Chapter - VII

Summary of Finding
Suggestions and
Conclusion
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SUMMARY OF FINDING SUGGESTIONS AND CONCLUSION

Health care industry being basically a human service organization management with maximum human touch is a must in any hospitals, maximum human touch is a must in any hospital set up. In hospitals, maximum efficiency can only be achieved if all the staff in the hospital work together conscientiously and contribute to the management. For tapping the practical and intellectual resources of all the health personnel for the beneficial to everyone, they have to be properly motivated. Even though money is the best motivator, it is not the only motivator and those who have met their basic psychological needs need to be motivated by more serious factor like job satisfaction, achievement orientation, recognition, acceptability, etc. These can be provided only when the management creates a cordial atmosphere of mutual respect, where the individual is recognized and becoming increasingly democratic and people are learning to influence the policies and decisions of the management, directly or through their representatives. Viewed against the rapidly changing cultural context, employee participation in management is inevitable with inherent benefits.

The study was confined to the private health care institution in the state of Karnataka. The prime aim of the study was to find out the opinions of employees regarding the feasibility of participative management in the private health care industry in Karnataka. The study focussed on the following specific objectives;
1. To study the human resource management practices followed in private health care institution in the State of Karnataka.

2. To examine the existing system of participation of employees in the management of private hospitals in the State of Karnataka;

3. To ascertain the possibility of implementation of participative management in the private health care industry in Karnataka.

4. To suggest a model of participative management system for private health care institution in Karnataka.

A sample of 30 hospital has been selected on the basis of the number of hospitals existing in each size (small, medium and large) and in each zone (south, Central and North). Altogether 13 small-sized hospitals, 10 medium-sized hospital and 7 large-sized hospitals were sample respondents using a structured interview schedule. The study covered a sample size of 836 respondents, consisting of 45 Administrators, 341 Doctors, and 450 PTM staff. Simple random sampling technique was applied for the selection of the respondents.

The data collected for the study were processes and analysed with the help of Computer Soft were-SPSS. The tools used for analysis of primary data were mathematical and statistical techniques such as Percentages, Mean, Two-way ANOVA technique, Chi-square analysis and Factor analysis.

The Introductory Chapter deals with the nature, importance, objectives concepts and definition used, methodology adopted, survey design, andd earlier literature related to this research topic. The conceptual and theoretical framework of the study is dealt with in the next chapter.
In the analysis part, the major findings of the study with regard to the existing Human Resource Management practices and Participative Management practices are presented first, followed by the opinions of employees regarding the feasibility of Participative Management in the private hospitals of Karnataka. In this chapter, the findings and the suggestions on participative management, including the proposal of a model of participative management system for private health care industry in Karnataka is attempted followed by a note on the scope for further research.

**SUMMARY OF FINDINGS**

Now, an attempt is made here to summarise the findings of the study followed by the major conclusion drawn on the basis of the findings as regards participative managements in the private health care institutions in the State of Karnataka.


   **Job-related Factors**

   The analysis revealed that the majority of the respondents in small, medium and large hospital expressed a very high level of satisfaction with the and large of staff selection’. This is because the highly skilled, qualified and experienced staffs were mostly inducted into their job with sufficient incentives by the managements, and they in general had nothing to complain about. Most of the management, and they in general had nothing to complain about. Most of the semi-skilled and unskilled workers, with the existing level of unemployment in the state, were only too happy to have landed in their present job and hence had no reason for complaint regarding their selection.

   They however expressed the least satisfaction with ‘training facilities’, when compared to all other job-related parameters. The information gathered
from most of the hospitals was that the managements was keener on getting trained personnel from other hospitals than on training people in their own hospital. Real training is imparted only when a new procedure, protocol or equipment is pressed into service, about which all staff members appeared to have good opinion.

Regarding ‘salary’, the majority of the respondents in small, medium and large hospital expressed a very high level of satisfaction. There is a big monetary divide, with the super-specialists getting monthly salary in lakhs, while an unskilled labourer has to be satisfied with a few hundreds. The highly-paid employee had nothing to complain, while the low-paid worker would rather be an employee with a low salary than be an ex-employee who complained about his salary.

Regarding the level of satisfaction with the ‘work-place rules’, ‘working conditions’ and ‘welfare facilities’, all the employees were found as satisfied and the same was the opinion regarding ‘the status of the job’.

Opportunities for Personal development

The study revealed that there were good opportunities for the employees to use and improve their knowledge and skills, and to take decisions about their own work. This is not surprising, considering the fact that each employee is qualified to perform independently in the which he is trained.

Regarding ‘promotion opportunity’, the rating was uniformly poor across all categories of employees in different type of hospitals. This can be explained by the organizational set up of a hospital, where highly skilled to unskilled labourers worked as a congregation with no scope for vertical promotion beyond a particular level.
Another interesting finding was the poor rating regarding the ‘opportunities to influence managerial decision at higher levels’, which makes it clear that many hospitals are run in a totalitarian way with no effective participation of employees in managerial decisions.

**Communication**

The Administrators, Doctors and the PTM staff in general were satisfied about the effectiveness of the communication system. Also, the comparison across small, medium and large hospitals revealed no difference and the effectiveness of the communication system received more or less the same rating.

The fact that a hospital, unlike other industries, cannot survive without proper communication between all strata of employees, irrespective of its size, stands confirmed by our survey result which show more or less uniformly good rating for inter-personnel communication. This further leads us to conclude that there is at least informal participation among the peers, immediate superiors and subordinates.

The majority of the superiors and subordinates were satisfied with their respective communication skills, which leads to the conclusion that there was proper two-way communication between superiors and subordinates in the functioning of private hospitals.

**Motivation**

The important motivating factors among different categories of employees in hospitals of Karnataka were then analysed. The foremost could be identified as the ‘remuneration package’, constituted by variables such as
salary, job security and working condition. The second was found to be ‘opportunity to participate in the decision making process’, constituted by variables such as opportunity in managerial decision making and opportunity in making decision with regard to own job. The their factor of motivation was found to be non-interferences in own job by others.

