line with the

chosen methodology (Heidegger 1962; Smith 2004; van Manen 2001).

b) Ethical considerations

Addressing ethical issues which may arise as a result of research is regarded as sound research practice within occupational therapy phenomenology research (Clouston 2012; Denzin & Lincoln 2005; Reid et al. 2005). According Brooker (2002:121), ethics is: "the study of the code of moral principles derived from a system of values and beliefs and concerned with rights and obligations". When research involves human participants, as Pollit and Hungler (1997) assert, ethical approval must be gained from an ethics committee of the institutions involved and participants' informed consent is an integral part of the investigation. In addition, it is important to ensure the credibility of the study findings by adhering to anonymity and confidentiality issues involving the participants' identity and the storage of volunteered data by following strict human research ethical guidelines as outlined by respective Human Research Ethics Committee guidelines. Given the importance of these ethical guidelines, I adopted several ethical principles for this research study to achieve these objectives.

Firstly, the research proposal for this study was submitted to the two Human Research Ethics Committees for verification. Subsequently, the University of New England Human Research Ethics Committee's approval no: HE09/206 for the study was granted on 04/01/10 (Appendix E). For individual research sites' Human Research and Ethics Committees, best practice guidelines were followed; approval was sought and granted. Following this process, I then considered the following potential ethical situations, pursuant to the Australian Health Practitioner Act's (2001) ethical standards, that were likely to arise during and after the study and implemented relevant remedial strategies.

i) Non-cohesion and non-manipulation

The principle of justice (House 1990; Sieber 1992) that states that researchers should ensure a reasonable, non-exploitative and carefully considered procedure and fair administration to potential participants, was applied when accessing study participants. Once the individual Study Site Approval was granted by respective study facilities I sent out invitation packages that included prepaid return mail to potential participants using their respective Occupational Therapy Departments requesting those interested to make direct contact with me (Appendix A, B & C). Also a reconfirmation email was sent to each participant three days prior to the interview. At the beginning of each interview I started by restating the study aims and objectives and attended to other housekeeping issues relevant to the study. Also in all instances, with the exception of an oversight that occurred during the first interview, I prompted participants to briefly outline factors that motivated them to volunteer their participation in the study.

ii) Informed consent

In view of being a potential participant in a research study, individuals required sufficient information to enable them to make an informed decision on whether to participate or not. According to Dearnley (2005:26) informed consent is: "the voluntary and revocable agreement of a competent individual to participate in a therapeutic or research procedure based on an adequate understanding of its nature, purpose and implications". In this study, I applied the principle of mutual respect (House 1990) and the right to individual privacy to seek participants' consent. Within qualitative

inquiries, Butler et al. (2009) emphasised the importance of researchers to understand their potential informants' aims and interests in order to safeguard their self-esteem and respect.

Nevertheless, Esner (1991) and Shiri (2006) argue that truly informed consent is impossible in qualitative studies because events in the field and the researcher's actions such as following up new and promising leads cannot be anticipated. In this thesis, I therefore considered informed consent to be an ongoing negotiated process between myself and each participant. Initially, I provided potential participants with written consent to being involved in the study. This consent process was voluntary and freely given. Participants were given time to read the information and to request any further information or explanations if they so wished. Sufficient information was provided so that participants could give informed consent to take part in the study.

A Consent Form for Participants (Appendix A) was signed prior to the commencement of data collection after I had explained the study aims and potential benefits of involvement. Furthermore, each participant read the information sheet and had questions answered to her satisfaction prior to signing the consent form. In this inquiry, the Information Sheet for Participants (Appendix B) and the Consent Form for Participants (Appendix A) stipulated that participants had the right to refuse to answer any particular questions during the interview by remaining silent, requesting not to be audio-recorded, withdrawal of consent without giving any reason, and that their line manager was unaware about who took part in the study. At one of the research sites, a

potential participant exercised this right by withdrawing participation after initially giving consent without explanation for the action. She did not experience disadvantage of any kind.

iii) Anonymity and confidentiality

Roberts and Taylor (1998) suggest that the researcher should build appropriate procedures to protect the anonymity of the participants and protect data from unauthorised access. The principle of respect (Sieber 1992) was applied with the aim to protect the autonomy of persons. Assurance was given that anonymity and confidentiality would be maintained at all times. I used pseudonyms to replace participants' real names and place names according to participants' consent and preferences throughout all written and reported documentation. Audio recorded and interview data is being kept in a locked cabinet for a period of five years from the date of approval of the research, after which it will be destroyed. Only the researchers have access to the data. At the end of the study, I destroyed all raw data with personal information about the participants. In this study, I also avoided collecting information that had potential to identify study participants such as age, names of places, and the employers' names. Prior to each interview I complied with the ethics approval guidelines by being a signatory to Appendix A.

iv) Beneficence and humanity

Mathieson, Ross & Cornett (1992) emphasise the need for researchers to ensure that the information is used based on the pre-study agreements between the researcher and

participants. In this study, I applied the principle of 'beneficence' and 'humanity' by adhering to content of the Information Sheet for Study Participants (Appendix B) and Consent Form for Participants (Appendix A) pertaining to use and management of information collected from participants during and after the study.

3.14   Conclusion

In this chapter I provided an overview of the hermeneutic phenomenology both as a philosophical and a practical guiding framework to the research design and methods. Firstly, I discussed key concepts of the abstract hermeneutic phenomenology as informed by Heidegger (1962) and Gadamer (1975) in relation to the investigation of human experience. This was the case because researchers who ascribe to the philosophy of phenomenology have failed to provide an indisputable phenomenological method in an objective sense, and on this basis it was not an easy task to achieve in this study for the researcher. As recommended by van Manen (2001), it was instead my task as the phenomenological researcher to seek and make available a phenomenological research method that was consistent with the abstract philosophy.

Following this argument, I then justified the inclusion of Heidegger's (1962) and Gadamer's (1975) philosophical framework in its abstract state in relation to the investigation of the OTCL working world by undertaking a critical review of previous phenomenological occupational therapy research. This process helped to set the foundation for adopting van Manen's (2001) hermeneutic phenomenology as a practical guide to the study's research method and design and Smith's (2004) IPA to understand

and interpret participants' perspectives. I chose van Manen's (2001) hermeneutic phenomenology's six research activities to identify and describe research methods and design, and Smith's (2004) IPA to understand and interpret the lived experiences of study participants because they are consistent with the abstract philosophical framework and were most appropriate to interpret the research findings.

Specifically I first pilot tested this method to examine the appropriateness of the interview questions, its ability to respond to the research questions, and to meet the purpose of the study. In addition, employing this method allowed me to explicate my pre-understandings with regard to the study phenomenon. I was also able to describe the process of recruiting study participants and their characteristics and to describe interview settings, which enabled me to fully understand the process of data collection and to interpret the findings. Then I was able to address the study rigor and ethical issues that presented during the research process and their mitigation, which improved the trustworthiness of study findings. In the following chapter I presented the IPA trail and emerging themes and their interpretation in view of literature reviewed in Chapter Two.

Chapter Four

Interpretive Phenomenological Analysis

4.0   Introduction

In this chapter, 10 participants' perspectives of their working experiences as OTCLs are explored in the form of themes. This chapter sought to provide answers to the following two research questions and address the three study aims, from the participants' perspectives: "What are the experiences of working as an OTCL both in terms of the clinical and managerial components of the role?" and "Are there common or shared experiences among participants? If so what are these common issues?" The purpose of this study was firstly to describe and interpret lived experiences of OTCLs in terms of the dual clinical and managerial roles and responsibilities to facilitate understanding of such individual OTCLs. Secondly, to articulate common issues that were experienced by OTCLs who were involved in this research. Then, to make information available for future practice and policy formulation, pertaining to the OTCLs' role.

The first section of this chapter provides a justification for the interpretive phenomenological analysis method, demographic analysis, and statistics as a guide to the reader about the decision trail utilised to draw themes on the basis of collected data. The exploration of data using an interpretive phenomenological analysis (IPA) (Dean, Smith and Payne 2006; Smith 2004) led to the generation of themes. The themes are not discrete entities and can include some overlaps (Denzin 2005). Five themes and thirteen sub-themes emerged from the IPA with the aim of describing and interpreting

the participants' viewpoints. The outcomes are discussed in conjunction with contemporary research and literature evidence drawn from Chapter Two as advised by Clouston (2012); Cooksey and McDonald (2011); Smith (2004) and Reid, Flower and Larkin (2005). Cooksey and McDonald (2011:531) assert that:

> "It is now common practice to combine results and discussion … the discussion aspect of this chapter should focus on interpretation, and not on drawing of conclusions, generalisations, speculation or implications. What you want to accomplish is to display the meaning of what you have learned to the reader",

whilst Dean et al. (2006) and Reid et al. (2005) underscore the importance of this form of analytical interpretation in IPA research as vital in gaining useful insights in the data specific to allied health, which can result in wider relevant implications to findings.

By following the process of providing verbatim extracts supported by literature reviewed in Chapter Two, my intention was to create a pathway for the reader to follow. The first four themes and ten sub-themes that emerged from this study addressed the first two study aims and research questions. The last theme, Theme 5, Strategies for the future, and corresponding sub-theme 5.1: competencies needed, sub-theme 5.2: clarity in form of practice jurisdiction, and sub-theme 5.3: setting realistic goals, addressed the third study aim. Briefly the emerging five themes and 13 sub-themes that are supported by verbatim extracts and literature reviewed in Chapter Two, describing the scope of the OTCL role are: Firstly, the scope of the role in terms of tensions and power struggles; secondly, implications of the dual nature of the role in terms of meanings based on participants' working experiences in the clinical and managerial components; and thirdly, challenges in the form of lack of clarity in the

practice boundaries and expanded roles and responsibilities, which resulted in having unmet workload demands. Participants also identified existing opportunities in terms of having access to both formal and informal organisational support. They indicated there was a vital link between senior management and clinical settings, which provided a key stepping stone for them into opportunities for promotion. Finally, the participants suggested some strategies for coping with dual roles such as skills, role clarity and some structural reforms to ensure that adequate positional authority was achieved to get the job done.

Data emerged from interviews with each participant, plus the researcher's field notes and reflective journals. These field notes and reflective journals described and re-constructed the researcher's experiences of the process in a manner consistent with Gadamer's (1989) viewpoint of *fusion of horizons,* Heidegger's (1962) *hermeneutic circle* process and Smith's (2004) IPA, which acknowledges the researcher's presence and influence in the research process. This facilitated some specific interpretation of participants' stories where it was appropriate.

4.1   Justification of the Interpretive Phenomenological Analysis technique

Denzin and Lincoln (2005) described qualitative research methods as a way of understanding any phenomenon about which little is yet to be known, by gaining new perspectives on things about which much is already known or gain more in-depth information that may be difficult to convey quantitatively. As Patton (2002) points out, the particular design of this hermeneutic phenomenological study depended on the

purpose of the inquiry and the nature of information that I regarded as both important and the most credible to respond to the research questions.

In order to understand social actions, researchers must grasp the meaning that actors attach to their actions by seeking to 'gain access to people's common-sense thinking and interpret their actions and their social world from their point of view' (Bryman 2001:14). There are no methods according to Denzin and Lincoln (2005) and Patton (2002) that are agreed upon for data analysis in phenomenological studies in order to draw conclusions and verify their strength. It has also been stated that there are no absolute rules except for researchers to do their best to represent the data and communicate what it revealed, given the purpose of the study. In view of this argument, Boucher (2001); Finlay (2006) and Moran (2000) advised researchers of the importance of describing the manner in which research findings will be represented from the outset of the research process. This, according to these authors, is vital because the process of exploring alternative forms of data representation in an academic context is a political act, which challenges long established and revered traditions.

In this data analysis section, before opting for IPA, I first considered another research method, storytelling or narrative analysis (Welch 2001). This approach seeks to gain access to the lived world of the participant's personal experiences using stories. However, I discarded the narrative or story telling approach, an emerging field, because it does not provide concreteness (Wertz, 2005). Wertz (2005) posit concreteness in terms of key qualities in the data that are able to describe details about the person's

lived situation rather than an abstract view of the experience. In this study, as Larkin, Watts, and Clifton (2006) suggest, I was looking for a data analysis approach that involved an ongoing cyclical process required to integrate into all phases of the project beginning with interviews. This approach could also give voice and make sense of the phenomenological interpretation process by examining the transcriptions, including participants' verbatim extracts, and categorising emerging themes through a process of analysing and grouping the data, to address the aims of the study.

Following Briggs' (2010) representation of findings from an exploration of lived experiences of Australian health services managers in their role, plus Cooksey and McDonald's (2011) recommendations, this study's findings are represented in the form of themes that are constantly punctuated by verbatim extracts and literature evidence reviewed in Chapter Two.

The data were analysed using an IPA (Dean et al. 2006; Smith 2004; Smith & Osborn 2008). As Butler et al. (2009); Clouston (2012); Dean et al. (2006); Denzin & Lincoln (2005); Smith (2004) and Neuman (2006) postulate, I employed this approach to uncover the knowledge that was latent in the data regarding the lived experiences of working as an OTCL, rather than applying a template through which it was examined or tested. In this manner, the approach shared many of the features of thematic analysis (van Manen 2001) and was consistent with the central ideas of the abstract hermeneutic phenomenology (Heidegger 1962; Gadamer 1975).

Equally important, IPA acknowledged my presence and influence in the research process as the researcher, in a manner that is philosophically consistent with the person-centred nature of occupational therapy. Smith (2011) postulates that there is a noticeable gap in the IPA health related literature at present and underscores that IPA has much to contribute to the understanding of a lived experience. As previously stated, the approach involved a thorough and intensive engagement with the data. It consisted of preparing a written database containing all collected data (field notes, observational notes, OTCL position description, researcher's reflective journals and interview transcripts), shifting and classifying it in numerous ways whilst looking for themes and ideas as advised by Butler et al. (2009); Clouston (2012), Smith (2004) and Smith & Osborn (2008), to translate these into a narrative account of the phenomenon of working as an OTCL.

The process was iterative and non-linear as described by Bouma (2000); Charmaz 2006; Clouston (2012); Minichiello, Aroni, Timewell and Alexander 2000; Smith 2004; Smith and Clayton 2009, and Smith & Osborn 2008). In its presentation the data analysis followed van Manen's (2001) suggested framework for thematic analysis and Clouston (2012) and Smith's (2004) IPA, Boucher and Holian's (2001) and McMillan and Schumacher's (1997) analytic induction and further advised by Colaizzi (1978), Miles and Huberman's (1994) coding and classification process. Kvale (2006) referred to this classification as meaning categorisation. What emerged needed to be validated by participants in the form of returning of copies to confirm if they were authentic. The

researcher did not seek validation from the participants other than their confirmation of authenticity of the transcribed interview.

Interpretive phenomenological analysis began during data collection, which allowed me to refine interview questions and to pursue emerging issues, as suggested by Smith (2004). As advised by Campbell and Morrison (2007), the thrust in this analysis was to organise the data into themes and identify patterns or relationships among themes. After all the data had been collected, the researcher immersed himself by reading several times all data collected from the field and all the transcriptions, plus listening to the audio-recordings. This practice gave me a holistic perspective of the data. This stage of analysis was described by Merriam (1988:151) as: "one of holding a conversation with the data, asking questions of it (sic), making comments and so on".

In a related viewpoint, Heidegger (1962) attributed this process of phenomenological data interpretation as a hermeneutic circle. I obtained themes by constantly comparing and contrasting gathered data. This process allowed me to build thick descriptions and interpretations, themes and sub-themes, which had direct relevance to the study phenomenon (see Appendix F). I then constantly compared and contrasted the different themes over a long period. This was done to identify relationships or differences that existed between themes. During this process new themes emerged, and some existing themes were combined or discarded.

In this study, analysis began in the field in a similar manner to Briggs (2010), when I consulted my research supervisors regarding the main themes that appeared to emerge immediately after each interview, but the overall analysis was done after all data were collected and transcribed. An independent analysis of some of the transcribed interviews was undertaken by one of the supervisors before the analysis was discussed with and provided to both supervisors. This approach was utilised as a core supervision session. The purpose of the ongoing data analysis was to determine the stage at which saturation was reached and at that point data collection was terminated. In this study I transcribed all the audio-recorded data and compiled the notes obtained from the field in the form of a reflective journal.

After the establishment of new relationships between themes I then drew conclusions from the data, determined the implications of the findings, and made recommendations in line with the purpose of the study. Data were collected until saturation was reached, implying a data collection stage involving development of a strong sense of the experiences of study participants regarding the phenomenon. In this study data, saturation was reached in the 10th interview and after consulting with project supervisors, data collection was terminated. Themes identified at this interpretive stage acknowledged that the essence of working as an OTCL is a complex phenomenon that was not only challenging but presented multiple opportunities, whose future needed some particular competencies, structural, and practice changes. As previously stated in section 3.8, I did not return the themes to the participants for comments. However, Following Kvale's (2006) and Dearnley's (2005) advice regarding study rigour, I

employed member checking. I sent back draft interview transcripts to the participants to enable verification, which allowed an opportunity for editing of the draft interview transcripts and tracking the correct representation of the views of study participants.

4.2   Analysis of demographic data

In Table 1 below, a summary of the participants' pseudonyms, ranges of work experience, work setting and gender is provided. A total of 10 practising OTCLs participated in the study. Four of these had worked as occupational therapists in various capacities for more than 16 years and the remaining six had occupational therapy work experiences ranging between 5 and 15 years. All participants at the time of study were employed as OTCLs in their respective fields of professional expertise of physical or mental health occupational therapy work settings. Eight of the participants practised in physical settings and only two were in mental health. Study participants' viewpoints captured their lived experiences and are presented in this chapter as themes with supporting quotations. However these themes were not discrete entities but had some overlaps as they captured the scope and notion of working as an OTCL both in terms of clinical and managerial components.

Table 1: Demographic Data

Interview	Work Setting	Name of Participant (pseudonym)	Years of OT experience		Gender
			5-15	16+	Female
1	Physical	Daphne	●		●
2	Mental health	Marcia		●	●
3	Physical	Rosie	●		●
4	Physical	Chloe	●		●
5	Physical	Isabelle		●	●
6	Physical	Lillian	●		●
7	Physical	Anna	●		●
8	Physical	Jo	●		●
9	Mental health	Sophie		●	●
10	Physical	Clara		●	●

4.3   Overview of study themes

Five themes and thirteen sub-themes around the scope of the OTCL role emerged from the research findings in response to the research questions on the phenomenon of working as an OTCL presented as follows:

Theme 1: Scope of the role

> **Sub-theme 1.1**: Existing tensions.
>
> **Sub-theme 1.2**: Power relationships.

Theme 2: Implications of the dual role

> **Sub-theme 2.1**: Participants' perspectives of clinical work experiences.
>
> **Sub-theme 2.2**: Participants' perspectives of managerial components.

Theme 3: Multiple challenges of the role

> **Sub-theme 3.1**: Lack of key team leadership and management competencies.
>
> **Sub-theme 3.2**: Lack of clarity in practice boundaries.

