Scientific Research Publishing

Health, 2022, 14, 629-649
https://www.scirp.org/journal/health
ISSN Online: 1949-5005
ISSN Print: 1949-4998

People Management in Hospitals: Where Doctors and HR Do (Not?) Meet

Myra van den Goor[1], Tanya Bondarouk[2], Anna Bos-Nehles[2]

[1]Company for Professional Physician Development, Q3 BV, Den Bosch, The Netherlands
[2]Faculty of Behavioural, Management and Social Sciences, University of Twente, Enschede, The Netherlands
Email: m.vandengoor@q3consult.nl

How to cite this paper: van den Goor, M., Bondarouk, T. and Bos-Nehles, A. (2022) People Management in Hospitals: Where Doctors and HR Do (Not?) Meet. *Health*, **14**, 629-649.
https://doi.org/10.4236/health.2022.146046

Received: December 13, 2021
Accepted: June 5, 2022
Published: June 8, 2022

Abstract

Objective: Although HR activities are known to enhance performance, this seems an often overlooked domain amongst physicians. Therefore, this cross-disciplinary interview study explores how physicians perceive high performance and what activities they find contributing to such performance. **Methods:** Drawing on HR and healthcare literature, we analysed in-depth interviews with 28 physicians and 7 HR professionals and hospital management representatives, following the grounded theory approach. **Results:** Our findings demonstrate physicians perceive high performance as a balance between quality of medical care and patient satisfaction and dedication and collaboration are indicated vital dimensions of high performance. Physicians offered suggestions regarding activities contributing to high performance. **Conclusion:** This cross-disciplinary study recognized dedication and collaboration as crucial elements for physicians to perform to the best of their abilities. These findings suggest that high performance can only flourish when doctors are seen as committed professionals, with strong humanistic values rather than just as providers of medical care. The results of this research furthermore indicate that people management is critical, it is recommended that this should be executed through close collaboration of all those responsible.

Keywords

Physician Performance, Humanistic Values, People Management, HR Practices, Healthcare

1. Introduction

It goes without question that, in a field as complex, high-stakes and resource-intensive as healthcare, optimum physician performance is vital for delivering high quality patient care. Although Human Resource (HR) activities are known

to stimulate and enhance performance, the management of HR has often been overlooked in the hospital sector, and especially concerning physicians [1]. Despite this, healthcare is undoubtedly a people business, depending heavily on the knowledge, skills and motivation of those responsible for delivering health services [2] [3]. On this basis, we concur that effective Human Resource Management (HRM) could, and should, play an essential role in enhancing physician performance.

In the HRM literature, the AMO framework, originally developed by Appelbaum *et al.* [4], is a widely used concept to explain the linkage between HR practices and individual and/or organizational performance. We utilize this framework and argue that physicians should be able to perform as the hospital organization expects of them provided their Abilities, Motivation and Opportunities within their work environment are "shaped" in line with those expectations [5] [6]. If all three characteristics are aligned with organizational intentions, then individual performance is likely to be enhanced. Each of these three factors is supposedly manageable by HR activities. The Ability dimension is usually associated with knowledge, skills and abilities (KSA), and ability-improving practices address aspects such as training and recruitment [7]. Motivation-enhancing practices include providing incentives that address both intrinsic and extrinsic motivation [8] [9]. The opportunity aspect takes individual characteristics as well as the work environment into consideration, and HR practices in this dimension target aspects such as individual empowerment and collaboration [7]. Marín-García & Tomas ([6], p. 1046) add to this that "some authors point out that this issue should be handled in a more comprehensive way, by integrating mediating variables", with organizational dimensions such as climate and culture being mentioned as examples of such variables. Hence, we consider physician culture to potentially be a contingent factor when considering physician performance and performance-enhancing practices.

While HRM research has shown the advantages of the AMO-based HR practices architecture in traditional businesses, the field of physicians has remained largely unexplored. Although AMO conditions that stimulate high performance are described in the HR literature, what exactly should be considered as high physician performance seems to be less certain. This observation calls for an examination and explicit articulation of physicians' performance, before one can proceed to consider practices that might support it. Here, the professionalism and professional values perspective accentuates the quality of care, quality of caring, integrity and accountability [10] [11] [12]. The more hands-on guidelines on "good medical practice" encompass characteristics such as knowledge, skills, communication, teamwork and maintaining trust and safety [13] [14]. Another component, physician wellbeing, seems to be a crucial contributor to high professional performance and is even seen as an indicator of an organization's quality of healthcare [15] [16]. At the same time, physician performance is what physicians are actually seen to do in practice, albeit taking into account the above-mentioned perspectives and elements [17].

The significance of high physician performance seems undisputed, as does the valuable contribution that HRM can make in supporting and stimulating high performance in "traditional business" environments including production or services. However, among physicians, the HR department does not seem to be acknowledged, and HR departments find it challenging to contribute to physician performance when they are not recognized by their clients, the physicians [1]. In broadening the traditional HR scope, this cross-disciplinary study views HR practices as all activities involving people (*i.e.* physician) management. We explicitly consider people management to be a joint activity for all those responsible, and do not regard these practices as strictly connected or limited to an HR department. In this view, physicians themselves can play a pivotal role in the management of their own and their peers' performance. Our analysis, therefore, centres on hospital-based physicians by asking the following questions: how do physicians perceive high performance and what activities do they find contribute to high performance?

2. Methods

2.1. Study Design

This interview study draws on methods inspired by grounded theory [18]. The data produced are participatory since the participants and the researchers are the origins of the empirical material. Grounded theory builds understanding of a phenomenon from "the ground up"; *i.e.*, from the individuals experiencing the phenomenon, by using in-depth interviews. We used our key topics, *i.e.* high performance, HR practices and professional culture, to guide us in the empirical fieldwork. The in-depth interviews enabled our participants to describe experiences and perceptions that were meaningful to them and, through interaction with the interviewer, to reflect upon their responses [19].