All these brings to the fore the stark reality that the finer aspects of motivation like ‘opportunity to participate in management decision’, ‘opportunity to participate in decisions connected with the job’ and ‘non-interference in one’s work’, can become determinants only when the basic factors like salary, and job security are met. This situation unfortunately leaves a lot to be desired in private hospitals where poor salary (very difficult to ascertain), long and tedious working schedules and job insecurity are the rule rather than the exception.

**Human Relations**

The analysis revealed that there is good relationship between the employee, his immediate superior, the management and his subordinates—which is not surprising, considering the fact that in a work environment where cooperation and coordination is a must, an employed with poor interpersonal or superior- subordinate relationship can adversely affect the functioning of the hospital itself, and in all probability, in private hospitals, may lose his job.

The levels of support and cooperation received from superiors, colleagues, and subordinates were also deemed good by the respondents. This is because no hospital without the support and cooperation of its employees can survive in this fiercely competitive field, and the managements and the employees are equally aware that it is a matter of survival.
Irrespective of the category of staff or type of hospital or category of personnel from various levels, the extent of resistance exercised when a new project is implemented was very low. The fear of losing job or other repercussions. coupled with the fact that human lives are involved rather than the existence of proper participation in the management was the most plausible explanation for this survey finding.

**Conflicts, Disputes, Discipline and Grievances**

Conflicts occurred only very rarely in hospitals. The presence of good two way communication in hospitals could prevent conflicts to a large extent.

The results reveal that there was high level of satisfaction regarding settlement of disputes. The two levels at which disputes were resolved were at the ‘concerned Department level’ and at the ‘top level management’. The good rating for resolution of disputes at Department level’ and suggests a reasonable amount of Intra-departmental participation. The faith expressed by employees in the top level management for dispute resolution indicates by employees in the top level management for dispute resolution indicates the high level of control the management had over lower level employees thereby showing poor delegation of power and very low level employee participation in management process. Also, the poor rating given to the involvement of committees in dispute settlements denotes very poor level of employee participation in management. Delving deeper into the data, one finds that employees of medium-sized hospital showed a slightly better satisfaction with committees, probably because of the presence and satisfactory working of many committees in such hospitals.

The analysis revealed that the level of discipline was quite good and employees at all levels understood the importance of it in health care.
The employee were satisfied with all the parameters regarding redressal of grievances. This leads to the conclusion that in the private hospitals, complaints and grievances were expressed and dealt with immediately so that they did not persist as a disturbing factor affecting the functioning of the hospital.

**Strikes and Unions**

All the employees reported that strike in hospital was unjustified. The employees of hospitals did not see strikes as a strikes as a justifiable means of achieving their goals as lives of patients would be at stake.

The date shows total absence of strikes in private hospital which goes hand in glove with the opinion that strikes are not justified in hospitals. Even though many hospital authorities feel that the recognition of the union is a direct invitation to strike, in the two hospitals in our sample where union is function there was n instance of strike.

The survey result show very low prevalence of unions in private hospitals. One of the strongest means by which an employee can influence management decision or participate in management function is through a truly representative, responsible union, the lack of which is a strong indicator of poor or no employee participation in management in private hospitals. Another point that needs mention is the difficulty in forming an effective single union or association as the hospital personnel belong to different cards, classes and professions.
The available data indicate that though union is present in a very few hospitals it’s functioning is unsatisfactory leading us to believe that just the presence of unions does not lead to participation in management.

2. Existing System of Participation

For of Participation

The ‘informative participation’, the least effective among all forms of participation, was dominant in small and medium size hospitals, while ‘consultative participation’ was dominant in the large size hospitals. The most noteworthy point is the total absence of ‘joint decision making’ or ‘collective bargaining’. which is a true indicator of effective participative management, in any of the small, medium or large hospitals.

Participation at lower Level

The majority of the Administrators, Doctors and the PTM staff reported that the employees’ opportunity to participate in decisions connected with their job was ‘high’ Even though the Administrators, Doctors and PTM staff gave a high rating regarding the opportunity to take decisions connected with their job, the rating given by the PTM staff was low when compared to with their jib, the rating given by the PTM staff was low when compared to the other two categories of staff, irrespective of the size of the hospital. From this we can that the Administrators Doctors had freedom to plan their work, irrespective of size, and the PTM staff did not enjoy the same freedom.

Participation at Higher Level

The survey revealed that managerial were taken by the investors. The Administrators had limited opportunity while the Doctors and the PTM staff had low or very low opportunity to influence managerial decisions. The fact that even the Doctor, who is central in making decisions regarding patients care
activities, starting from diagnosis, investigation and treatment, did not have much say in the management is quite surprising and does not augur well for these organizations. On the whole, the results indicate that there existed little opportunity for employees to influence managerial ascending participation.

Considering ascending and descending participation together, it is obvious that the Administrators had moderate participation at the higher level and high level of influence over the lower level. The Doctor reported poor ascending participation with high level of descending participation, which could be explained by their unique professional authority. The PTM staff had low level of ascending and relatively low level of descending participation. Taken together, all these factors indicate poor employee participation in management activities in private hospitals.

**Informal Participation**

Informal consultation was there among all employee, but its degree was low with the PTM staff. When comparing small, medium and large hospitals, informal consultation was found present in all the three types of hospitals; however, it was more in medium hospitals than in small and hospitals.