Theme 4: Opportunities

> **Sub-theme 4.1**: Career advancement.
>
> **Sub-theme 4.2**: Vital link between corporate and clinical worlds.
>
> **Sub-theme 4.3**: Stepping stones to full-time health care management.
>
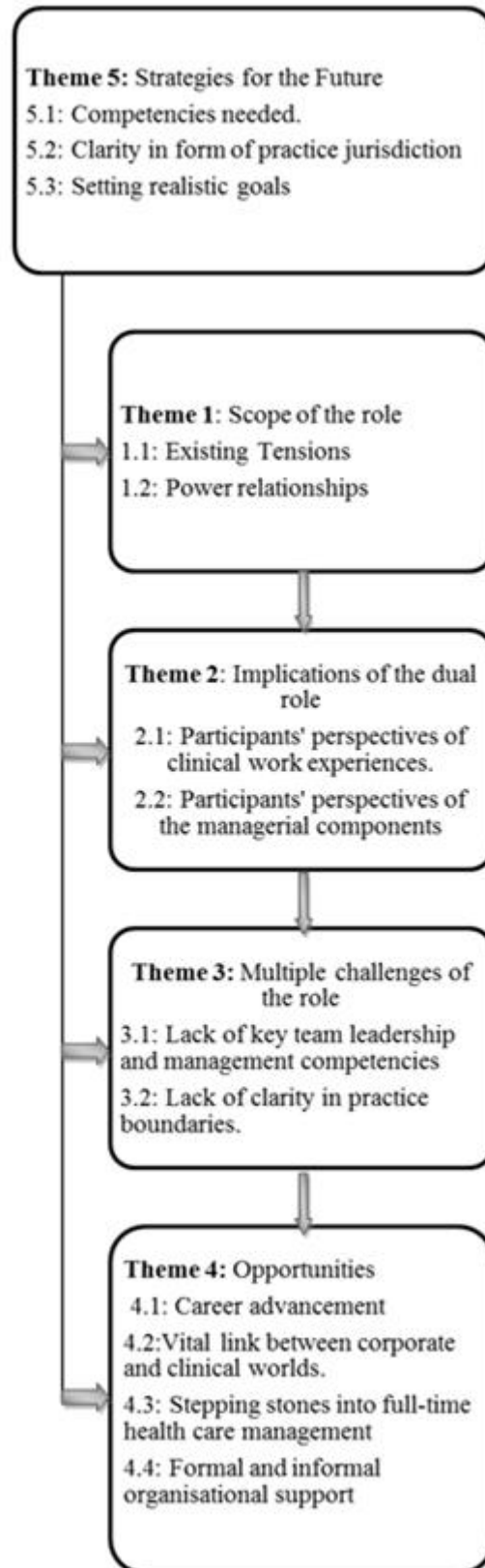> **Sub-theme 4.4**: Formal and informal organisational support.

Theme 5: Strategies for the future

> **Sub-theme 5.1**: Competencies needed.
>
> **Sub-theme 5.2**: Clarity in form of practice jurisdiction.
>
> **Sub-theme 5.3**: Setting realistic goals.

Figure 1: Interpretive Phenomenological Analysis Flowchart

Theme 5: Strategies for the Future
5.1: Competencies needed.
5.2: Clarity in form of practice jurisdiction
5.3: Setting realistic goals

Theme 1: Scope of the role
1.1: Existing Tensions
1.2: Power relationships

Theme 2: Implications of the dual role
2.1: Participants' perspectives of clinical work experiences.
2.2: Participants' perspectives of the managerial components

Theme 3: Multiple challenges of the role
3.1: Lack of key team leadership and management competencies
3.2: Lack of clarity in practice boundaries.

Theme 4: Opportunities
4.1: Career advancement
4.2: Vital link between corporate and clinical worlds.
4.3: Stepping stones into full-time health care management
4.4: Formal and informal organisational support

Study participants' viewpoints about working as an OTCL and role recommendations were based on their relevant previous work experiences. These viewpoints captured their lived experiences and are presented in a flow chart in Figure 1 and below as themes with supporting quotations from participants to help establish the data analysis trail. The thrust in Figure 1 analysis was to organise the data into themes and identify patterns or relationships among themes. Briefly, it reveals that Theme 5, Strategies for the future, is the superordinate theme that seeks to remedy multiple challenges identified in the dual OTCL role and to maintain inherent job and career opportunities in the role, categorized as Themes 1 to 4.

Overall the scope of the OTCL role was described in themes that reflected tensions, power issues, challenges, opportunities and strategies for the future. On the one hand study participants perceived organisational contexts as supportive in terms of access to opportunities, strategic information, staff support systems and resources needed to undertake their roles. On the other hand the same work environments presented challenges that constrained their efforts to accomplish the OTCL role demands as expressed in terms of communication obstacles, tension created by the dual components of the role, unmet workload demands and inter- and intra-professional power struggles. These shortcomings were viewed by study participants as a process involving managing through crisis. Nevertheless, study participants' mixed experiences of working in the OTCL role presented chances to make recommendations for structural changes and key skills that could assist OTCLs in their role.

4.4 Theme 1: Scope of the OTCL role

4.4.1 Introduction

There are two sub-themes that describe the scope of practising as an OTCL. These are portrayed by participants' perspectives of their lived experiences in the role as existing tensions and power struggles respectively. Firstly, tensions were mainly attributed to participants' perception of a mismatch of dual roles and responsibilities as elaborated in the first sub-theme. Secondly, participants alluded to the existence of intra-professional and inter-professional power struggles. These power struggles exhibited in homogenous teams in the form of members' loyalty to their leader and power issues between professional sub-groups who worked in heterogeneous teams.

4.4.2 Sub-theme 1.1: Existing tensions

In this study participants discussed how they struggled to meet practice demands in a work environment they perceived as challenging because the role lacked clear practice boundaries and there were complex expectations from key stakeholders. The resultant uncertainty in their daily work schedules was identified by participants as a source of anxiety and tension. During interviews many participants described the opportunity to participate in this study as a vital process that enabled them to share their lived experiences in the OTCL role as exemplified by the following perspectives:

> *I saw it as essential, personally as an OTCL working at a different facility I wanted to find out how others experience their day-to-day workload and the composition of the role. I felt really relieved to participate in this study not having been a clinical leader before, so I am happy to share some of the opportunities and challenges I encounter in my role.* (Rosie)

Rosie was relieved to access a platform for her to contribute her lived experiences that she summarised as anxious and exciting moments about her role.

> *I decided to participate in the study as someone working at a busy teaching hospital and currently feeling down. It is an opportunity to open up and share experiences with people in similar positions.* (Clara)

For Clara, the complex workplace environment was a source of her work-related stress. She perceived the opportunity to participate in this study as a gateway to relinquish her daily frustrations and to find out how her peers were also managing in the role.

In this situation, Rosie and Clara both accepted the opportunity because they saw it as an avenue to express their work-based emotions and to learn from others about working in the role. These perspectives affirm previous research findings that suggest that employees' individual ways of coping with high job demands should be considered by administrators when creating healthy work environments by establishing support and feedback mechanisms (Kluska, Laschinger and Kerr 2004; Paliadelis 2008). Fewer resources and little opportunity for advancement were associated with feelings of being devalued and exhausted, with many leaving the profession altogether (Albion et al 2008; Laschinger, Sabiston, Finegan and Shamian 2001; Meade et al. 2005; Shiri 2006).

Instead, firstly Lillian was attracted to participate by the title and nature of the study phenomenon, which is prioritised as an area requiring her contribution. She expressed that she had previously been involved with participating in research on a case-by-case

basis. Lillian, Isabelle and Marcia showed the urge to be heard whilst making a new professional contribution towards the role. In this study both Chloe and Marcia urged as vital for occupational therapy practitioners to participate in occupational therapy practice research. Elaborating, Chloe suggested the research area involving OTCLship as an important subject of study.

> *I always try to participate in research if I can, so I thought, oh, this is a bit different. Someone does not usually look into this area. So let me give it a go.* (Lillian)

> *I have accepted mainly because I believe occupational therapy practice research is always useful and perhaps we are not doing enough of it*. (Marcia)

> *To capture an understanding about the role from participants' perspectives.* (Isabelle)

> *It is essential to participate in research studies especially around clinical leadership and was happy to share experiences with others.* (Chloe)

However, it was a different situation for Anna who described her employment status as unique because it was an extended acting capacity in the role. In this respect, Anna was motivated to participate for some other reason, which she did not elaborate:

> *I am in a fairly unique position because I have been acting in the role for three years, so when I saw it I just responded to participate in the research.* (Anna)

The scope the OTCL role was shown in this study was a challenging one, with in-built tensions that arose from physical work contexts. Participants described organisation-based factors as constantly impacting on their role practice. Their perspectives of contextual factors were expressed as being consistently faced with limited resources such as time and appropriate skills needed to address complex work-related problems that arose as a result of several expectations from multiple key stakeholders. This work scenario, as Anna, Clara and Daphne viewed it, resulted in participants having to make compromises pertaining to clinical reasoning in complex work areas.

The other thing is finding time, being so busy and with also these complex priorities between clinical and non-clinical decisions. (Clara)

It is certainly challenging, hard work and an extremely busy role, with your working week over five days in terms of responsibilities. (Daphne)

There aren't enough hours in a day or days in a week whether it's clinical or non-clinical tasks. (Anna)

These findings support the tenets of Kanter's (1977) theory, namely, opportunity, information, resources and support, which contend that tenets must be present in the workplace to shape organisational behaviours and attitudes in a way that maximises effectiveness. Previous research linked time pressures, low opportunities, fewer resources and increasing job demands with increases in employee burnout and reduced

work effectiveness (Anderson, Spataro and Flynn 2008; Samiento, Laschinger and Iwasiw 2004; Upenieks 2002).

4.4.3 Sub-theme 1.2: Power relationships

The issue of existing power relationships in the scope of the dual OTCL role was in the form of a perceived lack of positional authority that was attributed to the expanded roles and responsibilities. In this study all participants described their dual role as highly challenging and complex. In this study, the most challenging areas of the role in terms of power relationships for Chloe were a triple-phased lived experience. Firstly, the idea of providing leadership to peers meant that she had compromise on some personal friendships in order to get the job done.

> *Whilst you are providing leadership it is also a challenge simply because you cannot please everybody, but you have to do your job at the end of the day.*
> (Chloe)

Secondly, power struggles were reflected in decision-making tasks such as staff performance and providing operational management to professional colleagues. These areas revealed existing power dynamics within teams because the decisions that participants like Chloe and Jo took were often inconsistent with their professional colleagues' expectations. Despite this, they understood that part of managing people involved having to make tough decisions.

> *Some staff may not like decisions that are made and I guess that is the challenge. Why I say that is because sometimes you hear people commenting*

about decisions you would have done and that is a challenge at the moment.
(Chloe)

It is difficult delivering the bad news, sitting down and having difficult discussions about performance or having difficult discussions about needing someone to do intensive changing in their caseload or declining leave requests. It is very easy to be everyone's friend and tell them what they want to hear but sometimes you can't. (Jo)

Lastly, evidence drawn from one participant, Chloe, expressed an existing conflict within the role in terms of power relationships regarding decision-making processes. This was viewed as a challenging experience for her, in part because of age differences amongst team members. In doing so Chloe linked existing power relationships in professional teams to age:

Some people are older and younger than me so it can be a challenge. (Chloe)

A fluctuating workload created further uncertainties and challenges involving workload prioritisation and planning. This problem was manifested at one facility in terms of lack of autonomy in recruiting new staff members to specific independent programs as described by Daphne:

The other part of my role has a different cost-centre yet I am not allowed to make independent recruitments from the general occupational therapy services.
(Daphne)

Whereas Anna faced some tensions in power relationships because of a bureaucracy in decision-making process within her organisation:

> *There are things I have single accountability but others have multiple layers of reporting.* (Anna)

Despite the scarce human resources presenting a challenge for the role in terms of resource allocation, participants viewed their role positively.

Another problem related to team members' power relationships arose from a mismatch in reality of practice and team loyalty expectations where participants worked across several teams. At one facility, Sophie, postulated that:

> *There is a shift in relationships by becoming a manager of people and you cannot stay as close friends-it won't continue to work.* (Sophie)

At another facility, the problem was both intra-professional and inter-professional as Lillian portrayed it:

> *Challenges mainly dealing with part-time OTS and staff shortages. Then, MDT working especially with nurses.* (Lillian)

In this situation, Lillian described power relationships that exist in multidisciplinary teams over practice jurisdictions, especially with nurses.

Research into job satisfaction by Atwal (2002); Hom and Kinichi (2001); Shaw, Gupta & Delery (2005) and Shiri (2006), negatively identified multidisciplinary teams as professional battlegrounds characterised by inter- and intra-professional rivalry, jostling between members for resources, supremacy of individual professions, and professional recognition by the medical profession. All participants indicated they were accountable to several clinical and management teams. The structure of teams ranged from single professional-based groups to hospital-wide multidisciplinary teams in which they were accountable, both as clinicians or leaders, for hospital-wide quality improvement activities. Several participants described themselves as leaders of quality improvement portfolios, based on professional knowledge, with multidisciplinary team membership structures, such as Falls Prevention Work Committee, Emergency Response Team for Mental Health settings, Cancer Care Committee and Workplace Health and Safety. As a result these participants assumed several key responsibilities outside the general scope of the OTCL role, which created a blurring of role perception, team loyalty and practice boundaries, as shown by Clara's experiences:

> *I think if I'm being pulled out to do other things and being accountable to other team leaders, it is very difficult to have that time to foster that environment of doing quality activities for my occupational therapy team.* (Clara)

The additional responsibilities and work structure created by hospital-wide quality improvement work committees increased workloads for those who were already under immense stress from their core role. Accompanying these new structures were new line management reporting systems, which created further blurring of the OTCL practice

boundaries. The additional work structure forced participating clinical leaders into new work relationships, creating further challenges for them to maintain support for junior practitioners. The perception of an inconsistency in practice expectations was identified as another source of power relationships within occupational therapy teams. If the OTCLs failed to meet the performance expectations of their subordinates, this was interpreted as lack of team loyalty and evidence of incompetent practice. Participants reported abdicating authority to junior practitioners by delegating key responsibilities, such as staff performance management and operational management tasks that involved conflict resolution, without providing the required support. Participants also reported spending a significant amount of time on tasks that involved completing paperwork, providing direct patient care, attending meetings, and workforce planning. Daphne summarised the nature of tensions and the resulting dilemma as follows:

> *There is the admin side of the role as you know looking at Workforce Planning, making sure that you have got enough staff, looking at rosters, leave applications and attending lots of meetings. Certainly with the above responsibilities I do not do as much work as I would like to.* (Daphne)

In agreement with Clara and Daphne's experiences are previous research findings by Joshi & Jackson (2003) and Jackson, Joshi & Erhardt (2003) that link diversity in a team with an employee's ability to access a diverse array of external networks. In this situation, external networks bring diverse perspectives, knowledge and information. Many participants viewed teamwork as a source of a positive work experiences for team members. It provided some form of meaning, value, identity, learning

opportunities and internal support crucial for the economically-rationed health care sector.

Expanding on power relationships, participants at one facility stated that they consulted weekly with the director as a form of role coaching. This process was another frustrating experience because it took most of their sparse working time. Participants at this facility attributed this process to ongoing power relationships between themselves and their line manager. They frequently consulted with their line manager on issues regarding daily operational management and strategic decision-making processes as a way to get the job done. This consultation process was perceived as causing a communication barrier between them and their subordinates. As a result, several participants indicated it contributed to being viewed as weak leaders by team members who raised questions about their leadership abilities.

From their perspectives, constant consultation was a process that was established by the line manager in order to fully stamp her authority over their work. This consultation process delayed decision-making processes and created tension in power relationships between participants and respective professional team members, which negatively impacted on their effectiveness as clinical leaders. The responsibility for strategic decision-making processes and access to organisational information was described as the prerogative of the line manager at all study sites. Several participants attributed lack of adequate positional authority as an issue that significantly contributed to their failure

to undertake meaningful strategic clinical changes as exemplified by Lillian's experiences.

> *Yeah, ultimately it's …, as the Director, is the primary responsible person–you know, the person primarily responsible for all the strategic development. Ultimately we have to support whatever decision she makes.* (Lillian)

These findings support the contention that an employee's ability to influence others in organisations in terms of initiating change, obtaining assistance and implementing new ideas, is critical to each member's work effectiveness (Anderson et al 2008; Clouston 2012). Also, as Cable and Judge (2003); Enns and McFarlin (2003) and Friedson (2007) assert, above and beyond power, some influence tactics tend to be more effective than others. The effectiveness of a specific tactic can depend on the context, employee's power and status, as well as target of influence. In this study, the role demands these participants faced involved the requirements placed on their behaviours in the form of workload expectations, team norms by which they needed to abide, and the competencies that were needed for work effectiveness.

Participants drew extensively on their previous experiences of being managed. This was expressed by Daphne, whilst underscoring the importance of being exposed to several managerial styles and the vital role played by an effective manager as a support mechanism to get the job done:

> *Who your line manager is, is very important as well.* (Daphne)

Also, previous research findings associate occupational therapy as a subservient, female dominated profession that has an entrenched powerless image (Butler et al. 2009; Clouston 2012; Matuska 2011; 2012).

The scope of the OTCL role demonstrates that many participating OTCLs had little exposure to different management styles, as shown by Clara's experiences:

> *I have been at the hospital for 20 years now. Things have now changed but have been a steep learning curve getting into a management role.* (Clara)

Clara had been employed by the same organisation and been managed by the same manager for several years. However, despite the accrued working experience, Clara struggled to understand the scope of the OTCL role in relation to managerial responsibilities involving tasks such as managing cost centre budgets and workforce planning. This shortcoming in terms of participants' lack of key management and leadership skills was also highlighted by Isabelle when she suggested it as a key work dissatisfaction factor that many participating OTCLs faced in the role:

> *There is lack of skills among clinical leaders in terms of struggling to channel resources around patients' needs versus team's needs.* (Isabelle)

Harris and Associates (2002) provide a definition of a manager that resonates with Isabelle's perspectives. They portray a manager as one who is held accountable by the organisation for the work of others, settings goals, making decisions, allocating resources and organising people in order to achieve organisational goals. Key features of the OTCL role described by Isabelle involved utilising a set of managerial

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competencies to collaboratively match and re-align organisational goals. They also engage with prevailing external environmental forces such as policy changes and other stakeholders. Consistent with these viewpoints from study participants is Miller, Goddard and Laschinger's (2001) perception of formal and informal power as a useful predictor of employees' empowerment. The findings support the belief that employees recognise the importance of developing effective working relationships with their peers (informal power) and supervisors (formal power) for them to get the job done and for them to be valued by organisations. In this study, participants, as previously expressed by Daphne, found great value in the development of their staff's full potential through coordinated training, task delegation, team building, empowerment, participation, and paying attention to collegial relationships.

The lack of skills and tensions experienced by these participants highlighted the lack of positional power in the OTCL role needed to implement health reforms. Mackersy, Robertson & McKay (2003) state that the effects of fundamental changes in workplace environments have negatively impacted on health professionals' focus and expectations regarding managing change and complex situations. Also, Walsh (2002) considered these repetitive reforms to be adding a further layer of bureaucracy without necessarily according adequate power and authority to those who are intended to achieve its purpose. These study findings underscore the value of structural factors, as prior research show, such as formal authority and interpersonal alliances within and beyond workplace contexts and organisational cultures, in shaping an individual employees' power (Anderson et al. 2008). The value of complementary fitness to organisational

effectiveness, is described by Clouston (2012); Kristof-Brown, Zimmerman, & Johnson (2005) and Reid et al. (2005) as the compatibility between an individual and a work environment that occurs when their characteristics are well matched. Specifically, compatibility occurs when an employee's characteristics fill the needs of the organisation.