2.2. Research Site

We conducted this study in a Dutch hospital setting. A characteristic of the Netherlands health system is the variety of physicians' employment statuses within the same hospital organization. Physicians can be either employed by the hospital or be organized in independent entrepreneurships. Most hospitals have employed physician groups on the hospital's payroll and various independent entrepreneurships that are autonomously responsible for their "mini-enterprises" within a hospital. All hospital-based physicians are unified under a medical board, a counterbalance to the hospital board. The medical board represents and maintains the interests of all physicians, regardless of their employment status. For example, quality and performance issues are regulated by the medical board on behalf of all physicians. In this study, we invited 28 hospital-based physicians (MS), both employed and independent entrepreneurs, linked to two different top clinical teaching hospitals to participate. In line with the grounded theory approach, they were theoretically sampled [20]. We aimed at a heterogeneous

participant group in terms of medical specialty, age and gender. We consulted with chief physicians that were responsible for quality and performance in their hospital, and also with the HR directors, to help with the selection of interviewees. To strengthen our data and our understanding in terms of our research goal, we also invited seven HR professionals (HR) and hospital management representatives (MAN) to capture their perspectives. We initially informed potential participants by email about the nature and purpose of our study and subsequently invited them to consider participation. On acceptance of the invitation, we requested individual informed consent from all participants at the start of their interview.

2.3. Collection of Empirical Material

The interviews were performed over a period of 15 months: from spring 2016 to autumn 2017. We held individual interviews, focusing on in-depth exploration, allowing participants to talk freely and without interference from others. Extensive discussions within the research group created a clear mutual understanding regarding the direction that the interviews should follow. We constructed an open-ended interview guide based on our research questions. The interviews started with collecting generic information about the participant and their working experience. Thereafter, we covered more specific items such as performance ("what are, in your opinion, characteristics of high physician performance?"), HR practices ("what do you need in order to perform well, to stay fit and motivated?") and professional culture ("what do you perceive as significant regarding your profession and specialism?").

Physicians, HR professionals and management representatives were asked the same questions. The first 17 semi-structured in-depth interviews were conducted between July and September 2016. The second set of 18 interviews was conducted between April and September 2017. Interviews lasted approximately one hour. All interviews were audio recorded and transcribed.

2.4. Availability of Data and Materials

Due to the sensitive nature of the raw interview data on which this manuscript relies, it is not publicly available. The authors can be contacted at any time for further information.

2.5. Data Analysis

We adopted a reflexive approach to data collection and analysis, using a template analysis approach in analysing the transcripts. Following this technique, we constructed a coding template during the analysis comprising themes that we could identify in the data. In line with this approach, we discussed and in advance defined three themes that represented the major topics in our interview guide: 1) High physician performance; 2) HR practices; 3) Professional culture. The interviews were open axially coded during the process of data collection and iteratively analysed. This iterative coding process eventually resulted in three

top-level codes. *i.e.* the prior-defined topics, and 19 sublevel codes, divided into 7 second-level codes and 12 third-level codes as shown in Table 1 alongside illustrative quotes.

Table 1. Coding template with accompanying quotes.

Top level code	Second level code	Third level code	Accompanying quote
High Performance	Definition of performance		"High performance is excellent quality of care, good communication and good collaboration, those are the most important aspects" MS7
	Dimensions of high performance	Dedication	"That has medical-technical aspects, is about the right skills as well as interpersonal and communicative aspects" MS12
		Collaboration	"It is important that the team dynamics are OK, that there is trust to talk freely and share stuff" MS6
HR Practices	Ability based	Training and development	"Professionally, we are highly trained, but we lack expertise in speaking up and communication skills. We are simply not trained enough so those skills are lacking" MS3
		Recruitment and selection	"Get the good ones in and give them a chance to excel, that's the start: good selection procedures" MS7
	Motivation based	Intrinsic motivation	"I get my motivation from patients' feedback, the face-to-face contact, that keeps motivating me to go that extra mile" MS11
		Extrinsic motivation	"There are inequalities in the income of physicians in our team, that leads to major conflicts" MS25
	Opprtunity based	Individual oriented	"I am trained to be a peer coach, we know the dynamics in our hospital, that helps" MS12
		Work-environment oriented	"Top-down management as in: listen to me, this is how we do it", well, that doesn't stand a chance of working with highly educated professionals' MS1
Professional Physician Culture	Generic	Intrinsic motivation	"You are supposed to know everything, in no need of sleep or a break, you know. That s all part of the deal" MS12
		Tacit rules	"That everyone takes their responsibility, that we support each other, no matter what" MS6
	Specialism-specific	Own subculture	"We take a look at the medical, social and psychological development of patients, that's different from other specialties" MS7
		Surgical versus non-surgical	"Non-surgical physicians, in my opinion, are more open to change, they listen and look more closely. Surgeons, well, they just want to do their trick, like you just have to do it without nagging. You can just see that difference" MAN2
	Employment-specific	Work approach	"It is in your own interest to perform on a good level, be efficient and have good results" MS2
		Attitude towards the organization	"We make our own investments, we are less dependent and that feels good" MS12

The results, progress and data saturation were regularly discussed within the research team during the analysis process. All aspects of coding were discussed until a consensus was reached to establish credibility in the interpretation of the data. A final phase of analysis took place during the writing of this article, allowing us to reflect on our role as researchers in this process of knowledge building.

2.6. Our Role as Researchers

Our research was inspired by the idea of bridging the gap between two different worlds: healthcare and HRM. The combination of academic medical and HR backgrounds in the research team allowed us to combine knowledge from these two disciplines with the aim of delivering "the best of both worlds". This inspiring collaboration brought an extra dimension in the interpretation of our data, in addition to the already present co-creation by researcher and participant. All researchers participated in the sense-making and sense-giving process where dialogue sessions enabled us to share our interpretations and views, thereby strengthening this iterative process [21]. For example, the participation of doctors in our study was experienced as exceptionally selfless and enthusiastic by our academic HR researchers, compared to their experiences in other, more for-profit driven, business environments. Whereas participation outside working hours was perceived as more-or-less "business as usual" by our medical researcher, who would not have highlighted this as extraordinary.

3. Results

Participants

All the physicians and HR professionals approached agreed to participate. We interviewed 28 physicians representing 17 different (sub-)specialties from two top clinical teaching hospitals. Additionally, seven HR professionals and management representatives were interviewed. In total, we interviewed 22 men and 13 women. What clearly stood out was the physicians' eagerness to participate in this study. They all wanted to contribute, giving their time to talk despite their heavy workloads and time restraints. We were positively surprised by the almost limitless time and attention the physicians were prepared to give the interviewers, being very eager to provide input on their perceptions, needs and potential improvements. We felt they really wanted to contribute to improvements. The fact that some of the interviews were held outside working hours illustrates this enthusiasm.