From the result the obvious conclusion is that informal consultation, the least effective from of participative management, was prevalent in hospitals. In the hospital settings, as time is an important factor, it is very difficult and cumbersome to arrange formal meetings and take decisions regarding issues which require immediate solution. So, depending on situations, whenever necessary, the persons actually in the field will be consulted informally and decisions taken. Such being the situation in any hospital, it is quite natural that so many of the employees acknowledge the fact that there is informal consultation.
Regarding the extent of influence of informal consultation, the majority of the Administrators gave a good rating about their influence in managerial decisions through informal discussions, while both the Doctors and the PTM staff gave average to low rating regarding their influence in management decisions. The relatively low rating given by the Doctor and the PTM staff indicates that the Administrators by virtue of their position or proximity to the owners are imposing decisions on there staff rather than making joint decisions. Hence, it may be inferred that though there is good amount of informal consultation in hospitals, it cannot be counted as a true manifestation of participative management.

**Team Work in Hospital**

The survey result revealed that the extent of superiors’ ability to promote team work’ as well as ‘the extent of team work’ existing in the private hospital in Karnataka was good.

Hospitals, unlike other industries, where the whole the whole unit can be considered as a team, are run by multiple task-centred teams. Each patient care activity is carried out by a team comprising a limited category of workers only, and the satisfaction level expressed by an employee can only be taken as that of this task-oriented small team. This sort of teams, even though limited to a few categories of employees, lead to cross-category involvement of employee in a task. This is inevitable in each and every patient care activity, and as such, there is no task or platform other than celebrations or formal events which can bring all the staff in a hospital together as a team. Participation cutting across categories as a concept in the true sense is far different from this task-oriented team approach. Hence, we can safely conclude that the satisfaction expresses
by employers in team work is not an indicator of the presence of participative management.

**Employee’s Participation through Committees**

There is total absence of committees in any form in small hospitals; only a small percentage of medium and large hospital have it to a limited extent.

In hospitals, joint committees can be considered as the single most effective mechanism by which participative management can at least be attempted. From the total absence of committees in any form in small hospital and very small percentage of hospitals in the medium and large sector having committees, it is apparent that there is no effective participative management.

In all hospital where there are committees, the members are nominated by the management and there is not even a single elected representative. Hence, the members of such committees cannot be considered as true employee representatives and their views and decisions will be in line with those of the management rather than those of the employees. So, the obvious conclusion is that even in hospitals where committees are present, the mode of selection of members negates the true concept of participative management.

In the hospitals where there are committees, the existing tenure of office of members of committees is unlimited [until transfer or retirement whichever is earlier’. This unlimited tenure, coupled with the undemocratic selection of the members, would lead only to near total absence of true employee representation in committee meetings.

The analysis apparently leads to he conclusion that the committees wherever they are present seemed to be effective on all parameters and
particularly in ‘its involvement in patient care’, according to the Administrators, Doctors and PTM staff of medium hospital and Administrators of large hospitals.

It seemed highly unlikely that this positive response was actually due to effective employee participation in management through committees. The nomination of committee members by managements and unlimited tenure of office of managers of the committee, in effect, annul the true concept of participative management. Hence, it is concluded that the high rating of effectiveness of committees can be the due rather to overt or covert coercion by the management than to employee participation in management.

The observation made in the field survey revealed that the management called the ‘Heads of Departments’ or ‘In-charges of Department’ for committee meetings and the committee meetings in many institution were just rituals with no meaningful discussion or decision. A management nominated committee is usually biased and the true problems of lower level employees are not taken up earnestly. Furthermore, the HOD being a member of the committee which is close to the controlling authority, the subordinate staff is naturally forced to toe the line with the HOD.

**Control and Participation**

The survey results revealed that irrespective of the size of the hospitals, the private hospitals in Karnataka were controlled by the investors only.

Doctors who have status in the hospital and are the actual decision makers regarding patent care had good control over the PTM staff. Doctors, though not promoting participative managements, directly or indirectly control or coordinate the activities of others to ensure better patient care.
All these factors together indicate poor employee participation existing in managements activities in the private hospitals of Karnataka.

Feasibility of Participative Management in Private Health Care Industry in Karnataka.

Opinion about Managing Personnel

The analysis revealed that the majority of the employees from all categories wanted hospital to be controlled by ‘the investor’ only because they felt that the controlling authority should be a single source.

Doctors and the PTM staff were unanimous in their opinion that ‘non-medical professional administrator’ would not be efficient in managing a hospital. A ‘Doctor without professional training in management’ also was considered to be average in his capacity to run a hospital efficiently. Good rating was given for: (i) ‘Doctor with professional training in managements; (ii) jointly by non-medical professional, training in management’ was the most preferred and a ‘committee consisting of representatives of all cadres’ came only third. Hence it is concluded that, as per the opinion of Doctors and the PTM staff, the highest level of efficiency in managing a hospital would be achieved when it was managed by Doctor with professional training in management. Here, the belief that medical knowledge and management a kill ought to be combined was found strong.

The satisfaction of the Doctors and the PTM staff was ‘good’ if working under any of the following parties in the order of their preference.

(a) Doctor with professional training in management; or
(b) Non-medical professional Administrator and Doctors; or
(c) A committee consisting of representatives from all cardres.
Non-medical managers simply will not understand the needs and priorities in health care delivery. If they are in control, then clinical care will be effectively dictated by people who do not have the ability to comprehend it. In others word, the reason why doctors should get involved in management is that, if doctors do not take collective actions to reaction to rationalize their own behaviour, then others will seize on this evidence and use it for their own, probably unacceptable, ends.

The Doctors felt that the control of the PTM staff should be with them and not with a Non-medical Administrator. The PTM staff of different types of hospital opined that their professional relationship with the treating physician was ‘good’. This presence of good professional relationship between the PTM staff and Doctor enables us to concluded that the PTM staff did feel comfortable to work under Doctor-managers.

The observation revealed that the Doctors and the PTM staff from all the different types of hospitals opined that coordination was a better option than control, to a ‘good’ extent. The obvious conclusion is that both Doctors and the PTM staff viewed coordination activities.