Many participants also struggled to articulate the scope of their role in terms of leadership and managerial tasks despite having worked as occupational therapists for many years, as indicated by Clara's perspective of the scope of the OTCL role:

> *I don't have a simple answer for that even though I have been doing this job for a long time, and still I haven't got an answer for that.* (Clara)

These lived experiences in the role in terms of tensions and power struggles resonate with previous research findings by Bagger, Li and Gutek (2008), which linked employees' placement of roles and identities into a noticeable hierarchy based on a system of subjective importance or preference. In the same manner, a feature of the role that ranked high in participants' perception held more personal meaning and entailed greater organisational commitment in terms of resource allocation and work accomplishment.

4.5   Theme 2: Implications of the dual role

4.5.1   Introduction

Participants in this study defined their role as a balancing act involving juggling the workload demands of the dual role. This role feature was regarded by many participants as a challenging and complex phenomenon because of competition in priorities to manage the dual components' roles and responsibilities. Communication was regarded as important and carried out in a transparent and consultative manner to support joint decision-making processes. The responsibilities ranged from providing direct patient care, indirect patient care by supervising delegated staff's workloads, and providing professional consultancy on clinical issues and completing managerial tasks such as monitoring allocated work units' budget, and human and material resource management.

According to Isabelle, implications of the scope are broad-ranging as:

> *It is officially called Senior OT Advanced role and has the following components to it mainly: Work unit management, Communication and Clinical delivery. It has a 50% clinical and 50% management.* (Isabelle)

For Rosie, the implications of the duality of the role were summarised as being able to balance the complex supply and demand resource issues for the two components:

> *It can be quite challenging trying to get a good balance between the clinical and staff management and ensuring that you provide the best for both your patients and staff.* (Rosie)

These perspectives show that participants viewed themselves both as professionals and managers with a strong connection to their clinical orientation. Consistent with the respondents' viewpoints is previous research evidence by Butler et al. (2009) and Marsh et al. (2005) that associate an increasing intertwining between vaguely defined managerial and clinical domains of health care services with constant health policy shifts. In this regard, the health reforms have imposed the demand for health professionals to demonstrate cost-effectiveness, efficiency, and the need to embrace evidence-based practice. The collective viewpoint of participants on the implications of the duality of the role is recognised in these sub-themes:

4.5.2   Sub-theme 2.1: Participants' perspectives on clinical working experiences

OTCLs who took part in this study overwhelmingly described their role as one that involves coordinating patient care in their capacity as professional role models. In this practice context, they provided advanced generalist occupational therapy advice to other practitioners and work unit multidisciplinary team members. Specifically, these responsibilities included direct patient care and indirect patient care, which involved the provision of professional consultancy on clinical issues. Isabelle's perspective of the implication of the role in terms of the clinical components reveals that:

> *It is officially called Senior OT Advanced role. The clinical component is at an advanced generalist level.* (Isabelle)

Elaborating, Rosie expressed this role component in terms of workload complexity as follows:

> *The clinical role involves managing a busy clinical caseload. So every day, I have to ensure that the clinical caseloads are managed well.* (Rosie)

Yet for Anna, despite expressing the role as challenging ranked the clinical component higher than the managerial one in terms of workload prioritisation:

> *It is really challenging. I think as I told you before typically our first port of call is our clinical because we've been trained in that sort of thing and we've known all along so you know we understand the clinical challenges and what the requirements are.* (Anna)

Similarly, Chloe expressed the challenge of the role in the form of the dual components that she viewed as splitting her work time:

> *The OTCL role is quite challenging, basically because in the role we are part-time managers and part-time clinicians. 0.5 of equivalent full time employee is clinical and ensures that you provide the best for your patient.* (Chloe)

Jo described the clinical responsibilities from a case management perspective as follows:

> *Managing mental health clients and case management, and that makes it very difficult.* (Jo)

Whereas Lillian reported her interest in clinical work and was not considering a career shift into a management role:

I've got an interest in the clinical area of oncology I should say, so I'm quite passionate about that area. So I enjoy it from that perspective and I thoroughly enjoy my clinical load. (Lillian)

These viewpoints relating to Sub-theme 2.1 are supported by Matuska (2010), who links the initial senior occupational therapist role with professional role modelling for junior staff and as a custodian one for quality professional practice standards. In this practice framework, the initial senior occupational therapy role was designed to provide support, nurturing and mentorship to new occupational therapy graduates.

Gamble et al. (2009) posit that there are unmet workloads in dual occupational therapy management roles because of expanded roles and responsibilities. The clinical domain factors of the dual role have been examined in Sub-theme 2.1 and the management domain features of the role are examined in Sub-theme 2.2.

4.5.3   Sub-theme 2.2: Participants' perspectives of managerial components

Study participants' perspectives of the managerial domain of the dual role suggest that it is strategic with unique and complex roles and responsibilities. The literature also supports that the structural and policy environment where OTCLs practise is constantly changing (Palmer & Short 2010). However, health sector reform is portrayed as a complex and jumbled phenomenon for both OTCLs and health organisations generally

in relation to selecting the most cost effective and efficient model to deliver and manage health services (Braithwaite & Goulston 2004; Liang & Shortell 2005). Participants' viewpoints show that the management domain of their role is a contested one.

In their responses participants defined their role as clinical leaders with responsibilities for coordinating patient care and professional role modelling through providing advanced generalist occupational therapy advice to other practitioners and work unit team members. In addition, participating OTCLs were tasked with communicating and implementing an occupational therapy vision, leading continuous quality improvements and setting clear performance goals for relevant portfolios in a supported environment. The role was also intended to lead change processes through role modelling for other occupational therapists. This role is particularly concerned with articulating performance appraisal and development including the relationship between clinical and management services. Communication was regarded as important and carried out in a transparent and consultative manner to support joint decision-making processes. The responsibilities ranged from providing indirect patient care by supervising delegated staff workloads, and completing managerial tasks such as monitoring allocated work units' budgets, and human and material resource management. According to Isabelle, the scope is broad-ranging and strategic:

> *It is a role that has been created to allow clinicians adequate room to learn about management in a supported environment. It is however strategic and has to manage the daily supply and demand issues for the allocated work unit,*

delegating, providing day-to-day direction and coordination of the team, problem solving, working within a multidisciplinary environment, managing staff performance, providing clinical supervision and function as part of the wider occupational therapy service management team. (Isabelle)

On the other hand, Rosie described the role by elaborating on the clinical and managerial components, which she perceived as competing:

It can be quite challenging trying to get a good balance between the clinical and staff management and ensuring that you provide the best for both your patients and staff. On the management side, it involves staff management tasks such as staff development, operational management, leave management, staff support mechanisms and reporting to the Occupational Therapy Director regarding staff issues. (Rosie)

Elaborating on the management domain complexity, Daphne explained:

When I am the OTCL, providing clinical leadership, leading quality activities, supporting staff, maintaining up-to-date workplace guidelines and supporting therapy assistants. Then there is the administration side of the role such as workforce planning, reviewing staff situation, staff roster, managing leave applications and attending meetings. Yeah, it is complex. (Daphne)

Globally, research evidence shows that the importance of good leadership is becoming increasingly apparent in the health care industry in which performance management

takes a critical role in most health care reforms (Beer & Nohria 2000; Firth-Cozens & Mowbray 2010; Larsson 2010). In this regard, the personality and behaviour of leaders has been shown to affect the quality of patient care, including safety. According to Liang and Shortell (2006), emphasis on performance management in the health sector makes the decision-making process unachievable for Australian clinical leaders because they are held accountable for what is outside their role.

Correspondingly, study participants described experiencing challenges presented by the dual components of the role generally viewed as competing with each other for their urgent attention as expressed by Jo. They had limited time to accomplish tasks that constantly demanded they split their working times and expertise between two components. As reflected by Jo's reflection on her experiences, participants were required to create a supportive work environment in terms of integrating and supervising junior practitioners' work in order to achieve positive patient outcomes:

> *You need that link between the clinicians and the management, the role has a foot in each camp. And then other times you got bogged down in so much paperwork that you feel like you're neglecting patients. So, you know, that – it's tricky to sort of go home and times and say, Oh yes! I did a very good job with everyone*. (Jo)

Expanding on dual OTCL role complexity, Chloe identified unmet workload demands as another source of conflict. Chloe described several reasons ranging from personal,

organisational and constant health care changes as a source of frustration and feelings of helplessness when unable to meet every day OTCL role tasks as follows:

It can be quite challenging, you feel helpless trying to balance clinical versus staff management and being there for staff. In case someone is sick as is often the case, I have to communicate to the team, let the ward know, allocate patient caseload, manage outpatient referrals on a daily basis, manage daily statistics, manage emails, complete supervision sessions with my staff and attend scheduled meetings. In addition, managing change all the time is also a challenge. (Chloe)

In addition, the role was depicted as having complex competing priorities between clinical and non-clinical duties with virtually no solution in sight. Clara, who had worked as an occupational therapist for more than twenty years with half of her career at senior level, was unable to make any suggestions to address the various challenges encountered within and outside the scope of their role as follows:

Something that I found out with being part of these committees, I end up on more committees and that has become more difficult to foster that environment of doing quality activities. (Clara)

Other descriptions indicated their work units are centres of care in which health professionals interdependently work together to achieve positive patient outcomes beyond professional and organisational boundaries. The wide role expected of OTCLs is evident in this description from Anna:

I represent our department and our profession on a number of other committees throughout the hospital. I'm one of the CPR Resource Persons committee. I'm also the chairperson of the Allied Health Workplace Health and Safety committee. I also attend an Intensive Care Electronic Documentation Committee and I am also the State-wide Chairperson of the Burns and Trauma Special Interest group. (Anna)

The role was described as a fully encompassing one that involved providing direct patient care and creating a supportive working environment needed to provide safe occupational therapy services. Overall, the management component of the role aims to create an enabling framework for clinical excellence through undertaking patient care coordination, participating in quality improvement activities, work unit resource management, boundary spanning duties, coordinating staff development activities, line managing occupational therapy staff, and management of work unit-based resources.

4.6　Theme 3: Multiple challenges in the role

4.6.1　Introduction

Participants in this study's perspectives of challenges faced in the OTCL role are double-faced. Firstly it is concerned with a perception that OTCLs lack key leadership and management competencies needed to get the job done. Secondly, there is a common viewpoint that the OTCL role's dual components lack clarity in form of issues of practice jurisdiction and expectations of the constituents of the role. These two main challenges are further discussed below.

4.6.2   Sub-theme 3:1: Lack key team leadership and management competencies

Participants identified that working as an OTCL demanded one to have key competencies such as sound human, clinical and physical resource management skills in terms of conflict resolution, workforce planning, advanced clinical occupational therapy skills, and time management in order to ensure quality service delivery. Isabelle's lived experiences mirror employees in first line management roles who face a lack of key management and leadership competencies needed for the role. Isabelle identified lack of leadership skills in terms of equitable resource allocation, developing own leadership style, and failure to distinguish between leadership and management as key challenges:

> *There is lack of leadership skills among clinical leaders as expressed by challenges around negotiating and developing own leadership style. The key problems relate to inability to channel resources around patients' needs versus team's needs, negotiating the dual clinical and managerial components of the role, and delineating between clinical leadership and management*. (Isabelle)

Anna portrayed that one has to be intrinsically motivated to pursue a management career. In doing so, she identified people management, flexibility, change management, and communication skills as critical competencies needed for the role. Anna's experiences revealed that some clinical leaders were undecided about their career pathway and, in her viewpoint, that aspect of a double-mind was a reflection of relevant leadership and management competencies:

> *Some people say I want it all and that's fine but I don't think until you're further in your career then you decide which one is for you or a little bit of*

each, but I think to be in a management role like this you really you have to love

people management and dealing with people. It is not a predictable day where

you know you will come to work and you see all your patients and go home.

Anything can change or arise during the day so you need to be someone that

likes dealing with people, likes dealing with challenges and they can be flexible

and change your daily plan on a whim, and I think for some people they

wouldn't enjoy that so I think that's something that you would have to consider.

So I think that's something that you need to choose, to deal with people

management and meetings and things like that. (Anna)

In a related manner, Sophie's experiences underscore the importance of human and physical resource management skills in terms of conflict resolution, workforce planning, multidisciplinary team working, communication skills, flexibility and time management to get the job done. She also expressed the value of developing an interest in management to ensure work effectiveness:

Challenges, mainly dealing with part-time occupational therapists, staff

shortages and MDT working, especially nursing services. I have to juggle

things, so there is nothing typical, every day is different. Flexible

communication and negotiation skills are paramount. You have to be a good

time manager. You have to love the area. (Sophie)

These perspectives are important in that previous research findings link an overarching image of health managers as a product of a career shift from clinical positions, with

professional and management ideological conflicts that require a mental shift in order to enhance and acquire new competencies (Pilling and Stacey 2004; Reedy and Learmonth 2000). In this study, clinical leaders' work effectiveness is portrayed as a consequence of their professional and personal beliefs. There was need for clinical leaders to be flexible in their work approaches as they demonstrated specific management competencies to get the job done. Confirming this are investigation findings by Anderson et al. (2008) and Kristof-Brown et al. (2005) that associate best approaches to management such as power to influence co-workers, complementary organisational fitness, role flexibility, change management with the ability to deliver, and lead efficient health care.

4.6.3   Sub-theme 3:2: Lack clarity in practice boundaries

There are expanded roles and responsibilities in the OTCL role, which contribute to unmet workloads. These expanded roles and responsibilities present a practice challenge for participants because of additional responsibilities and blurring of practice boundaries. In this study, participants expressed that they were expected by their employers to lead organisation-wide quality improvement activities in the form of Quality Portfolios that were beyond the standard scope of the OTCL role as shown in Appendix G. This practice environment resulted in blurring of practice boundaries between participating occupational therapists and other team members who worked as part of multidisciplinary teams. Participants identified challenges pertaining to role overlaps between themselves and other multidisciplinary team members such as nurses and physiotherapists, which arose as a result of unclear practice boundaries.

The scope was perceived as an expanded one in terms of roles and responsibilities both within and outside the Occupational Therapy Service. There was a lack of adequate resources needed to manage these roles and responsibilities. Part of the problem was due to high staff attrition rates that were interpreted as creating constant staff shortages and limited skills to get the job done. The lack of appropriately trained staff was regarded as a significant factor. Participants indicated it was the main cause of role duality because organisations intended to reduce staff-related costs. This was particularly felt at one of the facilities, as exemplified by Chloe's lived experiences:

> *We also take leadership of hospital-wide quality improvement initiatives outside the scope of OTCL role. We lack skilled staff. I am juggling two full-time jobs at present due to vacant positions and lack of skills in the team. We advertised for a locum but have not got any yet. I have to work overtime, it is tough.* (Chloe)

Participants indicated a lack of adequate leadership and management competencies which was attributed to inadequate intra-organisational management training opportunities targeted at clinical leadership. In their daily practice, they were expected to take on board other responsibilities outside the scope of the OTCL role. Under such limited work conditions and unclear practice boundaries, OTCLs like Chloe felt helpless and frustrated when they were unable to meet workload expectations:

> *Also I recently got asked to support a change management process in another area and I had to step out to carry out the task. I don't think there is a lot in Queensland Health in terms of the Emerging Clinical Leadership Training, it*

does not address all aspects of management required to prepare for the OTCL role. (Chloe)

This discourse effectively reinforces Kanter's (2003) and Paliadelis' (2008) research findings on first-line management roles that link lack of access to lines of structural power such as information, resources, support and opportunity to employee's work effectiveness. In this instance, Chloe described organisational power limitations such as lack of skills, training opportunities, and human resources as imbedding factors to her effectiveness in the job.

Overall, the participants' work experiences provided little opportunity to develop skills in human and material resource management, plus the specialist clinical skills needed to practise as clinical leaders.

4.7   Theme 4: Opportunities

4.7.1   Introduction

In this section, I posited organisational power in terms of job accomplishments. This perspective resonates with Kanter's (1979) assertion that formal and informal systemic structures reflect sources of workplace empowerment. As previously stated, Kanter (1977) theorises that employees with high formal and informal power have greater access to structural lines of power and opportunity. Miller, Goddard and Laschinger (2001) define opportunity as relating to job conditions that provide individuals with the chance to advance within the organisation and to upgrade their knowledge and skills. In

this context, as is the case with findings from an investigation of NUMs (Paliadelis 2008), clinical leaders with low opportunities experienced low self-esteem, limited aspirations and limited upward influence. In saying this, I associated the presence of opportunities in workplaces is linked to greater employee work productivity and job satisfaction. Based on these viewpoints, I argue that workplace and job conditions provided study participants with the chance to advance within the organisation, get the job done, or upgrade their job-specific skills and knowledge.

However, despite the tensions identified in the role, the participants revealed that they were determined to make a difference to the role. Lillian indicated that they were driven by an intrinsic motivation, positive organisational contexts, and a professional value system as manifested by their strong professional and organisational team loyalty:

> *I have now realised the OTCL role has given me enough background for future opportunities that I did not have before. I have come from a situation when I felt I could not do the job to a situation when I am confident that I have the capabilities to do the job because of staff support.* (Lillian)

This discourse showed that organisational contexts in terms of a supportive culture positively influenced participants' perception of their lived experiences, work effectiveness, work satisfaction and organisational commitment. In agreement, Clouston (2012) associates a supportive organisational culture that embraces employees' social, professional, economic, and political needs with greater employee-life balance and organisational commitment. Tariah et al. (2011) and Wielandt and

Taylor (2010) stress that staff satisfaction is a global concern for health organisations because it affects service provision, quality of patient care, staff attrition rates and professional growth. Lillian's discourse on lived experiences in terms of a positive workplace culture that valued teamwork is consistent with these previous research findings. In doing so, Lillian linked an existing positive workplace culture with participants' high self-esteem, work effectiveness, increased upward influence and chance to upgrade competencies needed to get the job done. The above factors positively influenced participants' perceptions of their work experiences and resulted in them remaining with the same employer for lengthy periods.

4.7.2   Sub-Theme 4:1: Career advancement opportunities

The OTCL role was seen as having unique characteristics, including a variety of strategic opportunities to actively contribute towards developing district-wide occupational therapy service management positions in an acting capacity. They were also offered the chance to lead subcommittees outside the Occupational Therapy Service and to enrol into workplace-based leadership training courses as shown by Anna's experiences:

> *There are a lot of opportunities in the department, outside, and in the job in terms of leave cover and through working as part of subcommittees. I also coordinate the annual leave reliever team and rosters as my other portfolio. I am covering two jobs and that is other opportunities. In the past I have provided cover for the assistant director when she was away.* (Anna)

I seek opportunities to get more professional development in the area of leadership because it is something that interests me, so I've attended some of the QLD health leadership short courses like the one-day courses and I have also been recently being accepted to the allied health leadership programme. (Anna)

Participants had opportunities to coordinate patient care, delegate some administrative tasks to senior practitioners, manage designated clinical resources and provide generalist advanced clinical skills that improved the occupational therapy service to achieve positive patient care outcomes. There were opportunities at one facility to take up acting-assistant and directorship of occupational therapy roles, as Chloe explained:

It is a wonderful role. I enjoy participating in the running of the service through fortnightly staff meetings and weekly management meetings, managing staff performance and other things happening in the organisation. In the past I have provided cover for the Assistant Director when she was away. (Chloe)

Several study findings affirm that communication, team- work, good staff relationships, access to organisational information, support and resources, and opportunity for career progression are important factors for consideration by first-line managers (Anderson et al. 2008; Gilham & Ristevski 2007; Meade et al. 2005; More et al. 2006; Samiento et al. 2004; Tariah et al. 2011; Upenieks 2002).