Figure 1 outlines the results of our research, clarifying the relationships that we found between perceived high physician performance, HR practices and professional culture.

We will now describe the findings in more detail based on the three main themes.

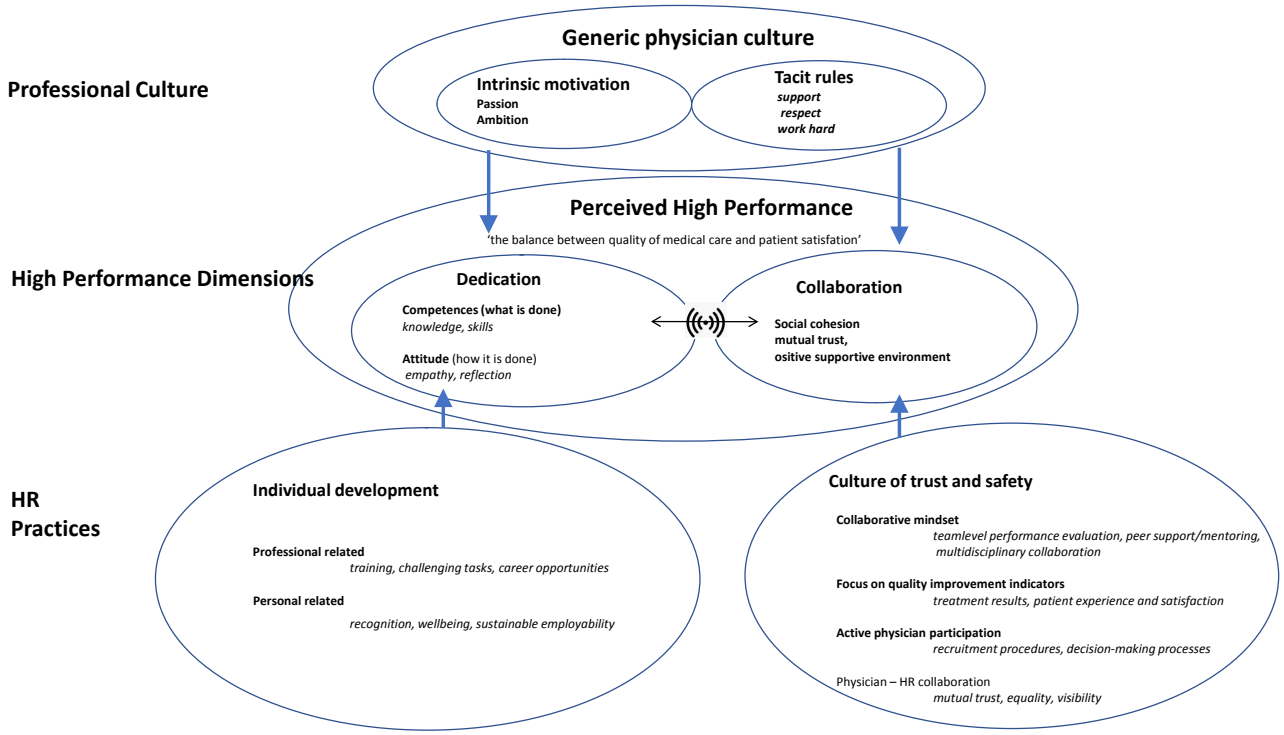

Figure 1. Relationships between high performance, HR practices and professional culture.

3.1. Perceived High Physician Performance

3.1.1. Defining High Performance

Participants perceive high performance as a balance between the quality of medical care (diagnosis, treatment and results) and patient satisfaction. In their opinion, improving the quality of life, working efficiently and achieving results all contribute to achieving the optimum balance. Both physicians and HR professionals/management representatives have similar perceptions of high performance:

Well, patient satisfaction is very important of course, as much as achieving results (MS9).

Doing the best for your patient, try not to harm, I think that's in the heart of every doctor (MS12).

I think that has two aspects: good and up-to-date techniques and patient satisfaction (MAN1).

The interview analysis allowed us to distinguish two vital dimensions of the performance of physicians: dedication and collaboration, as illustrated in **Figure 1**.

3.1.2. Dedication

Physicians perceive dedication to the patient as a leading indicator of high performance. To them the combination of passion and ambition is what represents dedication. In our interviewees' opinions, dedication reflects "what" you do as well as "how" you do it. In terms of the "what", competence-related issues such

as updating medical knowledge and skills are crucial. Equally indispensable on the "how" side are attitude-related items such as empathy, reflection, accountability, knowing one's limits, having an innovation and improvement-oriented attitude and transparency. Both physicians and HR professionals/management representatives accentuate the importance of the "how":

Knowing your profession, being aware of what you do not know or are unsure of, asking for a colleague's opinion if necessary, being aware of your own signals and communicating about that (MS7).

I would say being social, a good listener, being patient and being good medical-technical wise, bit difficult to measure (MS11).

I think it's about a human need to be seen and to be acknowledged in your sorrow or anger as a patient and, as a doctor, to be able to show that it gets to you as well when things go wrong. This attitude is not mentioned anywhere as a performance indicator (MS12).

Having time for the patient, listening, paying attention (MAN4).

3.1.3. Collaboration

Physicians and HR professionals alike deem collaboration to be another key element of high performance. They perceive collaboration as working optimally together to accomplish the best result for the patients. Our interviewees accentuate elements such as open, positive, supportive working, mutual trust, a feeling of safety within the peer group, social cohesion, knowing each other's strengths, a collaborative spirit and peer support as cornerstones in achieving high performance. This was illustratively formulated by the following management representative and surgeon:

Altogether, collaborating and daring to speak up, a safe climate where you can say: well Doc, we are not going to do that (MAN2).

If you can perform surgery well, you will not necessarily be a better doctor; if you behave as a bastard in the OR [*operating Room*], *putting your team on edge in an attempt to achieve good quality, then I consider you a bad doctor, even if you perform the surgery well* (MS20).

Physicians agree that the quality of the diagnostic and treatment process benefits from inter-colleague consultation, as explained by this physician:

Every patient will be discussed, everyone can explain their point of view, so an open culture is indispensable, to say what you want to say and give the best advice for the patient (MS3).

However, they also acknowledge that such consultation is time-consuming, which can have a potentially negative effect on the doctor-patient time. In achieving high performance, the importance of protocols is undisputed. However, physicians strongly advocate the significance of justified deviations from guidelines. They feel this is crucial in order to act in a patient's best interests.