**Concept of Participative Management**

All categories of employees, irrespective of the size of the hospital, have a uniform concept regarding participative management, (ie) ‘participation in all management functions but not in ownership’. It is interesting to note that all categories of employees have in-depth understanding regarding participative management as revealed by the low rating given to informal consultation and limited extent participation in management Also, the employees are practical in their outlook as they don’t conceptualize participation in ownership.
From of Participation

The analysis revealed that, as a whole, the majority of the respondent Administrator, Doctor and the PTM staff suggested consultative participation as the best form of participation. Another point noticed in the finding from small hospitals was that the Administrator and Doctors (who were part of the ownership) reported that informative participation, the least effective form of participation, was enough while the PTM staff expected consultative participation, thereby making it apparent that many small-sized hospitals were being run in a totalitarian way.

The majority of the employees opined consultative participation’ as the best form of participation. Even though the employees do not want joint decision making and collective bargaining, they want to be consulted in all management activities. This could be due to the fact that each employee trained in a particular field could only give authentic suggestion regarding that field or do not want any management decision to affect him adversely.

Often, we are forced to conclude that as the age-old mindset of management and employees leading to distrust between them, any extent of participation beyond consultative participation is beyond realms of their imagination.

Degree of Participation Expected

There was no unanimity in the opinions of the Administrators, the Doctors and the PTM staff regarding the level of hierarch at which the concept of participative management should operate. The PTM staff was the only group that gave the highest rating for starting from the bottom rather than starting simultaneously at all levels. This apparently was a reflection of the wish of the PTM staff for participation, thereby leading to freedom in work at least at their
level. The Doctors’ responses were divided between administrative level, departmental level and ‘starting from below’, from which no special conclusion could be drawn. The Administrators’ opinions were more or less evenly distributed between administrative level and ‘starting at the bottom’, which denoted a reasonable understanding and willingness to accept the concept.

**Opinion Regarding Sharing of Equal Powers**

Most of the respondents did not favour the idea giving equal powers to employee and manager representatives. The analysis revealed that the majority of all categories of the employees in all types of hospitals were only. Employees felt that they should be given freedom to express their opinion, and that all reasonable suggestions from them should be considered before taking important managerial decisions.

The reasons for favouring equal power to managers’ and employees’ representatives were analyzed, and the majority of the employees viewed that ‘without equal powers the very intention behind the scheme will be defeated’.

The reasons for not favouring equal powers to managers’ and employees’ representatives were analyzed. The analysis revealed that all the reasons suggested, like: (i) The employee representatives might become manager-representatives, trade unions becoming managerial organizations; (ii) The joint forum might degenerate into a collective bargaining counter or an arena for ego clash; (iii) Employee representative might develop hunger for power and cease to represent employees; and (iv) Employee representatives might be lacking in managerial competence and executive capacity, were the reasons contributing to the opinion against granting equal powers to manager and manager and employee representatives.
Extent of Participation

The survey reveals that only a limited number of employees were competent to take managerial responsibility. They hoped that in hospitals, an institution dealing with human lives, where experience is very important, control should not be disbursed to incapable and inexperienced personal.

From the results, it may be concluded that there is not much scope for increasing the extent of participation of employees in management to high levels. But the important point is that, as per the survey data, the employees who are competent to participate in management can effectively represent the employees found incompetent. Lack of competence to participate is the belief behind centralized control and unwillingness to share power.

Committees and Participation

The opinion of the majority of all categories of employees regarding the mode of selection of members of the committee was in favour of retaining the existing system, i.e., through ‘nomination by management; the second best option expressed WAS ‘through consensus’. Regarding Administrators and Doctors, this result was understandable, as by both nomination and consensus the employee representative most likely would be a person who toes the management’s line. Furthermore, this would reflect the innate distrust of the management towards lower level employees. What was quite by management. This could be due to many factors like.

(i) Absence of committee in a majority of hospitals, leading to lack of proper knowledge about their functioning;
(ii) The PTM staff is subordinated to such an extent that they are afraid to demand an election;
(iii) HODs or in-charges are nominated by the management in committees, and as the PTM staff has to work under the HODs
and in-charges at Departmental level, they don’t want to antagonistize them by speaking against their nomination.

Another mode of selection which got good rating was by consensus. This can be easily explained by the work culture of hospital where cooperation rather than confrontation is the rule.

The majority of the employees were of the opinion that the tenure of office of the members of the committee ‘should not be more than the three years’. This would not only go a long way in proper implementation of participative management but also neutralize to a reasonable extent the negative impact of the mode of selection of committee members through nomination by management. When the tenure of office is only for three years, everybody in a cadre is likely to get a change to be an employee representative. This new blood in committees can be expected to infuse recent, novel and innovative ideas in hospital management which could be beneficial to all.

For or against Implementing Participative Management

Though the majority of the employees accepted the inherent benefits of the concept and was willing to implement it in any industrial organization, a significant number of employees expressed objection to it in the health care industry as a special situation. For employees, it is still an indigestible concept for the health care sector.

The responses from the various categories of staff who favoured participative management, regarding their reasons for doing so, were more or less evenly distributed among the choices: (i) to get better understanding and cooperation between management and employees; (ii) to improve coordination in the functioning of the hospital; (iii) to improve efficiency
in patient care; and (iv) to offer opportunity for prior consultation. Of these choices, to improve coordination in the functioning of the hospital and to improve efficiency in patient care got slightly higher ratings. From this, we can conclude that there was no single reason for favouring participative management, but the employees, being aware of all its positive aspects, favoured its implementation.

Reasons for favouring implementing participative management but not in hospitals were analyzed. The majority of the respondents gave the reason that ‘non’-medical employees cannot be allowed to have a say in the running of hospitals’ as human lives are at stake.

Reasons for not favouring implementing participative management were also analyzed and it revealed that ‘no employee is professionally or temperamentally competent to assume managerial responsibility; and ‘the committee would degenerate into a body in which employees’ grievances will dominate discussions’. These are the grounds for the major objections to the implementations of participative management.