Sophie, Rosie and Marcia all expressed satisfaction with juggling issues between clinical caseload, research projects and operational issues. This involved them in supporting other occupational therapists that happened most times by employing skills such as problem solving, work prioritisation, communication and investigation skills, which made each day different as expressed by Sophie:

> *There are a lot of opportunities such as completing research, supervising other staff, managing other staff and teaching treatment techniques.* (Sophie)

Rosie identified opportunities such as the regular supervision from her line manager and participating in the Occupational Therapy Service Management Team meetings. This provided her with the chance to acquire management skills, plus a forum to provide feedback regarding individual work unit management and to influence the operational management of the service as follows:

> *Weekly supervision with the Director of Occupational Therapy is an opportunity to communicate concerns such as staffing issues, mentoring, or if you need guidance with your portfolio management. We also have a senior OT management meeting weekly, with set agenda items each week. For example, leave management, workload issues, resources, staffing and rosters, workplace health and safety, safety and quality, portfolio feedback and committee meeting feedback. The weekly senior management team meeting involves all clinical leaders, assistant director and director.* (Rosie)

Rosie's viewpoint is supported by Clouston's (2012) findings that link professional support to high employee job satisfaction and greater work-life balance.

Marcia pointed to opportunities she encountered whilst working as part of an Integrated Mental Health Multidisciplinary team. She was engaged in providing strategic professional leadership support to other occupational therapists and developing her ability to promote the occupational therapy profession among her peers, plus involvement in state-wide Quality Improvement Projects:

> *I am a clinical leader for mental health services across the district. I provide clinical supervision and strategic leadership for occupational therapists by ensuring that we do not work in isolation and educating other team members about our professional team contribution. Another part of the role is to be a state-wide representative, for example the Integrated Employment Service Research Project, the Mental Health Occupational Therapy Reference Group, the Inpatient Seclusion and Restraint Working Party, and the Behavioural Emergency Response Teams. So aside from being a Clinical Leader, you could be anybody in the service and be asked to lead on that priority area.* (Marcia)

In contention, literature shows that when teams network externally with other relevant workgroups in the organisation and beyond, they do not function in a vacuum. These operational contexts place both limits and opportunities on teams that shape the nature and extent of external team networks. In other words, teams deliver high quality goods and services by utilising their external networks to exchange and pool resources with

other workgroups in an organisation. Previous research findings by Joshi & Jackson (2003) and Korner (2010) associate diversity in a team with an employee's ability to access a diverse array of external networks, which in turn become a source of diverse perspectives, knowledge, and information. Similarly, in this study, participants discussed the opportunities they had in various team processes in the form of access to information, diversity of viewpoints, support and knowledge.

In this context, Marcia described opportunities, information, diversity, support and knowledge in the OTCL role. She received regular coaching about management from the line manager and participated in state-wide Quality Improvement Research projects, professional collaboration on workload issues providing professional team leadership, and participating in the management of Occupational Therapy Services.

4.7.3   Sub-theme 4:2: Vital link between corporate and clinical worlds

Notwithstanding existing challenges, the role of a first-line manager was highly regarded. For Jo it provided a vital link for organisations to deliver safe patient services:

> *Relinquishing the OTCL role would be a shame because it would extend the gap between the clinicians and the managers which I think is really a high risk.* (Jo)

Other participants described the importance of an interface between the out-of-touch senior hospital managers and frontline clinical staff, thereby helping to ensure sound health management practices. Rosie warned against relinquishing the OTCL role as

there would be a risk of widening the gap between clinical processes and corporate management in her viewpoints as follows:

I think one of the best things or the ways we can improve our service delivery in Queensland Health is breaching that gap between clinical and management. I think the OTCL role assists senior management to keep in touch with clinical processes. It is really important to maintain that role combination. (Rosie)

In addition, the vital link aspect of the role was a source of work satisfaction for Rosie. She highly regarded the ability to positively influence teams' work culture to achieve professional growth:

I enjoy the opportunity to influence the team culture through positive leadership. I also enjoy advocating on behalf of staff within my team and assisting them to grow professionally. (Rosie)

Participants were expected to integrate patient care services by keeping senior management informed regarding clinical processes and to uphold organisational values and communicate the employer' vision to relevant stakeholders as exemplified by Jo:

We're the voice of the clinicians and we know what the reality is out there in the work load. (Jo)

Daphne underscored the value of the role to improved patient outcomes from a liaison perspective:

The way it works is that you have to liaise with all the above and the other person we liaise with is Allied Health Director. A lot of times, it is just letting the OT director know what is happening and some decisions are made at quarterly rehab meetings. (Daphne)

The power to network and influence strategic decisions in terms of staff fall prevention beyond occupational therapy service boundaries was highly satisfying and beneficial for Clara:

There is a lot of patient falls because of staff non-training. I organise strategic training by running yearly departmental and hospital- wide in-services. The good thing about leading this committee is that I have made some really good contacts outside of Occupational Therapy. It's been very beneficial to network. (Clara)

The participants' perspectives of the OTCL role affirmed Braithwaite and Goulston (2004) findings which linked interface roles as essential entities in complex adaptive environments, with improvements in clinical accountability and patient safety. Research evidence from Eager (2004) underscores this important issue by describing an existing multi-factorial weak link involving professional and technological heterogeneity, between service recipients and payers of services and the resultant weakness arising from perceived relationship misconceptions negatively impacts on the quality of health services care provision. In this study, participants perceived the OTCL

role as an essential interface, which facilitated effective collaboration between them and employers to achieve organisational effectiveness.

4.7.4 Sub-theme 4:3: Stepping stones into full-time health care management

Elaborating on managerial learning opportunities, participants described their involvement in managerial tasks such as leading quality improvement tasks, service management meetings, staff performance management, recruitment initiatives, quality improvement projects, and workforce planning. These are shown in Daphne and Lillian's experiences below. In addition, participants were actively involved in designated work unit patient care coordination, in-house training, leading clinical change processes, managing allocated work unit human and material resources, staff development activities, and operational management activities. Daphne describes this as follows:

> *The OTCL role involves providing clinical leadership, leading quality activities,*
> *supporting staff, ensuring up-to-date guidelines, supporting therapy assistants*
> *as well. There is the admin side of the role such as Workforce Planning thus*
> *making sure that you have got enough staff, looking at rosters, leave*
> *applications and attending a lot of leadership meetings. I do like to take up any*
> *future opportunities, not director but who knows down the line?* (Daphne)

Expanding on managerial activities in the role, Lillian explained it as follows:

> *We have a senior management meeting once a week, where we link with all the*
> *other seniors and the Assistant Director and Director to service operational*

issues such as leave management, budget reporting by the Director, workforce planning issues involving staff recruitments, workplace health and safety issues, and professional development. (Lillian)

Despite the role being a dual clinical and managerial one, Rosie perceived the management component as an opportunity to further develop her team leadership skills received through regular mentoring by the director:

I think the management side of things is an opportunity. I guess if you are an experienced clinician you get involved in management as part of clinical leadership. Experience in leading a team whilst being a clinician is an opportunity to develop leadership skills, which is fantastic. Also ongoing mentoring and consultation with the Director ensures that decisions are better informed because you are on ground. (Rosie)

The role, according to Isabelle, provided an opportunity to learn more about management in a supported environment, ability to try out and make mistakes, and regularly consult with the service director for feedback. She perceived the role as an opportunity to collaborate with other services through performance feedback mechanisms. Information-sharing forum activities, such as weekly supervision with the Director allowed them to learn, make mistakes and get regular support and engage in management meetings:

OTCL is a role that has been created to allow advanced clinicians adequate room to learn about management in a supported environment. It is however

strategic and has to manage the daily supply and demand issues for the allocated work unit, delegating, providing day-to-day direction and coordination of the team, problem-solving, working in a multidisciplinary team environment, managing staff performance, and providing clinical supervision and function as part of the wider occupational therapy management team. (Isabelle)

The Queensland Health Emerging Clinical Leader Program was highly regarded as a way to develop the required skills. Peer support and regular meetings allowed participants to share experiences and provided opportunities to up skill. There was commitment to a learning environment through a buddy system, resource management roles, and consultative decision-making through weekly meetings. There were clear outcome measures for each OTCL and flexibility to accommodate new changes. A number of employer-sponsored leadership development programs were identified as vital in mentoring staff towards senior managerial roles, as Lillian explained:

I think it's moving well at the moment towards some leadership development so I think the development of the Leadership Development programme and the Emerging Clinical Leaders programme are great, and I think the managers sort of gone before us have done great on the job so I think that's great. They assist staff to really cement leadership skills. Down the track I think I like to aim towards being the Director of the service and angle more into the pure strategic management of it but at the moment I'm happy with a bit of both. (Lillian)

The OTCL role was strategically situated within a supportive framework to assist senior clinicians to step into full-time executive health service management roles.

Several previous research studies have linked key managerial competence requirements for clinicians transiting into managerial positions such as managing people, financial management, negotiation skills, decision-making, flexibility and adaptability, communication skills, results orientation, leadership and financial astuteness to effective health service management in terms of ability to control, implement and monitor organisational performance and resources (Boucher 2002; McConnell 2000; Pilling and Slattery 2004; Tyler 2003). Conversely, if these performance targets were not met, research findings show these gaps in competency as sources of frustrations for new managers. In this study, the OTCL role provided a career route to senior management positions within a supportive learning environment.

4.7.5 Sub-theme 4:4: Formal and informal organisational support

Regular professional supervision from the line manager at one of the facilities was highly regarded as a support mechanism by some participants. Supervision at this facility was described as unstructured and supportive in terms of providing an enabling environment for clinical leaders to acquire new management skills. Participants perceived their working relationship with their Director, characterised by an opportunity to consult weekly on management challenges, as positive. In this context supervision was highly regarded, as expressed at one of the study sites by Clara, Chloe and Anna:

I think the beauty is the working relationship we have with our Director. We each have a weekly supervision session so I feel very supported and actually we have our weekly seniors' meeting, that's another time and she is great, she is really approachable and so if she's not here we can always get her on her mobile and if she is here we can just drop into her office. I also have roster meetings with her and as a roster coordinator we have meetings each month, so depending on your portfolio she has support for you as well. (Clara)

Expanding on the above viewpoint on the nature of supervision, Chloe described the nature of support received from her Director in the form of general encouragement, budget information, conflict resolution, operational management, and human resource management as follows:

Actually I get pretty good support and direction. General encouragement and information about how to handle issues, day-to-day operational issues and staffing issues, to make sure that everything is OK. (Chloe)

Johns (2003) described clinical supervision as a model of clinical leadership by providing necessary developmental opportunities. In doing so, Johns stressed the important role played by formal organisational support, information and opportunities to continuously develop clinical leadership. Remuneration, nature of work, and supervision were rated highly as factors that contributed to work satisfaction by occupational therapists, who either occupy a management or a clinical-based role (Boshoff, Alant and May 2005; Moore et al. 2006; Wielandt and Taylor 2010). In this study, Anna explained supervision details by describing it as a forum for facilitating

feedback between the director and herself on a variety of issues such as Workplace Health and Safety, staffing issues, and performance feedback as shown below:

I meet with our Director as is the case with each of the seniors, once a week for an hour. We talk about any of the issues from my portfolio, such as Workplace Health and Safety, work experience or any of the issues from staff, whether it be this particular staff member is struggling with her case load or clinical issues or if something larger has appeared such as a multidisciplinary communication issue between our service and physiotherapy or speech pathology. During the process I also get feedback a lot through these meetings. For example, for sitting on the reference group, I'll talk to ... about what happened in that meeting and feedback and just get her opinion and perspective. But then she also feeds back the other way since she sits on executive, and there might be something that was discussed about my portfolio at an executive, and she'll feedback that down to me. So I'll be aware of it. (Anna)

Underscoring the significance of employee organisational support Struber (2004), whilst investigating the retention and recruitment challenges faced by Australian Rural Allied Health professionals identified professional and social isolation combined with rapidly changing health service delivery structures as major deterrents to long-term rural practice. Furthermore, lack of staff development and lack of organisational commitment to allocate resources such as time, training and money to improve both staff and personal competence were the main areas of concern. Workplace-based staff networking was highly regarded as a formal process for information dissemination that

was vital to address the asymmetrical relationship between various employee groups. In the context of this study, having both a supportive Occupational T herapy Director in terms of competency training, performance feedback, communication and availability, and formal professional networking and quality improvement forums, were identified as supportive by participants.

4.8   Theme 5: Strategies for the future

4.8.1   Introduction

In this section, I postulate that study participants were better informed to 'tell as it is' the lived experiences of working as an OTCL. Based on this notion, my assumption was that the same participants were in a better position to prescribe and recommend appropriate strategies needed for the future practice and policy-making involving the OTCL role. I also considered that my position in the research process, as previously described in Chapter One, was a symbiotic one as I had already entered into the working world of these participants. My role in this process was to make sense and interpret these participants' perspectives on their lived experiences, in a manner that was easily accessible to the reader. In this study, OTCLs who participated in this study suggested various strategies to rectify challenges they faced and to manage existing opportunities in their role. These strategies are expressed in form of recommendations for the future of the OTCL role as skills and knowledge about the role, issues of OTCL role clarity in terms of practice boundaries, and content of the dual components and the need to have adequate positional authority and power needed to get the job done.

4.8.2   Sub-theme 5:1 Competencies needed

It is evident from this study that for many participants working as an OTCL was a challenging and often traumatic experience characterised by a steep learning curve. The dual nature of the OTCL role and associated resources-restricted organisational contexts placed pressure on practitioners to develop innovative ways to both manage scarce resources and provide quality patient care. Participants found it challenging to accomplish everyday work schedules and worked overtime in order to minimise unmet workload demands. Overall lack of adequate material and human resources, the competing dual components of the OTCL role, and associated positional authority, were viewed as sources of conflict. Several participants identified the need to develop competencies in the form of relevant skills and knowledge in order to set practice boundaries around the dual role demands to maintain a work-life balance (Clouston 2012). These competencies involved an ability to manage people, delegate tasks, make decisions, manage change processes, communicate effectively within teams, and effective workload prioritisation.

Participants described communication competence, as including written negotiation, collaboration, conflict management, interpersonal facilitation, consultation and team building skills, as Chloe described her lived experiences:

> *Juggling issues between clinical caseload and operational issues demands skills*
> *such as problem-solving issues, communication, investigation skills that happen*
> *all the time, and work prioritisation, because every day is different.* (Chloe)

Many participants had limited exposure to various management styles because they had been directed by the same manager and worked for the same organisation for several years. Several participants reported adopting coping strategies, such as effective workload prioritisation, sustainable workforce planning, and taking up clinical roles as a generalist senior clinician for complex patient management. Based on these experiences, participants recommended to those aspiring succeeding as OTCLs to draw experiences from a range of role models and to employ above clinical competencies. Rosie provided a succinct analysis of competencies and OTCL role recommendations below:

> *Good organisational skills in terms of managing patient bookings, people skills and change management. An annual leave reliever comes in handy. Work flexibility, consultation skills, negotiation, adaptability, good time management and work prioritisation skills, as well as good communication skills. Striking a balance between the demands of both the clinical load and management components of the role in order to focus on service improvements and quality activities.* (Rosie)

Sophie used the professional memory pathway that spanned across almost five decades to reiterate key changes in competencies needed to get the job done. From Sophie's perspective:

> *I graduated in 1962, things were different then and now it has become EBP (Evidence Based Practice), it is different than it was. Some challenges were the same, such as MDT issues. Things move very fast now and that is different. I*

have to juggle things now. Flexibility, communication, and negotiation skills are

paramount. (Sophie)

Similarly, communication skills in terms of participants' ability to resolve conflicts and negotiate for practice boundaries in multidisciplinary team contexts were highly rated by Anna as a way to manage inter-professional practice-related disputes. The issue of tensions in teams over practice boundaries between occupational therapists and other team members, if not properly managed, was identified as a source of non-productive employee behaviours. In this situation, Anna hinted that participants, as first-line managers, possessed the discretional power to manage team-based conflicts using several strategies. In her description, Anna pointed out these in the form of problem escalation to the line manager, encouraging communication between conflicting parties to deal directly with conflicts and problem and input documentation:

> *Interpersonal skills with some of the therapists are essential to manage non-*
> *productive behaviour before escalation of the problem to the Director. If there*
> *is role overlap, you know, with other divisions then we encourage therapists to*
> *deal with it directly by explicitly documenting their input as evidence regarding*
> *involvement of occupational therapy.* (Anna)

It was equally important, in Daphne's viewpoint, for an OTCL to be highly organised and visionary in order to get the job done:

> *I think you need to have management skills, be extremely organised, visionary.*
> (Daphne)

Marcia approached this sub-theme by reviewing the role of occupational therapy within multidisciplinary teams. She highly regarded the value of effective communication and political astuteness for occupational therapy to be accorded high status within these teams, and for professional growth rather than making claims on the basis of professional training and orientation:

> *Communication around the role of occupational therapy and mindful of working within multidisciplinary teams, how to be clear about who you are and where you're coming from without claiming special benefits because of it, with no actual evidence of your value. I sometimes find an OT saying, "We should have this" and "We should have more time to do this" and "We're OTs, and we're special", but they're not really putting the effort into the service.* (Marcia)

For Marcia, effective and meaningful professional contributions in multidisciplinary teams were an effective marketing strategy for professional recognition and growth:

> *Seeing what it is that they can offer and making sure that maybe there's all these interesting initiatives. Don't actually say that I'm an OT first, first contribute to their cause, and then they'll say, "Oh, you're an OT" and then they'll want more of me. I think it's that way of thinking that's politically important, that OTs need to become a bit more politically astute to move the profession forward.* (Marcia)

Laschinger, Sabiston, Finegan and Shamian (2001) link great access to learning opportunities, resources and support as forms of empowerment with higher levels of self-rated work effectiveness, control over practice, and job satisfaction from findings drawn from an investigation of nurses' work experiences in a down-sizing hospital setting. Similarly, in this study, organisational skills, job flexibility, people and change management skills, and staffing resources, were identified as key empowerment resources needed by OTCLs to get their job done. Intuitively, availability of these resources in their workplaces resembled power for participants, which resulted in them achieving positive organisational outcomes.