Although physicians and HR professionals/management representatives agree on all the above-mentioned aspects, there was a salient difference. Whereas HR professionals and management representatives emphasize these facets as impor-

tant in meeting organizational standards and values, physicians primarily highlight these characteristics as being crucial in meeting patients' concerns. The HR professionals/management representatives "managers" language consists of phrases like "procedures" and "organizational norms", illustrated by these two management representatives:

I am convinced that a physician is good when they align themselves to all the norms and values of our organization (MAN2).

We have this planning, a cycle of control, so we report measures and outcomes, and we put them in a plan-do-check-act cycle, everything that goes wrong has to be analysed and improvements should be put in new processes so that we go forward (MAN4).

In comparison, "doctor talk" aligns with patients rather than the organization since this is considered to be at the heart of being a doctor and even regarded as a way of life, as this physician points out:

It is so enjoyable to really mean something to your patient, that is sort of a way of life, you want to contribute to that (MS10).

Summarizing the abovementioned, high physician performance is perceived to be a balance between quality of medical care and patient satisfaction. Dedication and collaboration are seen as the two vital dimensions of high performance. Dedication is formed by passion and ambition, reflecting both competence as well as attitude-related aspects. Working together in achieving the best result for the patient shapes a necessary collaborative mindset. Such a mindset results in a working environment with strong social cohesion and a feeling of safety, where each other's strengths count, and peers support each other.

3.2. HRM Practices to Support and Stimulate Physician Performance

Physicians offered suggestions related to all three aspects of the AMO framework (Ability, Motivation and Opportunity) in terms of concrete "should dos" and "could dos", summarized in Table 2 and described in more detail below.

3.2.1. Ability-Based Management Practices

The ability-related suggestions can be divided into "training & development" and "recruitment & selection" categories. Participants highly value training and developmental opportunities. They voice a desire for more in-company options. This would meet their need to engage in life-long learning activities within their working day, thereby having a positive effect on their work-life balance, as stated by this physician below:

I think we could focus more on the personal development of our physicians, time to do so is lacking during working hours (MS5).

Physicians express a strong need for support focused on non-medical competences such as collaboration, communication, professional development, leadership and social skills as argued by this doctor:

Professionally, we are highly trained, but we lack expertise in speaking up and

communication skills. We are simply not trained enough, so those skills are lacking (MS3).

Physicians and HR professionals/management representatives alike admit that training and development remains an individual responsibility. Furthermore, HR professionals/management representatives acknowledge they are hardly involved in physicians' training and development as this head of the HR department concludes:

We do not play an active role in training skills or communication, but we do add value in the recruitment and selection process (HR1).

Considering the recruitment and selection procedures, participants agree on

Table 2. Suggested HRM approach for physician performance management.

AMO framework item	HRM practice	Approaches for enhancing high performance for doctors
Ability-based practices	Training and development	—In-company training
		—Specific focus on non-medical competences:
		Collaboration
		Communication
		Leadership and social skills
	Recruitment and selection	—Active physician participation in the process
		—Candidate complementarity to the team
Motivation-based practices	Incentives intrinsic motivation	—Attention to appreciation and recognition
		—Focus on physical and emotional wellbeing
		—Attention to work–life balance
		—Opportunities for age-specific working conditions
		—Offer challenging tasks
		—A focus on quality improvement indicators such as treatment results, patient experience and patient satisfaction
		—Performance evaluation on team-level, following guidance and support
	Incentives extrinsic motivation	Financial focus on quality improvements such as treatment outcomes, quality and safety
		—Continuation of awareness for wellbeing and sustainable employability
Opportunity-based practices	Individual-oriented opportunities	—Continuing, increasing or designing peer support, peer mentoring, internal coaching
		—Distinct personal career-path possibilities
		—Creating a culture of trust
		—Multidisciplinary collaboration
	Work-environment-oriented opportunities	—Awareness of fruitful collaboration between physicians, HR and management based on mutual trust and equality
		—Physician involvement in decision-making processes
		—Visibility of HR and managers to physicians

motivation and dedication being crucial characteristics. Furthermore, candidates should be complementary to those already present in a team. According to one of our HR professionals, the procedures could benefit from active physician participation:

It has to come from them, because if we as an organization tell them they have to do it, the answer will be that they do not want to, it's as simple as that (HR1).

Furthermore, the standardization of selection criteria and distinct job descriptions for hospital-employed staff, and a decline in the bureaucratic involvement where it concerns physicians in entrepreneurship, are perceived as beneficial, as stated by this entrepreneur-based doctor:

HR does not play a huge role for me, but when we need to hire personnel, we have to deal with HR, that's quite bureaucratic, it takes a lot of time (MS8).

3.2.2. Motivation-Based Management Practices

Motivation-based practices that enhance high performance involve both intrinsic and extrinsic incentives. In participants' perceptions, all physicians intrinsically strive for continuous improvement in order to achieve the highest levels of quality and safety in patient care, as highlighted by these two doctors:

Ambition and passion, otherwise you cannot provide top performance (MS1).

The face-to-face contact, that keeps motivating me to go that extra mile (MS11).

Doctors generally feel that stimulating intrinsic motivation and contributing to a sense of autonomy is vital for achieving high performance, as expressed by this independent entrepreneur physician:

For us, it is important that we are independent, that we can make our own decisions rather than the hospital board telling us how many holidays we have to take or what procedures we can or cannot do (MS3).

Appreciation and recognition are the predominant drivers that enhance intrinsic motivation: from patients, from colleagues and from hospital management. That patients are the most important is emphasized by this physician:

That is why our job is so nice, because there is so much appreciation from our patients. That reward is not in money but in seeing that you helped someone (MS5).

A fertile ground for these drivers is a safe and comfortable work environment. A healthy work-life balance and attention to aspects such as physical and emotional wellbeing and age-specific working conditions support such an environment. Physicians feel that ambition and motivation are stimulated by challenging tasks, clear treatment results and a focus on quality improvement. They suggest broadening the quality improvement focus to include indicators involving treatment results, patient experiences and patient satisfaction. In evaluating their professional performance, physicians plea for widening the scope of such assessments to the team level:

There could be more attention to teams, reflecting on what each of you can do better, learning from each other's strengths (MS7).