In the light of these responses, it was found that more than two-thirds of the employees favoured the implementation of participative management in an organization. Of those who favoured it, a significant number were highly sceptical about its implementation in the hospital setup. Further analyzing the reason for the responses, we could safely setup. Further analyzing the reasons for the responses, we could safely come to the conclusion that the main objection aired by those who were against its implementation in hospital was not against the concept but against one important aspect, namely, the possibility of ‘non-medical employees taking decision’s on the running of an
organization whose prime objective is patient care, in which human lives are involved.

**Statutory Participation**

The majority of the Doctors and the PTM staff from small, medium and large hospitals were in favour of making participative management statutory while the majority of the Administrators from different types of hospitals were not in favour of making it statutory. This revealed that the majority of the Administrators who favoured. This revealed that the majority of the Administrators who favoured implementation of participative management were against making it statutory, either due to their inherent, inflexible and condescending mindset or due to lack of trust in employees or their capacity to take management decisions. The Doctors and the PTM staff favoured making it statutory, thereby revealing that, with the present set up, there was little or no scope for their effective participation in management and that they saw statutory participative management as the only feasible means for that.

Reasons favouring statutory Participation revealed that compulsion in the form of statutory regulation only will bring the management and employees together, thereby implementing participative management.

Reasons not favouring Statutory Participation were also analyzed. The obvious finding was that compulsory participation would not yield the same results as voluntary participation. Furthermore, a statute would not eradicate the existing distrust between the management and the employees. This leads to the conclusion that participative management need not be made statutory because the successful implementation of this scheme depends more upon the willingness of both the parties, i.e., a mental change from both the employees and managers, than making it statutory because the successful implementation
of this scheme depends more upon the willingness of both the parties, i.e., a mental change from both the employees and managers, than making it statutory.

**Human Resource Management in Karnataka**

The majority of the Administrators and the PTM staff felt that participative management ‘will not be successful’ in Karnataka. But a significant number of employees gave the verdict that it would be successful in Karnataka, but not in the healthcare industry. If these responses were counted along with those supporting that it would be successful in hospitals also, the scale would tilt in favour of the opinion that it would be successful in Karnataka.

The opinions of the employees regarding the reasons for the success of participative management in Karnataka were analyzed. The majority of the respondents opined that Karnataka has an educated politicized and socially conscious labour force that can be trained in managerial functions’ and so participative management would be successful in Karnataka.

The majority of the employees irrespective of their category, from different types of hospitals thought that participative management would be successful, but not in the healthcare industry in Karnataka, because non-medical staff could not be entrusted with the task of decision making in an institution that deals with human lives. So, the obvious conclusion is that the employees were not against the concept of participative management. So, as a whole, the positive responses received regarding this aspect can also be taken as the voice of those who felt that participative management would be successful in Karnataka.
The opinions of the employees regarding the reasons for the failure of participative management in Karnataka were analysed. The discussion leads to the conclusion that the main reason contemplated for the failure of the scheme was ‘management’s unwillingness to come forward to introduce this scheme’.

So, the obvious conclusion is that the employees were not against the concept as they expressed that participative management would be a success in Karnataka. So, as a whole, the positive responses received regarding this aspect can also be taken as the voice of those who felt that participative management would be successful in Karnataka.

**Hurdles to Participative Management**

A comparison across the different categories of employees in different types of hospitals revealed that: (i) the mere advisory nature of the existing participative bodies; (ii) inter- and- departmental rivalries; (iii) lack of education and managerial training among employee representatives and their lack of self-confidence; (iv) restriction on employee representatives’ opportunity to voice their views; and (v) managements flair of superiority and the consequent district between managerial and employee- representatives were actually the hurdles to making participative management a success. A good number of the PTM staff had opined that lack of education and managerial training among employee representatives as well as their lack of self-confidence was the main hurdle to making participative management a success.

**Test of the Hypothesis**

The analysis of the data collected substantiates the different hypotheses set for the study. The first hypotheses was tested by using Two-way Anova test and Second by Factor Analysis. The remaining hypotheses were tested by using Chi-Square Test.
H₁: The extent of satisfaction regarding communication system for different parameters relating to communication were collected and the differences in the mean level among different categories, types of hospitals and their interaction were statistically examined. The test revealed that the mean difference by category, type of hospital and their interaction effect on all the different parameters studied were statistically insignificant.

When comparing the views of Administrators, Doctors and the PTM staff, all parties had a good rating about the effectiveness of the communication system. Also, the comparison across small, medium and large hospitals revealed no difference and the effectiveness of the communication system received no significant difference in the rating.

H₂: Data regarding the factors which motivate the employees of the private hospitals in Karnataka were collected and analyzed. The analysis revealed that for all categories of employees in all types of hospitals, the remuneration package is the major motivating factors. This brings to the fore the stark reality that the finer aspects of motivation like non-interference in one’s work’, ‘Opportunity to participate in management decision’, and opportunity to participate in decisions connected with the job can become determinants only when the basic factors like salary and job security are met.

H₃: The association between ‘form of participation’ and different types of hospitals’ was statistically examined and the analysis revealed that there is statistically Significant association between ‘form of participation’ and ‘different types of hospital’.

The analysis leads to the conclusion that informative Participation, the least effective among all forms of participation, was widely Prevalent in
hospitals irrespective of their size. However, its presence was more prevalent in the small and medium scale sector. Even though the prevalence of ‘Consultative participation’, Which is slightly better than informative participation, was more in large-sized hospitals, the difference was not Statistically significant. the most noteworthy Point is the total absence of joint decision making or collective bargaining, which is a true indicator of effective participative management, in any of the small, medium or large hospitals.

H₄: The association between ‘the parties controlling the hospital’ and ‘different types of hospitals’ were statistically tested and the analysis revealed that there was no statistically significant association between the parties controlling the hospital and the different types of hospitals. This leads to the conclusion that irrespective of the size of the hospitals, the private hospitals in Karnataka controlled by the investors only.