4.8.3   Sub-theme 5:2 Clarity in the form of practice boundaries

Akin to dual or hybrid health management roles, are key features such as an expansion in the position's roles and responsibilities, lack of practice jurisdiction delineation between the two components of the role, and lack of adequate positional organisational power needed to get the job done (Clouston 2012; Gamble et al. 2009; Paliadelis 2008). Organisationally, these dual roles are first-line management roles and exhibit powerlessness within the management structures (Kanter 2003). In this study, participants struggled to negotiate and develop their own leadership style as expressed previously by Isabelle when she identified lack of leadership as a key challenge for OTCLs. The challenge related to their inability to equitably manage scarce resources around patients' needs versus team's needs. Furthermore they faced challenges such as negotiating the two components of clinical and management and delineating between

clinical leadership and management, as well as finding time to accomplish the complex priority tasks.

Whilst describing problems associated with working in multidisciplinary teams such as conflicts arising out of control over practice jurisdiction because of lack of role clarity and interpersonal communication problems among team members, Anna put forward some coping strategies:

> *There is a bit of role overlap issues with other multidisciplinary team members working in the Discharge Facilitation Unit, such as physiotherapists and social workers.* (Anna)

Similar sentiments regarding problems associated with blurring of professional practice boundaries within multidisciplinary teams were echoed by Anna. She expressed the conflict resolution process linked to this nature of problem as a complex, confronting and challenging one to deal with because of strong differences in professional orientation and opinions about each member's contribution in multidisciplinary teams:

> *At the moment it tends to be a bit of role overlap issues with other multidisciplinary team members. It is challenging managing personalities, performance management issues, and dealing with confrontation. It can be quite challenging because as a senior, you know, you'll be responsible for putting forward the OTs perspective against another multidisciplinary team member who's got a gripe about something. Dealing with that conflict and resolving it can be challenging.* (Anna)

Daphne stressed the need to have clarity between the two components' roles and responsibilities because the presenting role split involving more clinical work rather than management was, in her perspective, very exhausting. She suggested role split in favour of more management responsibilities than clinical ones as follows:

> *I will definitely separate the TL and CL role. Do not get me wrong I do enjoy some clinical, but I think it is very exhausting and may be 1/7 clinically.* (Daphne).

At one facility, the role was theoretically stated as equally split between clinical and management roles and responsibilities. However, in practice this was not the case, as revealed by Chloe's lived experiences in the role, it was heavily tilted towards clinical responsibilities. Participants compensated for this disproportionate role-split by working overtime to accomplish outstanding management tasks:

> *It is usually a 50/50 role but it is never like that, it is always tilted towards one side. It depends on the day (laughs). It is probably more 60/40 or 70/30 management low and sometimes I do a lot of overtime.* (Chloe)

Upenieks (2002) associated organisational structures that allow adequate access to opportunities, information, resources and formal and informal power with leadership effectiveness for the nurses. This investigation concluded that nurse leaders with access to informal and formal power are empowered and successful, experienced high job morale and work effectiveness. Similarly, employers need to create suitable workplace

structures that provide opportunities for improved work effectiveness and job clarity. Opie (2002) recognised the organisational value of teamwork by describing patient care as an interdependent task that cannot be addressed by one health discipline that creates creativity, reduces errors, and ability to increase professional accountability. However, as Opie (2002) argued, if teamwork is not well managed, teams can be a source of problems that lead to organisational ineffectiveness. To this end, Shiri (2006) based on investigation of physical acute care occupational therapy practice, recommends professional role clarity for every team member. In this study, participants expressed problems with practice jurisdiction between occupational therapists, social workers, and physiotherapists, the split between the dual components' roles and responsibilities, and offered clarity in communication and sustainable workload distribution in the dual role as solutions to this challenge.

4.8.4   Sub-theme 5:3. Setting realistic goals

In this study, the OTCL role is shown in Appendix G and from participants' perspectives, as a mixture of a transformational and transactional leadership style that involves motivating and transforming teams to perform exceedingly beyond set targets on one hand. However, in order for these teams to perform within expected outcomes for the role, the process also involved daily transactional leadership activities such as performance monitoring, supervision and task delegation. Cahill (2002) examined the impact of transformational leadership, management of meaning, and vision characteristics on the growth of dotcoms. Findings revealed that transformational leadership is a popular management style that expresses two opposite dimensions,

known as transformational and transactional leadership styles. In this context, Bass's (2003) viewpoint on leadership, as a management concept is employed; this describes leadership as the 'management of meaning'. Simply put by Bennis and NaBass (2003), this approach assumes that leadership becomes real in the process of framing and defining reality for employees and that there is a clear distinction between leaders and managers based on presentation of a vision. In this manner, transformational and transactional leadership styles co-exist in practice contexts that demand use of effective leadership and management to achieve desired organisational and client goals. Consistent with the literature evidence is Daphne's discourse on the value of realistic workload allocations to achieve optimum employee work effectiveness that suggested employers to set realistic and sustainable workloads:

> *I think I will tell employers to recognise the workload issues, by setting a realistic workload for us.* (Daphne)

A number of participants involved in this study regarded effective change management skills as essential for one to succeed in the OTCL role. It was reported that the constant health sector reforms were strategic to the role and demanded effective change management skills. Several participants indicated that change was frequent, unavoidable and unpredictable, with subsequent impact on personal and structural arrangements of the delivery and management of occupational therapy services. Therefore OTCLs are continuously required to be able to familiarise themselves with health sector reforms and adopt sustainable change management strategies for the future survival and strategic position of the profession. The Emerging Clinical Leaders

Course was highly recommended as important to prepare clinical leaders to manage change processes:

> *The Emerging Leadership program is really good in terms of leadership development and change management.* (Rosie)

Whilst acknowledging that public health sector reforms are likely to continue and its complex adaptive nature, it is essential for some to develop realistic practice strategies and employ sustainable strategies such as workload delegation and prioritisation, as succinctly expressed by Chloe:

> *Change is happening everywhere. Managing changes to my workload especially when I want to do everything but I cannot, I can get overwhelmed by the change. I am doing my best and not worry about things I cannot complete. Work prioritisation is a key skill. I also have the opportunity to delegate as well.* (Chloe)

In this situation, Chloe emphasised the importance of developing realistic expectations of oneself and the role, ability to delegate tasks, emotional resilience needed to deal with unavoidable role conflicts, willingness to get support from peers and superiors, collegial relationships, and political astuteness. Chloe's perspectives are reciprocated by previous research findings by Clarke, Lewchuk, de Wolf and King's (2007) investigation of influence of organisational change on employees' well-being, which identified rapid change, loss of autonomy over work, and high workloads as causes of staff job dissatisfaction. Yet for Lillian, for one to succeed in a fast changing practice and work context it was important to:

Always keep your eyes open to learn formally and informally about the role.

(Lillian)

Likewise, Anderson et al. (2008); Gamble et al. (2009); Kristof-Brown (2005), and Smith Randolph (2005), underscored job flexibility, autonomy to make decisions, power to influence co-workers, and effective clinical leadership skills as best practice management approaches needed to deliver and lead efficient world-class health delivery systems. Given this, it was essential for OTCLs to adopt hopeful realism approaches in order to succeed in the role by employing the above skills and seeking new ways for professional gratification other than direct patient care.

4.9   Conclusion

In this study participants provided a mixed reaction to the experiences of working as OTCLs. The role was described as a dual one that involved carrying out both clinical and management responsibilities. On one hand the duality of the role was identified as beneficial. In this case, participants found meaning and reward in producing positive patient care outcomes and personal growth through coordinating care, providing expert patient care, and improvising care when resources were in short supply. It is clear that OTCLs were empowered by the formal managerial supervision they received from their superiors and informal support that came from their co-workers. These participants viewed the role as building a strong career foundation into senior management positions.

Furthermore these participants exhibited a commitment to the journey as OTCLs, which made a difference to the provision of quality occupational therapy services. On the other hand, working in the dual OTCL role was perceived as a source of tension and power. This was the situation because the two components were perceived as demanding high priority with blurring of roles and responsibilities' practice jurisdictions. Power tensions were visible within heterogeneous multidisciplinary and homogenous professional teams. In addition, the constant health reforms significantly unsettled several participants because firstly, they lacked appropriate skills and knowledge to manage the reforms and, secondly, the health reforms caused changes to their primary responsibilities that resulted in OTCLs assuming additional roles and responsibilities.

Despite the support participants received from their line managers, it was clear from participants' experiences that the scope of the role was impacted upon by other external forces and often encountered challenges. These forces were reported as fluctuating patient caseloads, sick leave, health sector changes, limited human resources and unpredictable workload expectations and complexities. Given these challenges, good work prioritisation, taking on board realistic workloads, more clinical staffing resources, specific workplace-based leadership training opportunities, flexibility when working in the OTCL role, change management capabilities involving effective communication, persuasion, work prioritisation, and delegation were recommended as vital for one to succeed in the OTCL role. Nevertheless, participants' perspectives

reflected a positive aspect of the role and expressed commitment to making a difference in peoples' lives despite facing these challenges.

Chapter Five

Discussion and Conclusion

5.0   Introduction

The preceding chapter presented the findings of this study and identified themes that demonstrate key issues drawn from Australian OTCLs' perspectives of their working lives. The findings of this study have vital implications for policy and practice in relation to the general occupational therapy workforce, and in particular OTCLs. This perspective is in accordance with contemporary research findings that describe occupational therapy workforce critical shortages in Australia and internationally as a constant health workforce challenge (Gamble et al. 2009; Meade et al. 2005). These implications are discussed at a later stage in this chapter. Study findings revealed the participants' reality of the health care system, the experiences and challenges they faced in the OTCL's role, and how they managed these challenges. Study participants' perspectives on solutions to the challenges they face both in the health system and the OTCL role were similar.

In this chapter, the major conclusions and the study findings are discussed and interpreted with the use of phenomenological principles in the context of the purpose of the study and key constructs of the selected theoretical paradigm presented in Chapter Two. The major conclusions and findings are discussed in relation to existing contemporary literature that was critically analysed in Chapter Two. The utility of the chosen theoretical framework to assist in understanding the study conclusions is

discussed and future research directions are identified in light of conclusions from this study. This chapter concludes with a summary of the study outcomes in relation to the aims described in Chapter 1.

5.1   Overview of major conclusions

The five major conclusions drawn from this study are presented below and discussed in terms of how they address the purpose and aims of the study, provided in Chapter One. The main purpose of this study was to gain insight into the lived experiences of OTCLs in terms of their dual managerial and clinical role. In this context, the study investigated the lived experiences of OTCLs as a way to gain an understanding of this new role and explore the scope and responsibilities involved. The first four study conclusions address the first study aim that seeks to reveal the essence of working as an OTCL. Then the fifth study conclusions will address the practice and implications for health policy specific to the professional sub-culture group that is under investigation.

The first study conclusion based on theme 1 in Chapter 4 is that the OTCL role as a first-line manager role has inherent tensions based on the dual clinical and managerial components. Theme 1 showed that the scope of the OTCL role contains existing tensions and power relationships. The expanded dual clinical leadership role was occupied by senior occupational therapy clinicians. The role now involved a wide range of responsibilities in areas of clinical governance, information management, performance management and monitoring, professional development and quality improvement, as well as professional role modelling and mentorship to teams of OTs.

The OTCL role is expected to maintain professional and practice standards and to perform at an advanced level. The Queensland Health Practitioner State Award (2007) in Appendix G describes health practitioners who practise at an advanced level as Health Practitioners at Level 5. These practitioners, as previously discussed in Chapter 2, can either be in roles such as a clinical specialist position with a full-time clinical caseload (HP5 Clinical Specialist), advanced position (HP5 Clinical) that holds a dual clinical and managerial component with a flexible caseload between the two components. This is defined on the basis of organisational and service requirements with a significant clinical component and advanced position HP5 (Management).

The second conclusion, as reflected by theme 2 in Chapter 4, is that the OTCLs who participated in this study believed that their role lacked clarity and adequate positional authority in terms of their role, responsibilities and designated authority. Theme 2 and subsequent subthemes 2.1 and 2.2 discussed the implications of the duality of the OTCL role from the participants' perspectives as a balancing act involving juggling the workload demands of the clinical and managerial components. These participants struggled to clearly articulate their role, especially in the face of constant health sector reforms. Many participants suggested peer support, formal professional supervision, and work-based informal management training as key strategies that could better prepare them for the role.

The third study conclusion was that the participants were dissatisfied with constant change processes, which demanded they split their time between tasks involving direct

patient care and managerial activities within a practice environment that was characterised by limited human, material, and financial resources. This conclusion is drawn from theme 3 that reviewed the existence of multiple changes in the OTCL role in terms of participants' lack of key team leadership and management competencies, and lack of clarity in practice boundaries. Consistent with this study conclusion, Kanter's (1977) theory of organisational power that was discussed in Chapter Two provides insights into power as a reflection of the structural position held by an employee within an organisation. Kanter (1977) contextualises power within formal organisational structures and informal alliances. In this instance, the OTCL role, as is the case with all management roles, is both faced with multiple practice challenges and career opportunities. Study participants expressed facing role structural challenges such as people management, and constant policy and structural changes to the delivery of occupational therapy services. Other teamwork-based problems involved the blurring of professional practice boundaries between multidisciplinary team members and a lack of adequate communication between multidisciplinary team members.

There was also a perception of lack of adequate resources participants needed to get the job done. These participants also felt precluded from autonomous strategic decision-making processes because they were viewed as lacking key leadership skills and their workplaces lacked adequate role mentors to support them in this process. Furthermore, they struggled to describe roles and responsibilities associated with leadership and management positions. This lack of clarity in their perception of these roles and

responsibilities, which is evident in theme 3, contributed to their failure to prioritise their daily key tasks, which resulted in unmet workload demands.

The fourth conclusion was that the OTCL role is faced with multiple practice challenges, which causes it to be organisationally invisible and lacks adequate organisational power and autonomy to implement strategic decisions. Themes 1 and 3 in Chapter 4 clarified this point based on participants' viewpoints of the scope of the role in the form of tensions, power relationships, lack of key competencies, and lack of clarification of practice boundaries. This conclusion resonates with Kanter's (1977) theory of power that examines critical organisational factors such as the employees' ability to access structural lines of power and opportunity as contributing to employees' perceptions of empowerment, access to organisational power, and work behaviour in organisations. These structures that form tools for success at work include lines of formal information that is important to carry out a job and informal information that relates to the current state of affairs within an organisation. Another structure, support, involves positive feedback from superiors and significant others, as well as job autonomy (Laschinger 1996). Lines of resources address the ability to obtain the materials, money, and rewards necessary to get the job done. Kanter (1977) perceived access to opportunity as vital for professional growth and movement in the organisation.

Kanter (1977) claims that working in these conditions creates a positive impression on employees such as an increase in self-efficacy and job satisfaction, improved motivation, and less burnout. These empowered employees, as Kanter argues, are more

productive, highly innovative, have higher work effectiveness and are more committed to organisational goals. Previous research by Miller, Goddard and Laschinger (2011) using Kanter's (1977) theory of structural power in organisations to examine physical therapists' perceptions of empowerment, found a direct link between the empowerment score and the physical therapists' global rating of empowerment. Therefore it is vital for OTCLs to access relevant knowledge and information as a form of empowerment in order to function effectively in organisations. This process involves accessing open channels of essential managerial information that is directly work-related and information about the whole organisation such as budgets, salaries and operational data.

The final conclusion is that the OTCL role is described as one that involves mediating between senior management and subordinates for clinical resources and change processes. This conclusion, as shown by themes 4 and 5 in Chapter Four that described several opportunities and strategies that exist in the OTCL role, expresses study participants' experiences in the role in a positive sense. Theme 4 positively identified the OTCL role as one that offers career advancement opportunities, act as a vital link between corporate and clinical worlds, as a stepping stone into full-time management, and as easily accessible to formal and informal organisational support. Theme 5 identified several strategies for the future of the role such as competencies needed, importance of role clarity in the form of practice boundaries, and the value of setting realistic practice goals to get the job done. As Kanter (1977) argues, employees who do not have access to organisational information, support, resources relevant to the job's demands and opportunities, are less likely to succeed in their roles. In reality, these

employees have limited power to share with their subordinates. Corresponding research evidence from an investigation of NSW occupational therapy manager roles by Gamble, Lincoln and Adamson (2009), describes a range of mediation responsibilities played by both occupational therapy clinician-managers and manager-administrators within organisations involving consultation, advocacy, and representing the profession. These conclusions led the following overview of key study findings that will be discussed in more depth and located within the current body of knowledge about such roles and literature reviewed in Chapter Two.

5.2   Discussion of key study conclusions

In this section, the study conclusions are discussed within the context of the existing literature reviewed in Chapter Two. As discussed, health reform is a complex adaptive process, in which clinical leaders have to demonstrate their ability to draw meanings from the constant health reforms and implement these in a flexible and astute manner (Clinton 2004). According to Touati et al. (2006), the practice environment recognises the value of broad-based contextual organisational developmental strategies that equip clinical leaders with the required effective clinical and managerial competencies to deal with competing priorities in their roles and responsibilities.

The first major conclusion is that this first-line management role has tensions based on the dual clinical and managerial components, mainly concerned with patient care coordination. The participants described their main function as providing operational management of the human, clinical resources, financial monitoring, and physical

resources to enhance effective coordination of care. This conclusion supports the existing literature, for example Cook (2001); Dennis et al. (2000), and Touati et al. 2006) described in Chapter 2 Canadian clinical leaders' role as one that is responsible for an integrated clinical care service through providing patient coordination, staff, and asset management .

In this study, the role of OTCL was described as having both a clinical and a non-clinical administrative component. The participants viewed these as competing priorities, influencing their experiences of the OTCL role. According to Gamble et al. (2009), the essence of working in an occupational therapy management role is that the clinician-manager or manager-administrator nature of the job entails a balancing act involving juggling competing responsibilities, which is expressed in terms of existing tensions and power relationships. This situation was interpreted by participants as frustrating because of an overwhelming workload because of an expansion of roles and responsibilities. The first conclusion of this study certainly supports this view as the participating OTCLs described the tension caused by having both a clinical and non-clinical administrative role. These two components were viewed as competing priorities by the participants. This conclusion supports the findings of earlier studies of first-line management roles in health care, such as Gamble et al.'s (2009) investigation of NSW occupational therapy managers' roles, responsibilities, and work satisfaction issues. Paliadelis (2008) identified similar results in an investigation of the lived experiences of NSW NUMs.

These participants indicated that they found their role challenging because of the dual responsibilities for coordinating patient care and providing professional role modelling in their capacity as leaders. In addition, the OTCLs indicated that they were expected by their employers to demonstrate astute leadership capabilities that are needed to communicate and implement an occupational therapy service vision, information, and data management process. More so, participants stated that they were required to lead continuous quality improvement projects and professional development activities. These responsibilities involved clinical leaders setting clear service performance goals for designated quality improvement portfolios and staff as a way of managing performance and providing support to staff members.

Furthermore as evident in the position description provided in Appendix G, key responsibilities are implementing change management and positively influencing the work of other occupational therapists. These OTCLs shaped their everyday responsibilities and access to strategic organisational information, support, opportunities, and resources. Likewise, prior research by Braithwaite (2004) and Gamble, Lincoln and Adamson (2009) indicated study participants feeling tension and frustration between the two components in terms of time, role clarity, and lack of adequate power to make key organisational changes while also carrying an overwhelming caseload.