In order for these team assessments to achieve long-term improvements, they should be tied to a process of guidance and support. Furthermore, for physicians, motivation is seen as particularly originating from high quality patient care:

You do not become a doctor for the money, you know; if you're in it for the money, you should really go and do something else. It is about the patients (MS19).

Therefore, they feel that their extrinsic financial incentives should have that same focus, on treatment outcomes, quality and safety. Hospital-employed participants furthermore express a strong desire for greater equality in earnings, as one of them states:

There is inequality in incomes between physicians in our team, that leads to major conflicts (MS25).

3.2.3. Opportunity-Based Management Practices

Participants observed opportunities on an individual and on the work environment levels. On the individual level, the increasing awareness of topics such as wellbeing and sustainable employability was considered a positive shift. Further, peer support, peer mentoring and internal coaching possibilities are highly appreciated, as expressed by this doctor:

We have these colleagues that give you their attention when something happens, so you can talk about it and they can support you (MS10).

It was generally felt that HR could be more visible when it comes to opportunities concerning physicians' personal career path and goals after employment, as commented by an HR professional:

There are very few distinct career path opportunities for physicians, it seems that they organize that themselves (HR1).

Physicians stated they are eager to continuously develop themselves, and so clear hospital career-path possibilities would be supporting. Furthermore, they point out that performance would benefit from an increase in flexibility in job design, and even more so by a decrease in their heavy workload. In terms of their work environment, participants agreed on collaboration and teamwork as being crucial in enhancing performance, as this physician explained:

Collaboration is the key, working in a pleasant team is motivating, that you really work together and are in contact with each other, so our team meetings are very important to me (MS3).

Doctors view a culture of trust as comprising an atmosphere where team members feel valued, safe to speak up, able to be vulnerable, be accepted for who they are and be allowed the professional freedom to try something new. Multidisciplinary collaboration triggers dedication, passion and inspiration, subsequently leading to higher quality care, as strongly argued by this physician:

You notice that people in multidisciplinary teams are very dedicated and passionate, they have a lot of knowledge and they really complement each other (MS12).

In accomplishing collective goals on the department or organizational level, collaboration between physicians, HR and management should be based on mutual trust and equality. Physicians and HR professionals/management representatives all feel that physicians should be involved in decision-making processes and, as the following HR professional states, this connection seems to be the key:

I detect that, when the relationship improves, you can talk about policies (HR2).

According to HR professionals/management representatives, physicians in entrepreneurship units show greater resistance to adopting hospital policies and practices than do hospital-employed physicians. In collaborating with HR professionals/management representatives, entrepreneurship physicians emphasize a desire for managers to be more visible within the organization, and HR professionals similarly conclude they do not interact much:

Those employed in partnerships, I have little control over them actually, I don't have to deal with them very much (HR3).

Collaboration with physicians, in general, can be challenging for HR professionals and managers, since they do not share the same profession:

It's more or less: you are not a physician, so you don't understand (HR2).

A typical physician in our hospital: someone who does not keep appointments and, if agreements are made, they will make them among each other in corridors (MAN2).

3.3. Professional Physician Culture

We were able to distinguish three distinct aspects regarding culture: a predominant generic physician culture and two subcultures: a specialism-specific culture and an employment-specific culture. All the physicians view high performance similarly, regardless of their employment status or type of specialism. The predominant generic culture frames how doctors perceive high performance, through a lens of intrinsic motivation and tacit rules, as described in more detail below.

3.3.1. Generic Physician Culture

All physicians feel that ambition and passion are strongly associated with their profession and professional performance, as underscored by these doctors:

You need ambition and passion in what you do, you have to have the drive to learn and be committed (MS1).

All doctors chose this profession out of passion (MS26).

Most describe their culture as open, supportive and collegiate. In their professional culture, tacit rules serve as a code of conduct. These rules encompass "we support each other, we are respectful towards each other and we all work hard", as expressed by these doctors:

We are prepared to back each other, and we consult one another easily (MS7).

We work hard for our patients, we feel that we have to work hard, genuinely, that is what we expect from each other and everybody does so (MS9).

3.3.2. Specialism-Specific Culture

Participants furthermore described differences in culture depending on specialism. In general, it is predominantly the HR professionals/management representatives who perceive surgical versus non-surgical differences, as illustrated by this manager:

I can tell by the type of person whether it is a surgeon or an oncologist, I don't know how, you feel it, you can tell by the attitude (MAN2).

However, and perhaps more striking, physicians perceive their own group (*i.e.* specialty) culture as being unique and different from all other specialties. They experience a huge difference between their own culture and the culture of all other groups, thus viewing their own specialism as a distinct identity within the organization, with unique personality traits, skills, competences and approaches to their medical practice, formulated by these two doctors:

We are a very specific specialism, totally different from others (MS6).

When we are on call, it is extremely turbulent, that is a big difference from a lot of other specialisms (MS25).

3.3.3. Employment-Specific Culture

In terms of culture, employment status most prominently led to different perspectives, principally in terms of work approach and the attitude towards the organization. Physicians employed through entrepreneurship arrangements feel a strong professional autonomy regarding their job design, and they are perceived as being less receptive to HRM activities. They approach their work in a more production-oriented way with a focus on efficiency, have high expectations of each other with social pressure to work hard and feel closely related to one another as indicated in these quotes from a physician and a management representative:

We are more productive, we can arrange our time and do more if we want to. And because we can invest ourselves, we are innovative (MS11).

Those working in an entrepreneurship are closer to one another compared to those in an employed group (MAN2).

According to HR professionals and managers, hospital-employed physicians perceive themselves to be more ambitious but express less problem-solving behaviour than those in entrepreneurship:

They are hospital-employed, so they tell us: it is not our problem, you have to solve that one for us (MAN3).

Overall, we could thus distinguish a predominant generic culture plus two subcultures, *i.e.* specialism-specific and employment-specific. The predominant culture, centring around ambition, passion and tacit rules, serves as a lens through which physicians interpret high performance. These (sub)cultures do not influence the perception of how HR practices enhance high performance.

4. Discussion

In order to place out findings in context, we will first elaborate on the current discourse of physician performance and the impact of physician culture on performance.