H₅: The association between ‘tenure of office of the members of the committee’ and ‘different types of hospitals’ was statistically examined and it revealed that there was no statistically significant association between tenure of office of the members of the committees in different types of hospitals. It was found that the existing tenure of office of members of committees was unlimited i.e. ‘until transfer or retirement whichever is earlier’ in different types of hospitals.

H₆: The association between opinions about the concept of participation’ in different categories of staff in different types of hospitals was statistically examined and the analysis revealed statistically significant association between the opinions on ‘the concept of participation’ and the Doctors and the PTM staff in different types of hospitals. For administrators, the association was found statistically insignificant.
It was concluded that all categories of employees, irrespective of the size of the hospitals, have a uniform concept regarding participative management, i.e., ‘Participation in all management functions but not in ownership.

$H_7$: The association between opinions about ‘implementations of participative Management’ and different categories of staff in different types of hospitals was statistically examined and the test revealed that there was no statistically significant association between the opinions on ‘implementation of participative management’ and the different categories of staff in different types of hospitals.

$H_8$: The association between ‘opinion on the success or not of this scheme in Karnataka’ and different categories of staff in different types of hospitals was statistically examined and it revealed that there was no statistically significant association between the opinions on ‘success of this scheme in Karnataka’ and the Administrators and PTM staff in different types of hospitals. But with regard to Doctors, the association was found statistically significant.

SUGGESTIONS
In the light of the aforesaid findings about the various aspects relating to participative management Practices, the researcher would like to suggest a model for effective implementation of participative management in the private hospitals of Karnataka.

Before suggestion such a model, many factors need to be considered. First and foremost is that the hospital is a private enterprise and it goes without saying that profit is one of the prime motives. But being an institution
concerned with human health and lives, a significant number of humanitarian and social considerations come into play. Striking a balance between the investor and employee interest, resulting in optimum patient care, should be its main objective. The Survey results are balanced and obviously give due importance to all the aspects considered.

The broader framework for implementation of participative management has been obtained by analyzing the survey data. Keeping this in mind, the researcher would like to suggest the following model.

**Three-tier participative Management Model.**

A three-tier Participative model is suggested with Work Committee at the grass root level followed by Inter-Departmental Committee at the intermediate level and Joint Management Committee at the top level. The model, the structural role positions and committee workings are explained below.

**Ownership and Control**

The legally authority or the owner is the investor and hence the controlling authority. This has been proved in the survey also, Where the employees neither expect nor wants any part in ownership. This leaves the investor free to make policy decision, and handle financial matter or any other matter, as he deems fit, for the profitable functioning of the institution. Moreover, in an institution engaged in Patient care activities, it is advisable that authority emanates from a single source, thus minimizing or eliminating conflicts of ideas and that every employee from top to bottom has a clear cut ideas regarding his position, role, duties and responsibilities, as stated in the Organization Structure. In summary, participation in ownership is not Practical in the present scenario and as per the survey not desired by the employees too.
Management Personnel

The next issue is who should be running the hospitals as a day- to day routine as per the policy guidelines of ownership, with the cooperation of employees whose demands and aspirations are met, while keeping in mind the nuances of patient care, as human lives are at stake. The analysis of the primary data has clearly spelt out that it is a doctor, with professional management qualification, who should manage a hospital. One informal observation during the survey is that in most of the hospitals a doctor with professional management qualification doesn’t seem to find a place in the hierarchy.

Over and above, a good number of employees who support the concept of participative management are apprehensive about implementing it in hospitals, for the sole reason that a non-medical person cannot make decisions regarding the running of a hospital as human lives are involved. Hence, as per the employees’ opinion, only a medical person can be allowed to take decisions. Further, with the growing complexity of modern day hospital set up, Professional management qualification must be mandatory for the proper administration of the hospital. So a doctor with qualification in professional management without compromising the patient welfare.

Clinical Director

It is in this context that the researcher would like to suggest a new cadre of management personnel called ‘Clinical Director’, The Clinical Director should.

(i) be a doctor
(ii) have professional management degree;
(iii) be sufficiently senior to command the respect of all cadres of employee;
(iv) have firsthand experience in hospital administration;
(v) have rapport with the owner and not be the owner or part of ownership;
(vi) have rapport with all categories of employees;
(vii) be receptive to newer concepts and innovation; and
(viii) have freedom and authority to take decisions regarding the function of both clinical and non-clinical department.

The number of Clinical Directors in a hospital can vary according to the size of the hospital, from one in a small hospital to a Board of Clinical Directors in large corporate hospitals. The mode of selection of the Clinical Directors, considering the work culture of a hospital, can be through consensus (even though a secret ballot may be ideal) among the investors and all the employees. This would not be difficult, as the majority of the Doctors and the PTM staff were of the opinion that Clinical Directors would be the most efficient in management and that they were willing to work under a Doctor with management qualification. The tenure of office of Clinical Directors can also be three years, as suggested for committees in the survey.

Regarding the duties of the clinical Director, ideally, he should be the ultimate authority in matters concerning the day-to-day running of the hospital. But with the explosion of specialties, investigation and other facilities and the multi-faceted nature of recent –day patient care requiring the services of so many personnel who are specialized in their own fields, the Clinical Directors cannot effectively manage a hospital all alone. Moreover, as matrix design rather than one-line authority is prevalent in hospitals, it is imperative that there should be a set of Administrators or Assistant Administrators or HODs who assist the Clinical Directors. Hence, the work of Clinical Directors becomes more of coordination rather than control, as envisaged by employees in our study. Under each of the Administrators / Assistant Administrators will
be nonclinical employees, either based on category or task, while the clinical departments will function under HODs under whom will be the doctors and many other categories of employees concerned with a particular field, i.e., Patient care by that department.

**Implementation of Participative Management**

The next step is to study the actual implementation of participative management in this complex hierarchical setup, keeping in mind the various conclusions arrived at like.