Recent events in the economics of health care such as the establishment of clinical governance frameworks and health care budget cuts has increased existing pressure on

those in first-line management roles. Anderson and McDaniel (2003), Braithwaite (2005; 2006), Braithwaite and Westbrook (2005); Lin and Robinson (2005); O'Dowd (2005), and Segal and Bolton (2009), argue that these reforms have led to the creation of dual roles that involved health care organisations combining administrative and clinical responsibilities within a single role in order to reduce human-related costs. In this study, theme 1 that is the basis of the first study conclusion, depicts economic rationalisation in the health sector as an important factor, prompted by a rise in health care costs as a result of an escalation in demand for health services and an increasing fall in health care resources, which has given rise to the need to intertwine administrative and clinical issues. In an industry where there are dwindling resources against an increasing consumer base there is need to adopt cost-saving measures for resource utilisation such as combining clinical and administrative decision-making processes as a sustainability strategy (Braithwaite 2005). A key result of this marked interdependency in Australia was the establishment of the dual OTCL role and associated tensions arising from the interaction between the clinical and non-clinical decision-making processes. In this study, as Kanter (1977) observed in a related study of female employees in corporate organisations, these participating first-line managers lacked visibility in organisations.

The second study conclusion is that the clinical leadership role is blurred in terms of practice boundaries and positional authority. This conclusion was evident in the following themes 1 and 2, where the participants clearly felt they were frustrated by unfinished workload demands because of expanded roles and responsibilities. In this

respect, the OTCLs role is constantly exposed to constant health policy shifts and is challenging because of lack of adequate human and material resources needed to get the job done. Firstly, many study participants perceived health reforms as a recurring phenomenon in their practice environments that presented a constant management challenge for them. For example in theme 2 it was clear that was regarded by many participants as a challenging and complex phenomenon because of competition in priorities to manage the dual components' roles and responsibilities. Secondly, all of these first-line managers described the constant reforms as overwhelming to manage. They identified role challenges as negatively impacting at personal and organisational productivity levels in the form of lack of adequate management skills to manage the constant health sector policy shifts, lack of adequate time to manage the roles and responsibilities associated with the change processes, and inadequate staffing resources needed to get their job done. Previous research findings on first management roles by Braithwaite & Goulston (2004); Gamble et al. (2009) and Touati et al. (2006), revealed constant unmet workloads because of expanded responsibilities, lack of role clarity within teams and inherent tensions in team relationships as a source of frustration for employees that negatively affected their ability to sufficiently get the job done

Another point to note from the third study conclusion is that participants were dissatisfied with constant change processes. This was evident as in themes 3. These participants made it clear that it was a source of discontent because they lacked adequate leadership and management competencies, which was attributed to inadequate intra-organisational management training opportunities targeted at clinical leadership.

OTCLs in this study struggled to articulate their role in the face of constant health sector reforms that were marked by limited resources and a shift in focus towards consumer-based resource allocation as a mechanism to achieve better population health outcomes. Firstly, participants perceived their role as lacking clarity in terms of roles and responsibilities. Secondly, the OTCL role was described as one with expanded responsibilities created by the duality of the role, which contributed to their work dissatisfaction because of unmet workloads.

Anderson and Driebe (2000), based on an investigation of international health systems as complex adaptive systems, concluded that dual roles as central first-line management entities of organisations experiencing change processes but marked by diminishing health care resources. This was regarded by these authors as important for organisations that needed to simultaneously contain escalating health care budgets and deliver quality integrated patient services. In other words, an increase in health care costs and diminishing health resources has prompted the need to combine management and clinical roles, which subsequently challenged historical management and power structures in organisations. Furthermore, health management literature describe health care as becoming an increasingly scarce commodity, thereby making demand and supply a central framework of analysing health care utilisation for researchers (Palmer & Short 2010). Therefore, the third conclusion identifies the duality in the OTCL role as a by-product of the need to cost-effectively manage diminishing health care resources.

The fourth study conclusion showed that the OTCL role is both faced with multiple practice challenges such as inherent tensions, power relationships, lack of key competencies and lack of clarify of practice boundaries, and career opportunities. Themes 1 and 3 show that participants faced challenges such as people management, constant policy and structural changes to occupational therapy services delivery, personal management, blurred professional practice boundaries between multidisciplinary team members, lack of adequate communication between multidisciplinary team members, lack of adequate resources and lack of autonomy in strategic decision-making because of lack of leadership skills, and adequate role mentors to support them.

According to Sibanda (2003) many line managers abdicate their responsibility for people management for various reasons ranging from lack of training, lack of appreciation, and a biased view of the purpose of the human resource management function. In this study, participating OTCLs said they found it challenging to manage human resources based on sub-theme 3.1. In a cautionary approach, Albion, Fogarty, Machin and Patrick (2008) and Sibanda (2003) emphasised the importance of first-line managers to adequately deal with people-related problems to avoid expensive health care labour related costs in terms of absenteeism, work dissatisfaction, and turnover in order to avoid paralysis of operations.

This conclusion supports an earlier study by Stanley (2006), who found that role ambiguity and role tension can cause confusion about where the main focus of the role

should rest. Also, research evidence showed that first-line managers maintained a clinical caseload as a way to gain respect from clinical colleagues (Braithwaite 2004; Gamble et al. 2009).

Furthermore, the fourth study conclusion stresses the importance of role clarity as a way for employees to achieve effective job performance. Sub-theme 3.2 portrayed that there are expanded roles and responsibilities in the OTCL role, which contributed to unmet workloads. These expanded roles and responsibilities presented a practice challenge for participants because of additional responsibilities and blurring of practice boundaries between professional team members. Mickan and Rodger (2005) classified teams found in health care settings as either multidisciplinary or interdisciplinary. This shows that the OTCL role has blurred practice boundaries, which is a key source of team based communication and practice boundaries. In this study, a lack of role clarity was explained in sub theme 3.2 in terms of blurring of practice boundaries, which was identified as a constant source of intra- and inter-professional conflict by several study participants who worked mainly as members of multidisciplinary teams. These conflicts were expressed in the form of communication obstacles within teams and unmet workload demands because of a perceived OTCL role expansion.

Previous nursing and other health professional research evidence reported similar findings (Joshi 2006; Paliadelis 2008). In this study, participants who were drawn from first-line management roles expressed daily frustrations with managing multiple responsibilities that involved providing professional role modelling for junior

practitioners and existing tensions that were as a result of managing inadequate human, material, and financial resources. Participants from this study experienced constant role management conflicts which they attributed to a lack of delineation between the management and clinical components' roles and responsibilities. Working as an OTCL was identified as unpredictable, constantly changing, and requiring a greater level of flexibility to accommodate the various demands imposed by the expanded and unclear role.

The final study conclusion has expressed the OTCL role as one that involves mediating between senior management and subordinates for clinical resources and change processes. This was clear as evidenced by themes 4 and 5 in Chapter 4, which discussed opportunities and strategies for the future respectively. This process, as expressed by participants, involved participating OTCLs' ability to positively influence staff to deliver quality patient care in the context of constant health sector changes. According to Paliadelis (2008) and Ozaralli (2003), the process of negotiation involves a mechanism in which first-line managers utilise a suitable leadership and patient care provision style as expressed in terms of employee control, competency, and goal-seeking behaviour. In this context, power enables employees and teams to make effective decisions about the jobs they do. The study by Paliadelis (2008), which also drew on Kanter's (1977) theory of organisational power viewpoint about organisational power, found that employees who do not have access to organisational information, support, resources, and opportunities are less likely to succeed in their roles. In reality these employees have limited power that is needed to empower their subordinates. In

this study, support was in the form of supervision, coaching, team-building processes and performance management. In this study, theme 5 showed that work prioritisation, change management, political astuteness, technical, delegation, communication skills, human resource management, access to organisational support, information, opportunities, and resources were highly regarded as pertinent competencies to the OTCL role.

Previous health sector restructuring and policy changes in Australia have occurred whenever there has been a change in the political power in government. Commenting on the subject of organisational power, Paliadelis (2008) suggested the importance of accessing opportunities, strategic organisational information, adequate support, and the necessary support from the employing organisation in order to effectively participate in a decision-making role. As Paliadelis (2008) argued, first-line managers often find themselves in powerless positions because they lack access to adequate opportunities, strategic lines of information, support, and resources needed to get the job done effectively. These managers are therefore organisationally invisible and generally unrewarded. Also according to Paliadelis' study of the NUMs role, power is not a feature of an individual but the role they occupy.

In view of the fourth study conclusion, it is equally important at this stage to focus the discussion on the interpretation of the OTCL as a change management role, expressed by actions taken by participants during the course of completing the various tasks. In this study the constant health reforms were perceived by the participants as presenting

both opportunities and challenges. For example the fourth conclusion identified the OTCL role as organisationally invisible because of multiple challenges, whereas the final conclusion showed that the role has multiple opportunities in terms of career advancement, vital linkage between corporate and clinical worlds, and a key stepping stone into full-time management. Whilst there is paucity of occupational therapy research on the lived experiences of practitioners who hold a dual clinical and non-clinical role specific to Queensland, previous NSW research by Paliadelis (2008) and Gamble, Lincoln and Adamson (2009) on NUMs and occupational therapy managers respectively, have explored the subject in Australia. Paliadelis (2008) observed that rural NSW NUMs expressed their role as having multiple responsibilities that included coordination of care, attending numerous meetings, and financial, human and physical resources management. Similar research findings show that the NSW occupational therapy managers' roles and responsibilities presented both opportunities and challenges in terms of role expectations by their employers, which directly impacted on participants' work satisfaction issues.

In other words, it is challenging to allocate resources equitably to everyone's satisfaction when the work involved is of an unpredictable nature. It is on this basis that health managers, such as OTCLs, are required to possess sound knowledge about operations of complex adaptive systems and effective change management approaches in order to provide effective leadership. Another point to note relates to the importance for participating OTCLs to clarify the difference between leadership and management concepts in order to improve both their leadership effectiveness and work satisfaction.

In this study participants in sub-theme 3.1 struggled to distinguish between leadership and management of health services. Several study participants described clinical leadership as concerned with carrying out patient care duties and communicating the occupational therapy vision, while they see management as involving tasks such as managing the financial, human, and physical resources, setting the occupational therapy vision, and service development. This was clearly identified in themes 1 and 3.

According to Armstrong (2008), leadership has to be understood as a basic function of management that exists alongside other functions such as planning, organising and controlling, with a focus on human resources as a means to develop and communicate a vision for the future. By definition, leadership is an umbrella term that covers all or most of the people-oriented managerial activities such as change management, conflict resolution, staff development, motivation, communication, and team leadership (Armstrong 2008). On the other hand, Armstrong views management as concerned with achieving results by effectively obtaining, deploying, utilising, and controlling the entire human, financial, and material resources through employing effective leadership.

The next section explores the utility of Kanter's (1977) theory of organisational power to extrapolate on the essence of working as an OTCL.

5.3   The utility of Kanter's (1977) theory of organisational power

This research drew on Kanter's (1977) theory of organisational power to assist in understanding and interpreting the lived experience of OTCLs. This section explains the

utility of the theoretical framework to this study, and the synergy between the study aims, the methodology and the theoretical framework.

While there are many modernist perspectives that explore the issue of power in organisations as discussed in Chapter 2, Kanter's (1977) theory was selected as the most appropriate for this study because it identifies organisational role constructs instead of individual qualities as key factors influencing the power of first-line managers such as OTCLs. In this manner, Kanter's (1977) theory helps to explicate the notion of the OTCL role, which is a first-line management role, as reflected by the different activities described by the clinical leaders who participated in this study. Firstly, it describes this role as a first-line management role that has tensions based on the dual clinical and managerial components. Secondly, Kanter's (1977) theory portrays it as one that lacks adequate power needed to get the job done. Theme 3 described that participants struggled to articulate their role when they faced constant health sector reforms. Kanter's (1977) theory has assisted in understanding why competing priorities embedded in first-line management roles leads to work dissatisfaction. For example, the OTCLs discussed their difficulties with constant change processes and the need to split their time between responsibilities relating to directly providing patient care and managerial activities, as well as the need to allocate sparse resources in a meaningful way.

Kanter's (1977) theory depicts first-line managers as faced with multiple practice challenges and career opportunities. The fifth study conclusion that the OTCL role is

organisationally invisible, unrewarded, and lacked autonomy in strategic decision-making processes, suggests that these first-line managers experience similar challenges to those described by Kanter in 1977.

This study explored the phenomenon of working as an OTCL in terms of the scope of the role and concluded that these participants experienced tensions, opportunities and challenges on the basis of the dual clinical and managerial components. Kanter (2003:34) attributed powerless behaviours as a 'universal human response to blocked opportunities', when she observed that first-line managers of both genders were functionally powerless because they were frequently responsible for results without 'the resources to get them'. In the study involving NUMs, Paliadelis (2008) concluded that the role was a first-line management role that was organisationally invisible in terms of being able to access structural features such as information, resources, and support that were needed to get their job done. In this study, as was the case with the nursing study, Kanter's (1977) theory was useful in order to understand the relationship between OTCL role construction and power relations in their work settings, which showed that the OTCL is a first-line management role that mirrors similar role experiences as revealed in the Paliadelis (2008) study.

Briefly, in theme 1, all clinical leaders identified the various roles and responsibilities they carried out both inside and outside the occupational therapy service. In their viewpoints, participation in these activities presented an opportunity for participants to demonstrate their competence at managing multiple challenges and opportunities they

perceived as existing in their role. As previously discussed in Chapter Two Part 2 on theoretical framework, this process of role negotiation required participants' ability to access both formal and informal organisational power structures needed to get their job done. This brings another important feature of Kanter's (1977) theory, which is the belief that organisational structures create roles and work behaviours as reflected in the third and fourth study conclusions.

In this study, Kanter's (1977) theory of organisational power has been used in understanding the study conclusions based on the participants' experiences. For example, conclusions 1 and 4 showed a lack of adequate organisational power was experienced by the participants, causing them to feel less-valued members of the organisation. As previously discussed, themes 1 and 3 show that participants faced challenges such as people management, constant policy and structural changes to occupational therapy services delivery, personal management, blurred professional practice boundaries between multidisciplinary team members, lack of adequate communication between multidisciplinary team members, lack of adequate resources, and lack of autonomy in strategic decision-making because of lack of leadership skills and adequate role mentors to support them.

5.4   Implications for OTCL practice

This section addresses implications from the conclusions of this study for policy practice in health services relevant to the purpose of this study. The major study conclusions and findings from this study have underscored the critical challenges

surrounding the phenomenon of working as an OTCL in a rapidly-changing practice environment. This demonstrates how the conclusions informed policy and practice changes.

Consistent with the second, third and fourth study conclusions, the first implication for practice relates to the existing discrepancy between the expectation for clinical leaders as key change managers and the reality of the OTCL role as described by these participants. In this study, clinical leaders perceived their role as lacking adequate positional power and clarity of roles and responsibilities needed to meaningfully transform the health sector within their clinical work settings. This mismatch between their practice expectations and the reality of their practice was consistently identified by several participants as an ongoing source of conflict for them. Their perception of lack of adequate organisational power in their role, constantly identified as a work dissatisfaction factor, is likely to be a product of lack of OTCL role clarity in terms of the dual components' roles and responsibilities. It is therefore vital for OTCLs to get clarity in their position description in order to understand role expectations.

Previous research evidence has identified occupational therapy is a low status profession among other health professionals because of historical, social, economic, and political factors (Boyce 2001; Gamble et al. 2009; Griffin 2002; Shiri 2006). Therefore the following recommendations are made to assist in enhancing the status of those in first-line management roles in the discipline of occupational therapy. In this study, it was important for the clinical leaders to have strategic information, resources,

support, and opportunities, to enable them to perform their role effectively. It is suggested that by seeking role clarification the study participants could seize the opportunity to participate in a wider variety of hospital-wide committees and establish informal strategic alliances with other first-line managers in order to access support, a key component of organisational power needed to get their job done.

In this study, the OTCL position was described by the participants as lacking clarity in terms of their roles and responsibilities. According to McDaniel and Driebe (2001), this unusual interdependent relationship is vital for clinical leaders who practise within complex adaptive environments in order to improve both patient and organisational outcomes. In this regard, policy-makers need to encourage OTCLs to embrace practical quick-fix approaches to new health policy implementation and health management practices as a way to meet health care demand and reduce costs, instead of pursuing desired professional role autonomy when delivering patient care. This process should be achieved by established clear workplace instructions and core role competencies as a guide to safe practice.

Thirdly, given this paradigm shift in health policy and practice, it is equally vital to understand the purpose and implications this has on the OTCL as a by-product of recent events in Australian health economics that emanated from repetitive health sector structural and practice reforms. On one hand, theory evolution is a slow and methodical process that drives changes in contemporary evidence-based health care practice, thereby making it challenging to keep abreast of evidence-based practice in order to

inform both practice and health policy for health professions who operate in these volatile environments. These constant changes present the professional educational system with a challenge to teach effective roles and functions to new therapists as they will be required to handle clinical and administrative responsibilities in adaptable, flexible, and dynamic ways. In this study, participants felt that they lacked adequate managerial skills to manage constant health care changes they encountered in their daily operations.

Despite this, the foundational knowledge of occupational therapy practice, according to Kielhofner (2005), is based on empowerment of clients to gain independence with managing a chosen career. In this context, it could be anticipated that OTCLs would therefore seize the health sector reforms as an opportunity to market the profession. One way to achieve this objective is for study participants to embrace the changes, which resonate with professional beliefs of client empowerment, through re-structuring their practice using research evidence to justify their contributions to other health care team members and policy-makers on a case-by-case basis or within team environments. Secondly, in the context of economic, political, social, global, and historical factors that impact on the health sector reforms and their repetitive form, occupational therapists are urged to familiarise, adapt, and reposition their practice in order to remain relevant in the health industry.

Then, on the basis of the third and fourth study conclusions, effective change management, people skills and personal management skills are essential for the success

of the clinical leader's role. Participants in this study viewed the health care restructuring occurring in QH and nationally as likely to continue and constantly impacting on the delivery and management of occupational therapy services. It was seen as imperative for OTCLs to possess skills that were collectively referred as change management in order to continue to provide safe services. These attributes included effective communication, team leadership, performance management, human, physical and financial resources management, expert clinical skills, time management, organisational skills, and analytic and conflict resolution skills. OTCLs also viewed the bulk of their role as leading development of practices and changes in hospital-wide quality improvement activities. Therefore acquiring effective change management skills through targeted organisation-based training is essential for the successful practice of the OTCL's role.

The final study conclusion suggests that OTCLs are involved in mediation processes between senior management and their subordinates for clinical resources and change processes. In this regard and as a practice change recommendation, OTCLs need to evaluate their practice from the perspective of the prevailing patient service delivery models and management practices that favour patient-driven resource allocation methods. Then as part of their mediation responsibility, clinical leaders need to advocate on the basis of these evaluation findings, contemporary research evidence, and best management practice approaches, from their employers, for a suitable budget by utilising the historical and economic value of the profession as leverage to adequately cater for patient resources needed for successful client-centred care practice reforms.

Commenting, Anderson and McDaniel (2000) attributed the new client-centred approach of health sector resource allocation as a major shift from the previous provider-friendly one, which involved the disbursement of resources on the basis of providers' needs rather than patient's needs. The provider-driven approach was in contrast to client-centred care principles. To that end, as Baum (2000) and Finlay (2003) allude, study participants should seize the opportunity provided by the imminent changes in health care delivery models and systems to carefully evaluate their practice to ensure that it continues to be sensitive to both market forces and patients' needs.