4.1. Physician Performance

Providing high quality care is the primary goal of healthcare organizations, and physicians are primary responsible for delivering this care. The literature notes that the effective functioning of HRM processes significantly influences the quality of patient care [1]. Given that physicians play a pivotal role and often set the cultural tone in a hospital, our research focused on physician performance and HR practices that are beneficial in stimulating high performance. Physician performance encompasses many aspects ranging from adherence to ethical principles and core values, such as helping the sick and avoiding harm, to demonstrating expected skills and competences [10] [22]. Although there is no universally agreed definition of performance that covers all the important domains of professional medical practice, a range of preconditions can be identified in the literature. Competences, defined in the widely used CanMEDS, as well as from experience are regarded as necessary prerequisites of high performance [23] [24]. Relevant knowledge, skills and attitudes include both medical-technical aspects as well as communicative and leadership skills [22] [25]. However, length of experience and perceived mastery of knowledge and skills do not by themselves necessarily lead to outstanding performance. In fact, a very experienced physician who frequently carries out a specific procedure can still get it very wrong. Thus, in a dynamic and rapidly evolving field such as healthcare, lifelong learning seems prerequisite for high performance. Since physicians increasingly perform in teams rather than individually in modern healthcare, teamwork and a collaborative mindset have increasingly become important drivers of high performance of the individual physician [26] [27]. Thus, when viewing physician performance, the above-mentioned aspects should logically be taken into account. In this study, we explored how physicians themselves perceive high physician performance since this seems essential if one is to clarify desirable and effective methods for stimulating performance.

4.2. Professional Physician Culture

Drawing back from physician performance to the organizational perspective, organizational, or group, culture is described as an important driver of organizational performance [28]. As such, the professional physician culture could influence how physicians perceive high performance and/or effective methods to stimulate their performance. In general, culture emerges from that which is shared among colleagues within an organization, including shared values, beliefs and attitudes regarding norms of appropriate behaviour in an organization [29]. It can be considered as "the way things are done around here, as well as the way

things are understood, judged and valued" [30]. Although organizational culture appears to be a crucial factor in the ability of an organization to perform, the question remains as to whether and how organizational culture impacts success or performance as this has not been comprehensively empirically explored. To further complicate things, when turning to the issue of culture in medicine, traditional professions such as physicians tend to create their own culture [31]. As such, there seems to be a wide variety of sub-cultures both between and within organizations. These cultures are passed on to the recruits in the profession, but often remain obscure to others [32]. The culture of medicine is most often learnt through the so-called "hidden curriculum" that dictates customs, rituals and rules of conduct that define the cultural milieu of medicine [33]. A shared, stylized dress code (the white coat), shared pattern of speech ("doctor talk") and a shared system of beliefs regarding health (the physician explanatory model) are all examples of elements that are rarely taught explicitly [34]. Based on the above, it can be concluded that the medical professional culture can potentially shape physicians' view of performance, and that a variety of subcultures can potentially be present. Since there is no predominant classification of subcultures among physicians, we explored the specific cultures that seem to be present and consider if and how they shape physicians' views on high performance and/or on HR practices designed to stimulate performance.

4.3. Findings of This Study

Figure 1 summarizes the main findings of our study. It illustrates how the professional physician culture of passion, ambition and tacit rules colours doctors' perceptions of what constitutes high performance, defined as a balance between high quality care and patient satisfaction. It further highlights the two pivotal dimensions of perceived high performance that we uncovered, *i.e.* dedication and collaboration, as well as HR practices that require attention to stimulate performance.

Our findings show that physicians are highly committed professionals; even to the extent of considering dedication to be a key component of high performance. Whereas, in organizations, dedication is usually considered as an antecedent of high performance [9] [35], in our study we saw that physicians view dedication as an essential ingredient of performance. Caring for their patients is their top priority, and they see competence and attitude-related aspects as equally indispensable. Giving attention to and receiving appreciation from their patients drive doctors to go that extra mile in achieving their best. Such deep-seated dedication brings to mind the concept of having a "calling", a career that provides a sense of meaning or purpose and is used to help others [36]. Within the medical profession, meaning, purpose and the helping of others seem self-evident since humanistic care of those who are suffering is at the very heart of this profession. Our findings emphasize that concepts such as calling, dedication, commitment and intrinsic motivation are intertwined and all positively related to high performance [37] [38]. When humanistic care is central, it seems natural

that dedication evolves around human values like caring, compassion and respect [12]. Consequently, doctors' dedication will only flourish if these humanity-related aspects are given attention. Alongside dedication, collaboration surfaced as the second dimension of high performance. This echoes the literature associating teamwork with high quality care and greater patient satisfaction [39]. Physicians translate optimum collaboration into mutual trust, safety, speaking up, social cohesion and a supportive environment. These specifications remind one of psychological safety, defined by Edmondson [40] as "the shared beliefs that a team is safe for interpersonal risk taking and such environment exudes a sense of confidence that you are not embarrassed, rejected or punished for speaking up". Whereas Edmondson considered psychological safety as contributing to high performance in teams, the doctors in our study saw it as a vital dimension of high performance and thus as performance itself. Collaboration will therefore only thrive within a culture of trust and safety.

Our results emphasize the need for HR practices to increase and support abilities to build and lead teams of physicians that are focused on dedication and collaboration. Physicians formulate concrete "should dos" and "could dos" to stimulate individual development and a culture of trust and safety. They emphasize the need for leadership and communication skills, a focus on quality improvement indicators such as treatment results and patient satisfaction, and a collaborative mindset. Our findings suggest that high performance can only be achieved by reinforcing dedication and collaboration. We advocate seeing doctors not only as providers of medical care but also as sensitive and committed workers with strong humanistic values. Seeing physicians primarily as people, and highlighting general humanistic and relational aspects, seems to be emerging as a necessity to counterbalance the current "business-like" climate in healthcare that focusses on productivity and efficiency, with increasing bureaucratic requirements that reduce the time for face-to-face interaction with patients and colleagues [41].

Our study showed that physicians feel a strong professional culture. In general, as physicians, they feel highly motivated and their tacit rules concerning working hard and supporting each other serve as a code of conduct. This is in line with the literature that observes that the culture of medicine is learnt through a so-called "hidden curriculum" of unspoken rituals and rules [33]. On the subculture-level, doctors perceive their own specialism as quite different to most other specialties. Employment status also came to the fore as a second subculture, shaping physicians' perspective on their approach to work. Those in entrepreneurship units were more production-oriented and focussed on efficiency and hospital-employed doctors were less focussed on problem-solving behaviour. However, these distinct subcultures do not shape physicians' overall perceptions of what constitutes high performance. All the physicians perceive performance the same way, regardless of their employment status or type of specialism. It would seem that the predominant culture as a professional physician unites all doctors in forming a consistent view on performance. A consequence

of this is that there does not seem to be a need to differentiate, and HR practices should be applicable for all doctors.