(i) freedom to decide about their work;
(ii) consultative participation in all managerial decisions but not joint decision making or collective bargaining;
(iii) no need for equal powers.
(iv) nominated/consensus committee members;
(v) No statutory status for members; and
(vi) PTM not allowed to take decisions in hospital management.

A Confrontationist type of militant trade unionism is absent in hospitals, and strikes have been identified as unjustifiable by almost all the employees.

In such a set up, the employees want to participate in all management decisions through consultation. Hence, the only option through which such Participation can be implemented is committees. But the greatest difficulty is in formulating a viable committee in a hospital, where there is a very wide gap between the different categories of employees, intellectually, academically, socially and financially.

Over and above, there are so many functional units in a hospital which can only be considered together, even though employees from the highest to
the lowest cadre as a team provide patient care activity. For example, the various clinical departments like Medicine, Gynaecology, Paediatrics, Radiology, Pathology, and so on, vary in their function but have a common aim, patient care. Hence, the researcher would like to suggest a Work committee for each functional unit at the grass roots level.

Even though compartmentalization as functional units and departments is easy on paper, in actual practice, every patient care activity requires the services of more than one functional unit and at times many. For example, a patient being treated under the Surgery unit depends on the Radiology Unit for X-rays, the Microbiology Department for bacterial studies, the Catering Department for his food requirements, and so on. Each of these departments may have its own requirements, mode of functioning and limitations in resources. Hence, for smooth patient care activity, a high level of co-ordination among the departments is mandatory. Proper participation of employees or employee representatives for each of these departments is of utmost importance in coordinating the patient care activities of these departments. The researcher would therefore suggest a second tier Committee, Inter-Departmental Committee, above the Work Committee, in which the employees can participate in taking decisions regarding the running of hospitals.

The next level at which participation can be mooted is a level above the Inter-Department Committees, i.e., at the highest level of hospital administration. Before deciding on participation at this level certain important factors are to be considered. Foremost is the fact that, a hospital being a private institutions, the investor’s interest is to be considered and profitability guaranteed. However, being an institution that deals with human lives, profitability can’t be the motive at the expense of patient care either
qualitatively or quantitatively. In this context, a satisfied employee can meet the interests of both the investor and the patient as improved patient care benefits the patient and in turn increases profitability. So, involvements of employees or employee representatives at this level can only further the employee commitment towards the organization. Hence, the researcher would like to recommend a Joint Management Committee which is the top administrative body of a hospital. It would contain employee representatives, but as envisaged in our study, should not be in a position to influence decisions which can adversely affect patient care in any way.

One unique point, especially regarding patient care activities, is that as the health care need of each patient is unique, unexpected, situational problems or management bottlenecks may arise which require immediate decisions and which can’t wait for any committee. So, a single point authority to solve such emergency situation is a must in any hospital set up. Hence, all hospitals should have a Clinical Director with sufficient authority to take such need-based decision without which a hospital cannot function effectively. Decisions so taken by the Clinical Director can be ratified in the Joint Management Committee in its next sitting.

Next, the researcher would like to explore each of these committees with reference to its:

- structure and constitution;
- terms of reference;
- process at each level; and
- Parameters to evaluated the participation of elected and nominated members with special reference to the employee participation angle.
1. Work Committees

The work committees can be classified as medical or non-medical. The core function of any hospitals is patient care and grass roots level problem-solving starts through primary examination and clinical testing of patients. Hence, Medical Work Committees are the key source in the participative models. The number of Medical work Committees depends on the functional medical units in the hospitals.

However, due support from office administration and maintenance units is inevitable for comprehensive patient care, for which non – medical work Committees function.

(i) Work Committees - Medical

Even though the Work Committee is considered as the grass roots level Committee in Clinical Departments, there are many unique features in a hospital when compared to a low level committee would be formed by the lowest category of employees with or without junior managers. But in a hospital, the patient care activities revolve around the treating physician who takes most of the decisions regarding patient care, which can be broadly seen under two heads- (a) professional decisions; and (b) non-professional patient support activities. All decisions regarding the former- diagnosis, treatment, surgery and so on are absolute and do not in any way come under the purview of any committee or level of participation. Moreover, the treating physician is legally responsible and answerable for his decisions, and he cannot hide behind any committee.

In addition, all the activities carried out by the PTM staff regarding any patient are as per the explicit instructions of the treating physician. Hence, the Wok Committee of a clinical department should essentially be one that
coordinates activities rather than controls them, as the survey results showed. At this level, a non-medical administrator has no relevance and the committee can be headed only by the head of the unit who is medico legally responsible along with two junior staff- one Doctor and one PTM staff whose role is consultative, in line with our survey results.

The Work Committee can consider matters like diagnostic approach, clinical tests, nursing care, house keeping, hygiene, patient preparation, theatre preparation, instruments sterilization, resource mobilization, and so on.

From the above discussion, it becomes apparent that though considered by the grass roots level committee, it involves the treating specialist to the attender. Work Committees- Medical, may comprises the following members:

Convener- Head of the clinical department and two junior staff- one Doctors and one PTM staff.

The treating physician by consensus is the head of the Work committee, and the other members can be selected by consensus, seniority or election, as suggested in the survey. The tenure of office can be fixed as three years, as obtained from our survey results.

(ii) Work committee- No- medical can be of two categories: Work Committee Front office and Work Committee Integrated Services.

Work Committee- Front office, unlike clinical departments, can be more like what is seen in industries with professional administrators. the committee members would be;
(a) Convener- Chief Medical Superintendent;
(b) Chairman- Administrator (non- medical); and
(c) Two nominated/elected staff of front office (not Doctors).

The terms of references of the work committee are receptions, waiting time management, customer enquires, dealing with patient complaints and grievances, conveying hospital services, public relation, etc. Here also the member’s tenure can be fixed as 3 years.