5.5   Implications for policy

In this study, clinical leaders were expected to be experts in dealing with the surprise of each day's work by constantly monitoring responsibilities associated with both domains of the role and negotiating for adequate resources as part of their practice. Whilst role uncertainty can prompt innovativeness in practice (Postrel 2000), study conclusions drawn from this research and prior research evidence have associated lack of role clarity with increased job dissatisfaction (Atwal 2002; Moore et al. 2006; Shiri 2006).

As a policy recommendation, it is vital for employers to ensure that there is a role clarification and delineation of the OTCL position statement as discussed in theme 5 of Chapter 4 and the fifth study conclusion. In this manner, employers motivated by the need to curtail escalating recruitment costs involving OTCLs, can achieve OTCL role clarity by regularly reviewing position descriptions on the basis of research findings drawn from participants' perspectives and incorporated as part of recruitment and

performance management. This process ensures that participants are consulted about their experiences of working in the role as a way to ensure that the roles and responsibilities of the OTCL are consistent with both best practice standards and participants' expectations. Previous research evidence underscores the value of employee consultation with policy implementation and increased job satisfaction (Atwal 2002; Shiri 2006).

Research evidence suggests that occupational therapy practice in Australia occurs at a fast pace in a rapidly changing system that challenges the existing professional educational system's ability to adequately prepare clinical leaders to crack the code of health care reform (Duckett 2007; Gray 2006). In this second recommendation for policy-making and as prior investigations show (Boyce 2001; Braithwaite 2005; Gamble et al. 2009; O'Dowd 2005), it is imperative for policy makers to focus beyond structural hospital reforms and instead invest in funding research that is concerned with designing and implementing user-friendly workplaces, using practice guidelines for use in first management roles to address role clarity based on recent research evidence from this and earlier studies.. This approach to policy-making, as Dunn (2004) argues, ensures compliance with the implementation process because it is sensitive to the needs of the employees involved. Elaborating on the process of establishing workplace guidelines, Beer and Nohria (2000) argue that they should reflect shifts in positional power and authority to clinical leaders to ensure that leaders have adequate power needed to achieve sustainable health reform goals.

When considering the role of clinical leaders as drivers of health care changes, it is suggested that policy-makers better support the role by re-aligning corresponding structural power and authority in the form of ensuring adequate access to structural lines of organisational power and opportunities discussed in Chapter Two Part 2, in relation to the process of making strategic health reform decision-making. To this end, as discussed previously, perhaps a restructured OTCL role with clear practice boundaries and embedded with adequate structural power and authority will help organisations to realise success from constant health reforms. A consultative OTCL job position review on a regular basis consistent with policy shifts involving key stakeholders such as OTCLs and their managers could be implemented to ensure that it is structurally re-aligned with corresponding power and authority needed to get the job done.

However, in the context of repetitive Australian health reforms (Braithwaite 2006; Dwyer 2004) and current study findings and conclusions, together with recommendations for the practice of OTCLs and policy issues (Braithwaite 2004; Gamble et al. 2009), it is vital for future research directions to take into consideration the existing gaps in policy and the practice of the OTCL role.

5.6   Future research directions

This study has explored the lived experiences of OTCLs. The following questions arise from the study for further exploration:

i). Would recruiting male participants have any impact on the outcome of the study?

The Foundation of the American College of Healthcare Executives (2001) and Weil and Mattis (2003) indicate there has been active debate on the influence of gender on health care executives' employment. Generally, health care leadership is portrayed as predominantly male dominated. However research study findings by Briggs (2010) and Powers (2001) show that female health executives possess valuable complementary leadership attributes when compared with their male counterparts. In this study all participants were females. While it was outside the scope of this study to explore the impact of gender difference on the phenomenon of working as an OTCL, the current study findings can be compared with the findings of a similar study to explore the phenomenon of working as a male occupational clinical leader within the Australian public health context.

ii). What composition of leadership development and management program curriculum would prepare OTCLs for the role?

In this study, the participants expressed a shared perception that the formal training they received and the work based Emerging Leadership Program development course were inadequate to prepare them to effectively accomplish the complex practice and policy challenges presented by the dual OTCL role. They suggested further training in health sector leadership and management as strategy to enable them to adequately discharge their roles and responsibilities as clinical leaders. However it is unclear from study findings and conclusions what components of leadership and management skills

training need to be provided. Therefore further research could focus on specific occupational therapy leadership and management, and educational curriculum development to provide insight into the learning needs of these participants specific to their work contexts.

iii). What models of practice guide OTCLs?

Another area of potential further study is the managerial reasoning process of OTCLs in the Queensland public health system in order to establish how they make their decisions when managing change. In this study the clinical leaders struggled to embrace the business-oriented decision-making approaches, which were perceived as precluding the utilisation of the traditional professional practice models that are more humanistic in nature. Several clinical leaders expressed being personally challenged and frustrated by constant health changes, sparse time resources, high demands presented by the expanded OTCL dual role, and high role expectations in an environment marked by dwindling resources.

According to Beer and Nohria (2000); Braithwaite (2005) and Briggs (2009), for health management roles, leading change has become an important managerial responsibility because of the constantly high failure rate of reforms and staff resistance to change. To this end, health managers have attempted to implement a number of changes to management initiatives (Axelrod 2000; Bishop 2000; Mercer 2000; Pascale, Millemann & Gioja 2000) with limited success. Furthermore, financial targets and incentives are

often used as key drivers for change to align the interests of management with those of shareholders.

On the other hand, the use of high employee participation as a bottom-up approach to create a sustainable competitive advantage as a means to safeguard shareholders' long-term interests is another avenue for future research. In this view, change percolates from the bottom up and is highly sustainable because of high employee involvement in designing solutions. Ideally, as Bass (2003) argues, it is desirable for clinical leaders to possess backstage team leadership skills to effectively lead change, such as an ability to create urgency, build support, and alleviate anxiety through team motivation, empowerment, and communication. It is on this basis that further investigation is required to evaluate clinical leaders' self-perception with regard to the practice of effective change management to ensure that appropriate support systems are implemented.

iv). What value is there for changing Australian public hospital structures as a way to achieve better client outcomes pertaining to the delivery of occupational therapy services?

The Australian hospital system has been subjected to repeated structural changes as a result of factors such as the influence of consumerism, technology, new ideas, demographic population changes, application of business practices, the advent of clinical accountability, and performance management (Duckett 2000; Mickan & Boyce 2006; Palmer & Short 2010). In addition clients have become increasingly

sophisticated with weakening of traditional inter-professional boundaries in response to new business thinking management approaches and changes in health care delivery models (Brock 2006). However there is scant evidence to suggest the value of the structural health reforms both from previous research (Duckett 2005; Eager 2004; Braithwaite & Goulston 2004; Braithwaite 2005; Gray 2006; O'Dowd 2005) and current study findings and conclusions. The Australian health system continues to transform because of a plethora of public criticisms, among them public disapproval of the manner public health services delivery and management is carried out. In this study, study conclusions show that clinical leaders were dissatisfied with the rapid pace of health sector institutional changes and the impact of their role on the delivery and management of occupational therapy services.

Prior research has challenged the value and role played by hospital-based occupational therapy services by investigating roles and responsibilities of occupational therapy managers and identifying work dissatisfaction issues that continue to negatively impact on occupational therapy workforce issues (Braithwaite 2004; Fortune 2000; Gamble et al. 2009; Griffin 2002; Griffin & McConnell 2001; Meade et al. 2005; Moore et al. 2006).

Whilst continuous reform is a central feature for complex adaptive systems such as public hospitals to remain competitive (Anderson and McDaniel 2000; Braithwaite 1998), there is need to further extrapolate the nature of changes that are likely to bring better value to its consumers. This is important when considering the fact that every

structural Australian hospital change has previously and recently aimed to achieve better client outcomes by re-defining health care resource allocation through inter-sectorial stakeholder collaboration, local leadership, and consumer empowerment (Braithwaite 2006; O'Dowd 2005; Briggs 2009). Perhaps, as suggested by Braithwaite (2005) and Stanton (2002), it is time to re-focus health care investment on clinical leaders as health care change drivers rather than organisation structural reforms, by exploring their support mechanisms in areas such as teamwork processes and clarification of their role in public hospital services using qualitative inquiries.

In addition there have been significant human and fiscal resource concerns associated with reforming the Australian health system as shown by findings and conclusions in this research and prior studies (Braithwaite 2006; O'Dowd 2005). Furthermore the Australian health care industry human resource budget remains significantly high in comparison to the national GDP, despite several attempts to contain costs and constant public calls for improvements in the delivery and management of public health services (ABS 2008; Beer & Nohria 2000; Braithwaite 2005; O'Dowd 2005). In this regard a large quantitative survey based on the findings of this study could further explore the effectiveness of the role of OTCLs as targeted future research direction investigating the specific contribution of this role towards attaining successful health reforms in Queensland.

5.7   How the purpose of the study was met

Overall the study aimed to investigate the lived experiences of OTCLs as a way to gain an understanding of this new role and explore the scope and responsibilities of this role in terms of its multiple functions. Also, the study sought to make information available to other OTCLs and policymakers on factors that may impact on the study population's recruitment, retention, and professional development.

This study has presented a detailed analysis of the phenomenon of working as an OTCL in terms of the dual clinical and managerial functions as discussed in Chapter Three based on participants' perspectives and the researcher's journal of events. Kanter's (1977) theory of organisational power was used as the theoretical framework, while van Manen's (2001) hermeneutic phenomenology and Smith's (2004) IPA were chosen as the most appropriate methodology to achieve the study aims. This chapter has discussed suggestions for policy and practice change in the area of OTCLs by identifying opportunities, challenges and strategies to assist the participants to better cope in the role. The findings revealed that there are multiple factors influencing the scope of the OTCL role and strategies to manage in the role ranging from extraprofessional, intra-professional and inter-professional issues that are both philosophical and structural in nature.

The conclusions showed that the OTCL role is a complex and unique first-line management one that operates within a complex adaptive system. Study participants faced several challenges such as lack of managerial skills, teamwork-related problems

and the impact of constant policy shifts in their practice. However there were also some positive outcomes such as peer support, career advancement opportunities into full-time management, and formal supervision received by participants from their line managers.

It is hoped that the outcome of this study, while not generalizable, will inform policy and practice by resonating with first-line managers in similar positions and identifying issues relating to OTCLs' recruitment, retention and professional development needs.

5.8   Conclusion

This chapter has presented five study conclusions and discussed them in the context of literature reviewed in Chapter 2 and the selected theoretical framework. Suggested changes for policy-making and practice of OTCLs were also discussed. It is clear that these study conclusions see the OTCL role as a challenging and conflicting one. A range of factors clearly contributes to this. The role of Kanter's (1977) theory of power as the study's theoretical framework was provided to explicate its utility to understanding the conclusions of this study. Following this, suggested future research directions in the area of occupational therapy clinical leadership were presented and discussed.

One unique contribution of this study is that it has attempted to holistically explore the essence of working as a Queensland OTCL and the scope of the role in terms of the dual clinical and managerial components using a hermeneutic phenomenology methodology as informed by Heidegger (1962); Gadamer (1975); Smith (2004) and van

Manen (2001). No other study has explored this topic in this manner. This study provides opportunities for further investigation of the roles of OTCLs using other methods and sample sizes to explore the validity of the findings. It is hoped that the findings and conclusions of this study will assist in the development of future OTCL human resource reforms and their practice in Queensland and extend to other areas of similar practice. Finally, the results of this study show that in order to practice as an OTCL in a complex and an ever-reforming Australian public health system, it is vital to demonstrate competence at effectively managing health reforms by making sense of the changing practice trends in the management and leadership of health services. To this end, key stakeholders such as health care organisations and academic institutions need to invest in appropriate leadership training programs specifically designed in-depth postgraduate competency training such as offered in medicine for relevant levels of management at postgraduate certificate, postgraduate diploma, master's degree level and doctorate degree levels and effective human resource development strategies as a priority in order to realise and sustain successful health sector reforms.

In conclusion, I would like to thank the participants for so willingly sharing their experiences with me, my family and employers for their support, and my two project supervisors, Dr Helen Edwards and Associate Professor Penny Paliadelis for their unwavering support and sound guidance throughout the research project. I hope that the outcomes of this study contribute to the development of the position to more effectively meet the needs of the communities that occupational therapists serve.

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Appendices

Appendix A – Consent Form for Participants

Mr Simon Shiri
Faculty of The Professions
University of New England, Armidale, NSW 2351
Telephone: 0420 688 419
Email: sshiri@une.edu.au

Title of Project:
Exploring the Working World of Occupational Therapy Clinical Leaders

Project Researcher:
Simon Shiri

Supervisors:
Dr Helen Edwards and A/Prof Penny Paliadelis

1.   I confirm that I have read and understand the Plain Language Statement for the above study and have had the opportunity to ask questions.

2.   I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3.   I understand that the interview will be taped and agree to it being recorded on audio-tape.

4.   I understand that if any publications arising from the research refer to me, my hospital or my community then pseudonyms will be used and that we will be otherwise unidentifiable.

5.   I am aware that the Director of Occupational Therapy is not aware about my participation in this study.

6.   I agree / do not agree (delete as applicable) to take part in the above study.

Name of Hospital _____

Name of Participant (print) _____   Date   /   /

Signature _____

Researcher (print)_____   Date   /   /

Signature _____

1 for participant; 1 for researcher

Appendix B – Research Information Sheet for Participants

Mr Simon Shiri
Faculty of The Professions
University of New England, Armidale, NSW 2351
Telephone: 0420 688 419
Email: sshiri@une.edu.au

Title of Project:
Exploring the Working World of Occupational Therapy Clinical Leaders

[Please keep this for future information]
You are invited to take part in a research study concerning Queensland Health Occupational Therapy Clinical Leaders working in public hospitals in the Metro North and Sunshine Coast – Wide Bay Health Service Districts.

Before you decide whether or not to take part in this study, it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully, and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Purpose of the study

The study has two main purposes, which are as follows:
- To explore the views of Occupational Therapy Clinical Leaders about their role, opportunities and challenges, as well as its contribution towards the delivery of health services in Queensland Health.
- To make information available to Occupational Therapists and employers about factors that may impact on Occupational Therapy Clinical Leaders' recruitment, retention and development.

Participation

It is up to you to decide whether or not to take part, as participation is entirely voluntary. If you do decide to take part you will be given an information sheet and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, without experiencing any disadvantage, or being required to explain. If you withdraw from the study, any information you may have provided will be deleted if you wish.

Research Process

If you choose to take part in this study, you will be asked to take part in a face-to-face individual interview at a date, time and venue convenient to you. The interview will last between 60 to 120 minutes. Open-ended questions will be used to form the basis of the interviews. These may be followed with some semi-structured prompts to elicit further details if required. The content of the interviews will be recorded using a digital audio recorder.

Should you agree to take part in the study you will be asked to sign a consent form prior to the interview. Your names and any information about your location will be replaced with pseudonyms to maintain anonymity. A copy of the interview transcript will be sent to you, to confirm whether it is consistent with your perception of the interview. All information collected from you during the course of the research will be kept strictly confidential.

Results of the Research

The data from the study will be used to write a thesis in partial fulfilment of a Doctor of Health Services Management degree. The thesis will be stored at the University of New England Dixon Library. In the thesis and in any subsequent peer reviewed publications, you, your hospital and community will be identified only by pseudonyms.

Ethics Review

This study has been reviewed by the University of New England Human Research Ethics Committee Approval # HE09/206 Valid to 04/01/11. [Contact Person: Research Ethics Officer, Mrs Jo-Ann Sozou, University of New England, Armidale, 2351. Telephone: 02 6773 3449.] Should you wish to discuss this study with someone not directly involved, in particular in relation to matters concerning policies or the conduct of the research or your rights as a participant, or should you wish to make an independent complaint, please follow through this matter with either contact person.

Contact for Further Information

For further information about the study, please contact the research supervisors or project researcher:

Dr Helen Edwards	Dr Penny Paliadelis	Simon Shiri
Uni of New England,	Uni of New England,	22 Wentworth Court
Armidale, 2351	Armidale, 2351	Nambour, 4560
helen.edwards@une.edu.au	ppaliade@une.edu.au	sshiri@une.edu.au
t: 02 6773 2078	t: 02 6773 3666	m: 0415 549 180

Appendix C – Participant Invitation Letter

Mr Simon Shiri
Faculty of The Professions
University of New England, Armidale, NSW, 2351
Telephone: 0420 688 419
Email: sshiri@une.edu.au

Dear

Thank you for considering participation in this project. A central part of the process involves me meeting with individual participants to interview them. To organise the interviews I need to know the days, venue and times that would best suit you. Please note all interviews will be conducted outside working hours. Listed below is a range of start times and venue options; please select one or more that are convenient for you. Make your own suggestions if the options are not suitable.

Times: 4pm ☐   <u>Venue Options</u>:
Own Choice   ☐
4:30pm ☐   Researcher to provide   ☐

5pm ☐   Other (specify):

5:30pm ☐   ……………………………..

Any other time ☐

Specify ……………………………..

Days: Monday …………………☐
Tuesday…………………☐
Wednesday ……………..☐
Thursday………………..☐
Friday…………………..☐
Saturday………………..☐
Sunday…………………☐

After selecting the time and venue that is convenient for you, please return this information using the paid self-addressed reply envelope enclosed in the package. Please keep a copy of the consent form. I will confirm the interview by email three days before your selected date for the interview.

Thank you for your time and co-operation

Yours faithfully

Simon Shiri
University of New England
Armidale 2351
sshiri@une.edu.au

Appendix D – Interview Questions

Mr Simon Shiri
Faculty of The Professions
University of New England, Armidale, NSW, 2351
Telephone: 0420 688 419
Email: sshiri@une.edu.au

Participation in this study will involve volunteering to engage in an in-depth face-to-face interview for a period of 60 to 120 minutes. The following open-ended questions will be asked of all participants. Further follow-up semi-structured questions will be asked if more details are needed.

Open-ended Questions
1. What have been your experiences of working as an Occupational Therapy Service Clinical Leader?
2. What does it mean to be a Queensland Health Occupational Therapy Clinical Leader?
3. What opportunities and challenges do you encounter in your role?

Semi-structured Questions
1. Have you a sense of the relative importance of the things in your workplace, which mostly contribute to the above-stated opportunities and challenges in your role?
2. In the case of the things that present challenges in your role, how do you think these might best be overcome and by whom?
3. In the case of things that present opportunities in your role, how can these be maintained and by whom?
4. What recommendations about your role do you make to: a). Employers; b) existing Queensland Health Occupational Therapy Clinical Leaders
5. Any other issues pertaining to your role that you may want to bring to the discussion?