A notable observation, although not part of our research question or focus, was a perceived clash of cultures between the world of HRM and the medical domain. This gap was empirically observed and recognized by physicians and by HR professionals/management representatives. Although there is literature addressing the difficulties that doctors experience in bridging the medical and managerial worlds [42], there is little research regarding the cultural difference between the HR and healthcare spheres. Ultimately, they are aiming for the same thing, *i.e.* optimum patient care, but it seems that their perceptions of how to achieve this goal differ considerably. We argue that this difference could originate in their distinct value perspectives, resulting in differences in commitment. Whereas, for traditional HR and management, it is all about organizational values and commitment to the organization, for doctors it is humanistic values and commitment to the patient. This schism results in a focus on procedures, costs and efficiency on the one side versus caring and compassion, in our findings embedded in dedication and collaboration, on the other. As a result, despite aiming for the same outcome, they seem to think and speak in different languages while it is critical that they do communicate and collaborate in order to contribute to high performance. This aligns with Rider's observation that physicians might be overlooking the basic principle of working collectively with other healthcare professionals to create system changes and an organizational culture that delivers excellent, safe and efficient care while preserving humanistic values [43]. In our view, supported by the results of this research, it is all about people management and highlighting the humanistic and relational elements, regardless of who does or does not formally perform these activities. We recommend that people management should be an activity for all those responsible, be they HR professionals, management representatives or physicians, working in close collaboration. Only by bridging that gap will patients benefit from the best of both worlds.

4.4. Conclusion

Physicians sense a strong professional culture of intrinsic motivation and tacit rules that shape their view on performance. They perceive high performance as a balance between the quality of medical care and patient satisfaction. Dedication and collaboration are considered the two essential ingredients of high performance. HR practices to enhance performance should thus focus on these aspects by stimulating individual development and a culture of trust and safety. Furthermore, these HR practices should be available to all doctors, regardless of their type of specialism or employment status.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Townsend, K.L., Lawrence, S.A. and Wilkinson, A. (2013) The Role of Hospitals' HRM in Shaping Clinical Performance: A Holistic Approach. *International Journal of Human Resource Management*, **24**, 3062-3085. https://doi.org/10.1080/09585192.2013.775028

[2] Kabene, S.M., Orchard, C., Howard, J.M., Soriano, M.A. and Leduc, R. (2006) The Importance of Human Resource Management in Health Care: A Global Context. *Human Resources for Health*, **4**, Article No, 20. https://doi.org/10.1186/1478-4491-4-20

[3] World Health Organization (2000) World Health Report 2000: Health Systems: Improving Performance. World Health Organization, Geneva. https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1

[4] Appelbaum, E.B., Bailey, T., Berg, P. and Kalleberg, A.L. (2000) Manufacturing Advantage: Why High Performance Work Systems Pay Off. Cornell University Press, Ithaca.

[5] Bos-Nehles, A.C., Van Riemsdijk, M. and Looise, J.C. (2013) Employee Perceptions of Line Management Performance: Applying the AMO Theory to Explain the Effectiveness of Line Managers' HRM Implementation. *Human Resource Management*, **52**, 861-877. https://doi.org/10.1002/hrm.21578

[6] Marin-Garcia, J.A. and Tomas, J.M. (2016) Deconstructing AMO Framework: A Systematic Review. *Intangible Capital*, **12**, 1040-1087. https://doi.org/10.3926/ic.838

[7] Kroon, B., Van de Voorde, K. and Timmers, J. (2013) High Performance Work Practices in Small Firms: A Resource-Poverty and Strategic Decision-Making Perspective. *Small Business Economics*, **41**, 71-91. https://doi.org/10.1007/s11187-012-9425-0

[8] Hyde, P., Harris, C., Boaden, R. and Cortvriend, P. (2009) Human Relations Management, Expectations and Healthcare: A Qualitative Study. *Human Relations*, **62**, 701-725. https://doi.org/10.1177/0018726709103455

[9] Munteanu, A.I. (2014) What Means High Performance Work Practices for Human Resources in an Organization. *Annals of the University of Petrosani, Economics*, **14**, 243-250.

[10] Cassel, C.K., Hood, V. and Bauer, W. (2012) A Physician Charter: The 10th Anniversary. *Annals of Internal Medicine*, **157**, 290-291. https://doi.org/10.7326/0003-4819-157-4-201208210-00012

[11] Medical Professionalism Project (2002) Medical Professionalism in the New Millennium: A Physicians' Charter. *The Lancet*, **359**, 520-522. https://doi.org/10.1016/S0140-6736(02)07684-5

[12] Rider, E.A., Kurz, S., Slade, D., Esterbrook Longmaid III, H., Ho, M.-J., Pun, J.K.-H., *et al.* (2014) The International Charter for Human Values in Healthcare: An Interprofessional Global Collaboration to Enhance Values and Communication in Healthcare. *Patient Education and Counseling*, **96**, 273-280. https://doi.org/10.1016/j.pec.2014.06.017

[13] General Medical Council (2014) Good Medical Practice; Working with Doctors Working for Patients (2014). https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf

[14] Medical Board of Australia (2014) Good Medical Practice: A Code of Conduct for Doctors in Australia (2014).

https://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2F1277&dbid=AP&chksum=eNjZ0Z%2FajN7oxjvHXDRQnQ%3D%3D

[15] Hall, L.H., Johnson, J., Watt, I., Tsipa, A. and O'Connor, D.B. (2016) Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systemic Review. *PLoS ONE*, **11**, Article ID: e0159015. https://doi.org/10.1371/journal.pone.0159015

[16] Wallace, J.E., Lemaire, J.B. and Ghali, W.A. (2009) Physician Wellness: A Missing Quality Indicator. *The Lancet*, **374**, 1714-1721. https://doi.org/10.1016/S0140-6736(09)61424-0

[17] Lombarts, K. (2019) Physicians' Professional Performance: Between Time and Technology. 20/10Publishers, Rotterdam.