Work Committee- Integrated Services, May comprise the following members:
(i) Convener- Clinical Director,
(ii) Chairman- In- house officer; and
(iii) Two nominated/elected staff from Integrated Service Department.

The terms of reference of the Work committees are co-ordination between functional units, use of common resources, assessments of unit level impact on patient care, documentation of patient history, data base management, hospital information system, maintenance of common facilities, infrastructure support, etc. Here also, the member’s tenure can be fixed as 3 years.

As one of the major findings in our study is that a non- medical person cannot make decisions in hospital management, the above two Work Committees’ decision should be ratified by the clinical Directors who is medically qualified. The decisions of the Work Committees are ‘Implementable Decisions’ (ID) and ‘Implementable subjects to ratification (I/R) Decisions’.

**Inter-departmental Committee**

This forms the second tier in the model, as already suggested. It is constituted with the following members:
(i) Convener- Clinical Director 
(ii) Chairman- Chief Medical Administrator/ Non-Medical Administrator. 
(iii) Chairman of the concerned Work Committee, and 
(iv) One consensus/ nominated/ elected member from each work committee.

The scope of this committee is wide. It has to take up all issues brought to its notice by the Work Committee. It should be the coordinator/ arbitrator between the various Work Committees, which have to work in coordinated manner. It should be the authority referring issues to the Joint Management Committee. Also, it is the hub for upward, downward and lateral communication of decisions, reports, and feedback and performance appraisals. The tenure of office of this committee can also be fixed at 3 years. The elected members from work committees can participate in this committee.

**Joint Management Committee**

This is the topmost decision making committee in a hospital with employee participation. The membership pattern suggested is as follows:

(i) Chairman- Managing Director/ Chief Executive officer of the hospitals; 
(ii) Two nominated Directors- of which one should be a clinical Director; 
(iii) Conveners of Work Committees and Interdepartmental Committees; 
(iv) One Responsible Representative (RR) – Responsible Representative is an external member from the society. She/he should be an educated, independent and well- informed person who reflects the true feelings and aspiration of patients, and 
(v) Eight elected members- Four each from Doctors and the PTM staff (depending upon the size of the hospital)

This is the highest decision- making body and the presence of employee representatives allows the employees directly to participate in the decision
making Here also, the tenure of the nominated, consensus or elected candidate can be fixed as three years.

Irrespective of whether the committee be of the low level or high level, for employee participation to be effective, all the members should be given due importance and there should be free flow of ideas in either direction.

There would be exclusive decisions reserved for the Joint Management Committee and, in addition, they would decide on issues referred to them by the Work Committees and Inter-departmental Committees. The final decision based on Work Committees and Inter-departmental Committees will be taken by the joint management Committee with a right to withhold decisions of lower Committees, considering consequences and implications.

A diagram showing the suggested Model for the implementation of Participative Management is Given in figure 7.1.

For committees to be effective, the following basic Processes should be followed in their meetings:

(i) Sourcing information from all levels of employees regarding the day to-day functioning plus their creative suggestions;

(ii) Studying the information so gathered and understanding its implications in patient care and employee efficiency.

(iii) Thorough cordial discussion with all the committee members about the problem or process;

(iv) Getting expert opinion when needed;

(v) Reaching a decision by consensus and implementing it with the co-operation of the whole unit.
Model for the implementation of Participative Management

Note: The number of Work Committees and Inter Departmental committees may vary depending on the number of departments and variety of service provided by each hospital.

There should be a mechanism for the review of the results of a decision implemented and to study its impact and ultimate success or failure in terms of the following parameters regarding its members:

(i) involvement in decision- making process;
(ii) efforts to seek information;
(iii) efforts and ability to elicit ideas and suggestions from other members;
(iv) Effort and ability to accurately assess pro and cons;
(v) Contribution to the final decisions;
(vi) ability to communication ideas and decision convincingly.
Only such evaluation and corrective measures will help in fine-tuning the employee Participation in management, which can ultimately result in a win-win situation for both the management and employees in private hospitals.

The study has revealed that all categories of employees in private hospitals have a reasonably clear concept regarding employee participation in management. Also, the desire of the employees to partake in such venture stands revealed. The understanding of the ground realities in a private hospital as well as the maturity of the employees by placing the institutional interest ahead of their personal interest is made amply clear as they opted for consultative rather than for a collective bargaining through elected representatives. With all this in mind, the researcher has suggested the above model for employee participation in management, which is believed to be both effective and practical.

Participation is not something that can be forced upon someone. In Karnataka, or for that matter anywhere in the world, it can’t be brought about by unions or statutory laws. Participation in its true sense can only be brought about by appropriate mindset of both the employer and employee. It is high time that such mindset was nurtured at all levels of an institution like a hospital where it can produce amazing results.

The researcher sincerely hopes that this humble beginning through the suggested model would in future usher in a change in mindset of all concerned, resulting in extra-efficient hospitals which reap rich dividends for the society at large.
SCOPE FOR FURTHER RESEARCH

During the review of literature and survey for data collection, it was observed that there is vast potential for research on various aspects of hospital management. The general belief is that the failure of health care institutions is essentially born out of inefficient management. Therefore, there is the need to investigate further the finer aspects and various dimensions of Human Resource Management. The research would like to suggest the following areas for further research:

(i) This study is confined to the participation of employees in the management of private allopathy hospitals in the State of Karnataka. Further research may concentrate on the participation of employees in the management of Government hospitals, because the management style of government hospitals is different from that of private hospitals;

(ii) A comparison of the participation of employees of private and government hospitals in their management can be undertaken;

(iii) A comparative study on the management practices in private hospitals and other industries can be expected to yield fruitful results;

(iv) Comparative studies can also be conducted which should include private hospitals from other States so that a wide frame of reference may be developed.

(v) Case study analysis on participative Models implemented in the health care segment of other nations and the implication of such models can be studied.

It is hoped that the present study would provide a base for further research in the above mentioned areas of health care institutions.