Thank you for your time and co-operation

Yours faithfully

Simon Shiri
Doctor of Health Services Management Candidate
University of New England
Armidale 2351
sshiri@une.edu.au

Appendix E - UNE HREC Approval Letter

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: Dr D Edwards, Dr P Paltadelis & Ms S Shen
                  School of Education

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE   Exploring the Working World of Occupational Therapy Clinical Leaders

APPROVAL No.   HE09/000

COMMENCEMENT DATE   04/07/2010

APPROVAL VALID TO: 04/01/2011

COMMENTS   Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.
For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report on the completion of their project. The Progress / Final Report Form is available at the following web address: http://www.une.edu.au/research-services/researchdevelopmentintegrity/ethics/human-ethics/humanethics.php

The NHMRC / National Statement on Ethical Conduct in Research Involving Humans requires that research have must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse conditions of participants, proposed changes to the protocol and any unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.

18/12/2010

Jo-Ann Sozou
Secretary

Appendix F – Interpretive Phenomenological Analysis

Mr Simon Shiri
Faculty of The Professions
University of New England, Armidale, NSW
2351
Telephone: 0420 688 419
Email: sshiri@une.edu.au

Interpretive Phenomenological Analysis Trail

Ink Codes (Categories and Themes):

Category A: Purple: Reason for accepting to participate

Category B: Red: Nature of work/working experiences/role interpretation

Category C: Orange: Opportunities associated with working as an OTCL

Category D: Blue: Challenges in the OTCL role

Category E: Green: Strategies/recommendations to cope with the OTCL role.

Interview 3

Date: 7/8/10

Participant: Rosie

Rosie: RS

Simon: SS

SS: Thank you very much for agreeing to participate in this study.

This person is not defined above. RS: yeah. As you are aware, this study seeks to explore the OTCL's (OTCL) role, opportunities, challenges and any recommendations regarding the role.

SS:Yeah. I am also an Occupational Therapist (OT) and would like to explore your perception of this role. The other reason is to gather your recommendations regarding the role, professional development opportunities, recruitment and retention, and hopefully the information will be insightful to other OTs and employers. (RS: Smiles in agreement). Before we start, do you have any questions pertaining to the study that you may want to ask?

RS: Yeah (smiles): Nothing at all, it was all clear.

SS: Thank you very much. Firstly, may I ask what prompted you to agree to participate in this study?

RS: Yeah. I saw it as essential, personally and professionally as an OTCL working at a different facility, to contribute to our profession. Also, I was interested in finding out how others experience their day-to-day workload and what constitutes their role. I felt really privileged to participate in this study as I am a new clinical leader and I am happy to share some of the opportunities and challenges I encounter in my role. **(Theme one: Subtheme one: tension in OTCL role)**

SS: Thank you Rosie for the explanation. Now may I find out in your own words, what it is like being a Queensland Health OTCL? How would you describe your experiences?

RS: (Laughs). Mmm, yeah, I would define the role of a CL at …. as quite challenging as our role involves 0.5 clinical and 0.5 management. It can be quite challenging trying to get a good balance between the clinical and staff management and ensuring that you provide the best for both your patients and staff. **(Theme one-Role Scope)**

SS: Thank you very much. You stated that it is quite challenging mainly because it involves two components, that is clinical and managerial components. (RS: yeah): Would you like to tell me more of what is involved in these two components?

RS: Yeah. The clinical role involves managing a busy clinical workload daily - including clinics. So every day I have to ensure that the clinical caseloads are well managed. We work full time 40 hours a week **(Theme two: Subtheme one: clinical perspectives).** On the management side, it involves managing staff including staff development; leave, day-to-day operations, Annual Recreational Leave (ARL), training opportunities etc. (SS: yeah). Supporting staff clinically/professionally, fortnightly supervision of staff and reporting/communicating to my director regarding staff issues. **(Theme two: Subtheme two: management perspectives).**

SS: So Rosie, what I understood is that on the management side, the role involves leave management, coordinating professional development, supervision, coaching (yeah). Is there anything to add?

RS: We have 6 clinical leaders (CL) that collaborate with the director and assistant director, for assisting the operational management of the service, as well as designated department corporate portfolios. SS: so there are 6 CL? RS: yeah. So which one is your portfolio? **(Theme four: opportunities)**

RS: Outpatient management. Coordinating the clinical side of things, including triaging of all referrals, co-coordinating the outpatient templates, collaborating with admin and outpatient staff on a day-by-day basis **(Theme two: Subtheme one: clinical perspectives).**

SS: Within your portfolio, there are other OTs, how many other OTs do you have?

RS: Mmm, six (counting silently).

SS: What experiences?

RS: It varies. We have a new graduate program, a Health Practitioner Level 5 (HP5) clinical specialist and then various HP clinical positions/levels within each service line. **(Theme two: Subtheme two: formal and informal org. support)**

SS: So within your team you manage leave, what is involved in this process?

RS: Management of day-to-day unplanned leave within your service line. For example, if someone calls in sick you have to arrange for cover within your service line and prioritise caseload. We also facilitate planned leave requests within our service line. **(Theme two: Subtheme two: management perspectives)**

SS: Do you have sign off responsibility?

RS: In terms of ARL?

SS: Yeah and any other leave?

RS: No, in terms of ARL and conference leave, Director of Occupational Therapy Services (DOOTS) and/or Deputy Director of Occupational Therapy Services (D/DOOTS), have the sign off responsibility. We have the responsibility to facilitate the process, ensuring that there is adequate cover on a day-to-day basis within our teams **(Theme two: Subtheme two: management perspectives).**

SS: So in facilitating leave applications processing, you are able to make a decision in favour or not in favour?

RS: Yeah.

SS: Rosie, what else is involved in terms of staff support?

RS: Coordinating supervision depending on level of clinical experience (e.g. weekly, fortnightly), coaching and orientation to clinical caseloads. With Performance Appraisals and Development (PAD) we do it for all staff after three months in a caseload and link their PAD developmental and career plans to Professional Development (PD) leave applications. For example, if someone has identified a course in their PAD and then apply for conference leave, that becomes a priority as compared to someone who has not identified this in her PAD. Does that make sense**? (Theme two: Subtheme two: management perspectives)**

SS: Yeah

SS: Operational responsibilities?

RS: No. I guess the director coordinates that side of things, except day-to-day portfolio issues **(Theme two: Subtheme two).**

SS: What are those issues?

RS: Issues such as consumables.

SS: Do you have the sign-off responsibility?

RS: No. The senior team liaises with the Director regarding staff requests. We have a committee responsible for coordinating consumable management within our department. However, the Director has the sign off responsibility **(Theme two: Sub-theme two).**

SS: Can you please expand in terms of the actual process involved?

RS: The director has the budget responsibility. We identify within our service lines/teams any items needed clinically and then communicate these to the director. We have a senior OT management meeting weekly, with set agenda items each week. For example, leave management, workload issues, resources, staffing, and rosters, workplace health and safety, safety and quality, portfolio feedback, committee meeting feedback, etc. The weekly senior management team meeting involves the six OTCLs, (Assistant Director and director **(Theme four: Subtheme four).**

SS: So decision-making is between a director and CL?

RS: No it involves all the whole senior management team (6 x CL, D/DOOTS and DOOTS) **(Theme four: opportunities)**

SS: (both laugh): any other issues relating to the management component?

RS: No.

SS: Besides OT do you have any other supporting staff in your team?

RS: Yes, we have 4 OTA and an administration officer **(Theme four: sub-theme four).**

SS: What are their responsibilities?

RS: Yeah. The Assistant's role within the OT department is responsible for assisting with administration duties, stocking the consumables, cleaning the department, and garment manufacture. Unfortunately they do not have a large therapy base.

SS: Are they involved with patient therapy sessions?

RS: Minimally. Except occasionally with manufacturing garments in hands/burns (predominantly) or accompanying OTs on home visits (for at-risk patients). The OTA at …. does a lot of therapy sessions with patients.

SS: Initially you described your role as quite challenging, then you brought up the issue of weekly management meetings, you described your role in terms of support you provide OTs and OTS in your team, what sort of support do you get yourself?

RS: Weekly supervision with the director for all CLs (**Theme four: sub-theme four: formal supervision support).**

SS: What does it involve?

RS: It's an opportunity to communicate concerns, mentoring, whether you have staffing concerns. Or you have any concern with any staff member, or if you're needing guidance with portfolio management **(Theme four: sub-theme four).**

SS: Anything else?

RS: I think that's basically it. Yeah.

SS: OK, let us move to the next section of our discussion, opportunities in your role?

RS: I think the management side of things is an opportunity. I have found that if you are an experienced and skilled clinician you are often offered management opportunities due to your clinical leadership **(4:1).**

SS: So you work as a clinical consultant in your role?

RS: Not necessarily, a clinical consultant, just an advanced clinician. Experience in leading a team whilst being a clinician is an opportunity. Developing management skills whilst continuing in a clinical role is very rewarding. I really enjoy the patient contact. I also feel that you are able to make well-informed decisions regarding the team/ service as you still have involvement in the clinical world. The ongoing mentoring with the director is very rewarding. **(Theme four: Subtheme one: Career advancement)**

SS: I am sure there are more opportunities?

RS: Yeah. Another thing I find rewarding is being involved in the senior management team and the ability to influence the day-to-day clinical operations of your team. It is a really positive experience. The clinical leaders communicate every day in terms of caseloads and sharing information regarding what is happening in different areas (including staffing issues).

We are not really experts in the clinical side or management side but this role allows you to develop in both areas under the guidance of the OT Director. We rely on clinical experts within our service lines to advise junior staff on complex clinical issues **(4:2: vital link).**

I enjoy the opportunity to influence the team culture through positive leadership. I also enjoy advocating on behalf of staff within my team and assisting them to grow professionally **(4:2: vital link).**

SS: Within your team, there is an HP5?

RS: Yes there is a management and clinical HP5 and clinical HP4/HP3s. The HP5 and HP4 provide clinical expertise to less experienced OTs with the intention of succession planning **(4:4: formal support: delegation).**

SS: Any other opportunities?

RS: Mmm, I guess in terms of managing staff and being able to provide leadership to staff. Coordinating PD opportunities and communicating why and how strategic decisions are made, and how it impacts the team **(4:3: Stepping stones).**

SS: Thank you very much let us move to challenges (baby is now unsettled, some background noise, Rosie is a bit distracted).

RS: The biggest challenge is trying to balance the management of staff and clinical caseload because both are equally important. It is really difficult to balance the two when the clinical component becomes demanding **(Theme three: multiple challenges).**

SS: You mentioned the issue of formal supervision, yours and your team. RS Yeah. SS: What constitutes your supervision?

RS: Our weekly supervision with the OT Director is not structured; you come up with items for discussion.

SS: Any other challenges?

RS: Yeah, challenges… (Thinking loudly): Expectations from staff and the realities of practice in terms of what can actually be provided. That's a challenge **(3:2: lack of clarity in practice boundaries).** Another challenge is failing to self-reflect and allow for self-development **(3:3: consequences of expanded roles and responsibilities).**

SS: You mean lack of opportunities for own professional development?

RS: Yeah. It can be so busy that you do not think of your own professional development, despite the opportunities being available **(3:3).**

SS: What about challenges around management?

RS: Mmm, yeah, probably just in terms of not knowing what is happening at the broader level within the organisation and how that impacts on the OT Department and how to communicate that to staff. We are well informed about our own profession and allied health as a whole, just not at an executive level **(3:3: consequences of expanded roles and responsibilities).**

SS: Any other challenges?

RS: I think the issue of having different staff with very varied expectations and backgrounds **(3:1: lack of key team leadership and management competencies).**

SS: Can you highlight some of the expectations?

RS: Mmm, yeah, I guess for example, in terms of staff caseload allocations and preferences. Decisions are made around this issue for good reason, which is communicated to staff, yet some people are unhappy despite the explanation. I cannot think of any other examples but that is a challenge **(3:1: workforce planning, negotiation skills).**

SS: Regarding your team processes you mentioned, are you involved in recruitment?

RS: Yeah. We allocate an HP5 OTCL within the service line in the panel. The chair is the Director or Assistant Director and another external panel member (e.g. doctor, nurse) in one of those specialty areas to increase the robustness of the process **(4:1: career advancement: staff recruitments).**

SS: That's exciting having a doctor as a panel member

RS: Yeah we endure, we have a specialist from the clinical area because of the impact it has on the medical and allied health team. We are also trying to develop our relationships/networks with surgeons and this is an exciting opportunity. We also have a number of multidisciplinary committees that the OTCL sits on **(4:2: vital link).**

SS: In terms of reporting, whom do you report to?

RS: OT Director, who in turn reports to Allied Health Director **(4:4: formal line management support).**

SS: So the committees are functional teams?

RS: Yeah.

SS: Ok let us move to how you have managed those challenges? What strategies are you using to cope with the challenges?

RS: Yeah, in terms of managing staff and their expectations, I get a lot of support from the OT Director **(4:4).**

SS: Workload issues, supervision?

RS: I try to ensure I keep open communication with staff members within my team. I also get a lot of support from the other clinical leaders in terms of day-to-day issues **(4:4: peer support).**

SS: Any other strategies you employ?

RS: Yeah, I think that is about it really.

SS: What about the issue of duality of your role and the two competing priorities you stated?

RS: Within the department I utilise the support of the admin staff (where appropriate) in coordinating outpatient caseloads. We also have three annual leave relievers that can be used to assist busy caseloads if there are not three staff members on leave. Personally, you need to be highly organised in this position to manage both aspects of your role effectively. Yeah the ability to prioritise your workload is very important **(Theme five: strategies for future).**

SS: Any other recommendations you would make to other OTs aspiring to be in your role?

RS: Yeah, I think it will be helpful to have an external mentor to help with everyday workload issues. Flexibility, adaptability, good time management skills and ability to prioritise are important. And, most importantly, you need to have well-developed communication skills **(5:1: competencies needed).**

SS: If you were to make any recommendations to your employer about your role, what would you say?

RS: The Emerging Leadership program is a fantastic Queensland Health program that was developed to develop the leadership skills of our highly skilled clinicians **(5:1).** In terms of my personal work situation, I do not have any suggestions as I am really enjoying my job, and find it really rewarding.

SS: If you were asked to make changes to the duality nature of your role, what changes would you make?

RS: Reduce the clinical load to allow for a greater focus on the strategic vision of the department, including service improvements and quality activities.

SS: Anything else?

RS: No

SS: Thank you very much for your contribution and time taken to share information regarding your working world experiences. I will email you a draft copy of the transcript to ensure that the report is a true reflection of what transpired.

RS: Thank you, no worries.

Appendix G – Position Description

Mr Simon Shiri
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Queensland Health Occupational Therapy Clinical Leader Role Description

Position: Occupational Therapist (Advanced)-Clinical Leader

Work Unit: Occupational Therapy Service, Allied Health Department

Division/Location: District Health Service

Classification: HP5

*Award: Health Practitioners (Queensland Health) Certified Agreement (No.1) 2007
District Health Services Employees State Award 2003*

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Our behaviour is guided by Queensland Health's commitment to high levels of ethics and integrity and the following five core values:

Queensland Health's Four Core Values:

- *Caring for people:* We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.

- *Leadership:* We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.

- *Partnership:* Working collaboratively and respectfully with other service providers and partners is fundamental to our success.

- *Accountability, efficiency and effectiveness:* We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.

- *Innovation:* We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Our Vision: To be trusted as a leader in regional healthcare.

Our Purpose: Delivering quality healthcare in partnership with our communities.

Our Values:

- *Caring*: We deliver care, we care for each other and we care about the service we provide.

- *Doing the right thing:* "Doing the right thing" sums up that we do respect the people we serve and try our best. We treat each other respectfully and we respect the law and standards.

- *Openness to learning and change:* We continually review practice and the services we provide.

- *Being safe, effective and efficient:* We will measure and own our performance and use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.

- *Being open and transparent:* We work for the public and we will inform and consult with our patients, clients, staff, stakeholders and community.

Purpose:

Deliver specialised and complex occupational therapy services and professional leadership within designated health care units and across a multidisciplinary team, to stakeholders/customers of Queensland Health in accordance with organisational goals. Clinical Units include Acute Medical/Rehabilitation/Community and surgical/Orthopaedics Services.

The position is required to utilise a high degree of clinical leadership, independence and initiative to coordinate timely referral to Allied Health practitioners and support staff in order to facilitate safe discharge of patients presenting to your allocated work area.

Staffing and Budget Responsibilities

The position reports operationally to the Director of Occupational Therapy Services and professionally to the relevant discipline Director. The role does not have direct cost centre management responsibility and has indirect line management responsibility for other staff. You will work within the occupational therapy service, incorporating caseload and daily workflow management, clinical supervision, consultancy and quality services. This position operationally and professionally reports to the Director, Occupational Therapy Services, and has a role in supporting the development and management of a district-wide Occupational Therapy Service in an environment of significant change associated with service growth, specialisation and new capital works.

Your key responsibilities:

Fulfil the responsibilities of this role in accordance with Queensland Health's core values, as outlined above.

Clinical Practice

- *Deliver specialised Occupational Therapy and consultancy services, applying professional expertise and judgement to clinical problems of significant scope and complexity, in accordance with evidence-based principles, with minimal direct clinical supervision.*

- *Provide professional leadership in the development of clinical practices, procedures, protocols and standards that support the continuum of care engaging cross-discipline referencing where relevant.*

- *Facilitate the integration of services across specialties within a clinical area to coordinate the delivery of effective Occupational Therapy Services across the district.*

- *High quality, safe and timely flow of patients discharged from the designated work area.*

- *High quality clinical practice supervision, including a lead role in competency training and skill development with less experienced allied health practitioners and allied health assistants.*

Communication/Team Participation

- *Provide high-level advice within specific clinical areas of expertise to professional and operational teams, relevant service managers and other stakeholders regarding professional standards and clinical service development.*

- *Provide clinical direction and advice to occupational therapists in all aspects relating to their area of expertise.*

- *Work collaboratively and effectively across multiple professions, services and stakeholders within and external to the designated work area in order to ensure seamless transition of patients across the continuum of care.*

- *Produce high quality documentation and reports, consistent with the needs of future redesign initiatives undertaken for the Allied Health- Advanced Health Practitioner role, to the relevant managers and stakeholders.*

Leadership/Work Unit Management

- *Provide clinical leadership at an advanced level, and with infrequent need for direct clinical practice supervision, for allied health practitioners and allied health assistants within your designated work area.*

- *Provide clinical practice supervision and performance management, including a role in competency training and skill development, to less experienced Occupational Therapy practitioners, students and support staff within the specific area of expertise.*

- *Lead change management processes through collaborative development and implementation of occupational therapy practices, policies and protocols.*

- *Coordinate and monitor the workload distribution and resource management within the allocated clinical units.*

- *Monitor and evaluate service delivery with a focus on measuring outcomes and quality improvement, utilising this data to review guidelines on patient management and service delivery for the units serviced by the team.*

Research/Quality Improvement

- *Utilise a high degree of professional independence, research and evaluation skills, and organisational awareness to lead further redesign, implementation and evaluation of the scope of practice and model of service delivery for other areas of Allied Health advanced clinical practice in other settings.*

Qualifications/Professional registration/other requirements

Appointment to this position requires proof of qualification and registration or membership with the appropriate registration authority or association. Certified copies of the required information must be provided to the appropriate supervisor or manager, prior to the commencement of clinical duties.

- *Appointment to this position requires the possession of a tertiary degree in Occupational Therapy or Physiotherapy and eligibility for current registration with the Australian Health Practitioner Regulation Agency (AHPRA).*

- *A health related postgraduate qualification would be well regarded.*