[18] Strauss, A.C. and Corbin, J.M. (1998) Basics of Qualitative Research: Second Edition: Techniques and Procedures for Developing Grounded Theory. Sage Publications, Inc., Thousand Oaks.

[19] Rice, P.L. and Ezzy, D. (1999) Qualitative Research Methods: A Health Focus. Oxford University Press, South Melbourne.

[20] Watling, C.J., Cristancho, C., Wright, S. and Varpio, L. (2017) Necessary Groundwork: Planning a Strong Grounded Theory Study. *Journal of Graduate Medical Education*, **9**, 129-130. https://doi.org/10.4300/JGME-D-16-00693.1

[21] Watling, C.J. and Lingard, L. (2012) Grounded Theory in Medical Education Research: AMEE Guide No. 70. *Medical Teacher*, **34**, 850-861. https://doi.org/10.3109/0142159X.2012.704439

[22] Ten Cate, O., Snell, L. and Carracio, C. (2010) Medical Competence: The Interplay between Individual Ability and the Health Care Environment. *Medical Teacher*, **32**, 669-675. https://doi.org/10.3109/0142159X.2010.500897

[23] Charness, N. and Tuffiash, M. (2008) The Role of Expertise Research and Human Factors in Capturing, Explaining, and Producing Superior Performance. *Human Factors*, **50**, 427-432. https://doi.org/10.1518/001872008X312206

[24] Frank, J.R. and Danoff, D. (2007) The CanMEDS Initiative: Implementing an Outcomes-Based Framework of Physician Competencies. *Medical Teacher*, **29**, 624-647. https://doi.org/10.1080/01421590701746983

[25] Van den Goor, M.P.G., Wagner, C.C. and Lombarts, K.M. (2020) Poor Physician Performance in The Netherlands: Characteristics, Causes, and Prevalence. *Journal of Patient Safety*, **16**, 7-13. https://doi.org/10.1097/PTS.0000000000000222

[26] Valentine, M.A., Barsade, S., Edmondson, A.C., Gal, A. and Rhodes, R. (2014) Informal Peer Interaction and Practice Type as Predictors of Physician Performance on Maintenance of Certification Examinations. *Journal of the American Medical Association Surgery*, **149**, 597-603. https://doi.org/10.1001/jamasurg.2014.183

[27] Weller, J., Boyd, M. and Cumin, D. (2014) Teams, Tribes and Patient Safety: Overcoming Barriers to Effective Teamwork in Healthcare. *Postgraduate Medical Journal*, **90**, 149-154. https://doi.org/10.1136/postgradmedj-2012-131168

[28] Nembhard, I.M., Singer, S.J., Shortell, S.M., Rittenhouse, D. and Casalino, L.P. (2012) The Cultural Complexity of Medical Groups. *Health Care Manage Review*, **37**, 200-213. https://doi.org/10.1097/HMR.0b013e31822f54cd

[29] Kralewski, J., Wingert, T. and Barbouche, M. (1996) Assessing the Culture of Medical Group Practices. *Medical Care*, **34**, 377-388. https://doi.org/10.1097/00005650-199605000-00001

[30] Davies, H.T.O., Nutley, S.M. and Mannion, R. (2000) Organisational Culture and Quality of Health Care. *BMJ Quality & Safety*, **9**, 111-119.

https://doi.org/10.1136/qhc.9.2.111

[31] De Bono, S., Heling, G. and Borg, M.A. (2014) Organizational Culture and Its Implications for Infection Prevention and Control in Healthcare Institutions. *Journal of Hospital Infection*, **86**, 1-6. https://doi.org/10.1016/j.jhin.2013.10.007

[32] Hall, P. (2005) Interprofessional Teamwork: Professional Cultures as Barriers. *Journal of Interprofessional Care*, **1**, 188-196. https://doi.org/10.1080/13561820500081745

[33] Hafferty, F.W. (1998) Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum. *Academic Medicine*, **73**, 403-407. https://doi.org/10.1097/00001888-199804000-00013

[34] Boutin-Foster, C., Foster, J. and Konopasek, L. (2008) Viewpoint: Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence. *Academic Medicine*, **83**, 106-111. https://doi.org/10.1097/ACM.0b013e31815c6753

[35] Steyrer, J., Schiffinger, M. and Lang, R. (2008) Organizational Commitment—A Missing Link between Leadership Behavior and Organizational Performance? *Scandinavian Journal of Management*, **24**, 364-374. https://doi.org/10.1016/j.scaman.2008.04.002

[36] Duffy, R.D. and Dik, B.J. (2013) Research on Calling. What Have We Learned and Where Are We Going? *Journal of Vocational Behavior*, **83**, 428-436. https://doi.org/10.1016/j.jvb.2013.06.006

[37] Goodin, J.B., Duffy, R.D., Borges, N.J., Ulman, C.A., D'Brot V.M. and Stephen Manuel, R. (2014) Medical Students with Low Self-Efficacy Bolstered by a Calling to Medical Specialty. *Perspectives on Medical Education*, **3**, 89-100. https://doi.org/10.1007/s40037-014-0110-7

[38] Westerman, M. (2014) Reflections on Having a 'Calling' as a Medical Doctor. *Perspectives on Medical Education*, **3**, 73-75. https://doi.org/10.1007/s40037-014-0112-5

[39] Meterko, M., Mohr, D.C. and Young, G.J. (2004) Teamwork Culture and Patient Satisfaction in Hospitals. *Medical Care*, **42**, 492-498. https://doi.org/10.1097/01.mlr.0000124389.58422.b2

[40] Edmondson, A.C. (1999) Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, **44**, 350-383. https://doi.org/10.2307/2666999

[41] Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., *et al.* (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine*, **165**, 753-760. https://doi.org/10.7326/M16-0961

[42] Witman, Y., Smid, G.A.C., Meurs, P.L. and Willems, D.L. (2010) Doctor in the Lead: Balancing between Two Worlds. *Organization*, **18**, 477-495. https://doi.org/10.1177/1350508410380762

[43] Rider, E.A., Gilligan, M.C., Osterberg, L.G., Litzelman, D.K., Plews-Ogan, M., Weil, A.B., *et al.* (2018) Healthcare at the Crossroads: The Need to Shape an Organizational Culture of Humanistic Teaching and Practice. *Journal of General Internal Medicine*, **33**, 1092-1099. https://doi.org/10.1007/s11606-018-4470-2