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Medical management: hostage to its own history? The case of Italian clinical directors

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Abstract

Purpose – As a consequence of new public management reforms, leading professionals in public service organizations have increasingly been involved in management roles. The phenomenon of clinical directors in the healthcare sector is particularly representative of this, as this medical manager role has been adopted in many countries around the world. However, professionals' managerial role taking still falls quite short of expectations. While most research has searched for the causes of this gap at the individual level by exploring the clash between management and professionalism, the purpose of the paper is to argue that a contextualized understanding of the antecedents at the organizational level, and particularly the existing medical management roles, provides a more thorough picture of the reality.

Design/methodology/approach – The paper adopts an institutional perspective to study the development of existing medical management roles and the rise of new ones (clinical directors). The analysis focuses on the case of Italy, a country with a tradition in medical management where, following the example of other countries, clinical director roles were introduced by law; yet they were not incisive. The paper is based on a review of the existing literature and extensive field research on Italian clinical directorates.

Findings – The paper shows how in contexts in which doctors in management roles exist and are provided with legitimacy deriving from legal norms, historical settlements between professions and taken for granted arrangements, medical management becomes institutionalized, stability prevails and change towards new doctor-in-management roles is seriously hampered.

Originality/value – The paper contributes to existing knowledge on professionals' managerial role taking, underlining the relevance of contextual and nation-specific factors on this process. It provides implications for research and for policy making in healthcare and other professional public services.

Keywords Italy, Legitimacy, Clinical directors, Healthcare management, Hybrids, Medical management

Paper type Research paper

1. Introduction

One of the consequences of the new public management reforms in service sectors has been the managerialization of professional roles. This has been particularly common in

The authors thank the COST European framework and all the members of the Action IS0903 "Enhancing the role of medicine in the management of European Health Systems". They are also grateful to SDA Bocconi School of Management Research Division and Regione Lombardia – Programma Dote Ricerca Applicata, for their financial support. Finally, the authors wish to thank the anonymous reviewers for their valuable comments and suggestions.

International Journal of Public Sector Management
Vol. 27 No. 5, 2014
pp. 417-429

0951-3558
DOI 10.1108/IJPSM-06-2012-0070

those health care systems where doctors have become increasingly involved in management work to meet the demand for greater control of resources and develop a deeper government of professional activities. A relevant example of this can be seen in the spread of the clinical directorate (CD) model in hospital care, according to which clinical units in hospitals are grouped in directorates (or departments) and led by a senior doctor who is in charge of resource management and clinical governance and supports the hospital top management in decision making (Harrison and Miller, 1999). The CD trends in different countries demonstrate an international convergence of health policies and practices; however, there are variations both across and within countries, and the effective managerial role taking is not always achieved (Neogy and Kirkpatrick, 2009; Kirkpatrick *et al.*, 2009; Ham and Dickinson, 2008). The attitudes and skills of candidates, and the dynamics occurring within the professional group do certainly have an impact on the process of doctors' management role taking, yet they do not to entirely explain this variability. Drawing from the concepts of legitimacy and institutionalization (Scott, 2001; Selznick, 1992) we argue that, when searching for the causes that determine this mismatch, greater attention should be given to the organizational context, and specifically to the stability and resilience of existing management roles, both medical and non medical. Therefore in the paper we use a broad concept of medical management roles, not restricted to clinical directors but including those doctors with managerial responsibilities "setting standards, reviewing performance, and exercising supervision and control" (Freidson, 1985, p. 26).

For this purpose we analyse the Italian hospital sector, which is particularly significant as it is characterized by a long tradition in medical management, in which well established roles, professional groups and organizational structures were in place when, following the example of other countries, clinical director roles were introduced by law. After describing the roots of Italian traditional doctors-in-management roles, we show how their presence hampered the development of clinical director roles and their legitimation in the system. By drawing conclusions from the case of Italy, this paper provides reflections for international comparison.

2. An institutional approach to medical management

Healthcare reforms involving changes in professional work have attracted interest from different fields, including public management, organizational studies, sociology and health services. Most of the research focusing on doctors involved in management has analysed this phenomenon through frameworks developed in the field of sociology of professions, and clinical director roles have been considered as a prototypical object of analysis. According to this view, the effectiveness of doctors-in-management in their roles lies in their capacity to redefine his professional role by overcoming the conflict between management and professionalism (Hoff and McCaffrey, 1996; Llewellyn, 2001; Thomas and Davies, 2005; Noordegraaf, 2007; Numerato *et al.*, 2011) and to perform the managerial role without losing legitimacy and status within the professional community (Forbes *et al.*, 2004; Witman *et al.*, 2011). As a result clinical directors become effective hybrids, or "two way windows" (Llewellyn, 2001) finding a balance between the managerial and professional logics. This literature has often studied the phenomenon of clinical directors' managerial role taking at the individual level or looking at the relationships within the group of practicing physicians. Yet, as this process always takes place in complex organizations such as hospitals, in which contextual factors like formal and informal organizational rules, historical routines and conventions have a high relevance.

We develop this perspective by drawing from concepts of institutional theory, in particular from the notions of legitimacy and institutionalization. Legitimacy is defined as "a generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions" (Suchman, 1995). An organization's role, authority structure, order or power arrangement becomes an institution when it gains a relevant legitimacy, when it is "composed of cultured-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life" (Scott, 2001). Legitimacy can rest on a regulative basis, when there are rules and legal sanctions supporting the existing order; on a normative basis, when the order is coherent with shared moral values; or on a cognitive basis, when the order or way of action is considered meaningful and is therefore taken for granted (Scott, 2001). More recently Deephouse and Suchman (2008) have suggested to introduce a variant of normative legitimacy, namely professional legitimacy, to refer to legitimation provided by the congruence with the ethics and worldviews of a particular professional group, rather than by the congruence with general societal values. If a social order is highly institutionalized stability prevails, the existing norms and practices will not be questioned and change will be hampered. Or, as stated by Selznick (1992): "institutionalization constrains conduct in two main ways: by bringing it within a normative order and by making it hostage to its own history".

The institutionalization of medical groups and practices in the hospital sector has been a popular topic of research in the last years. For instance in his famous study Barley (1986) has analysed the social structure (and the change process) of radiology departments of two US hospitals, while Kitchener (2000) has described the institutional forces which influenced inertia and change in professional roles when CDs were introduced in UK hospitals. Hospital medical groups develop their own identities, belief systems and cognitive maps. And the settlement between professional groups, in terms of distribution of power over decision making, endowment of resources (people, technologies, beds, etc.) or the boundaries of professional practice areas, constitutes the main organizing principle for the hospital functioning. Change in this stable social order can occur only if a "deinstitutionalization" process takes place in which, as a consequence of functional, political or social pressures (Oliver, 1992), existing groups or practices lose legitimacy, weaken and disappear, while new groups or organizational practices take their place. Change therefore can occur only when the regulative, normative or cognitive sources of legitimacy of a group or practice are undermined and existing arrangements are perceived unable to respond to the strong tensions which take place in hospitals. Although "traditional" professional groups have usually been considered as a subject of institutionalization, the same theoretical perspective has been adopted to understand the logics and dynamics of "hybrid" medical management roles and groups. For instance the acquisition of different types of legitimacy in healthcare organizations by emerging medical management groups has been studied by Hoff (1999) in the USA and Marnoch *et al.* (2000) in the UK NHS. Therefore the degree and type of legitimation of existing medical management roles and groups has a major influence over the change towards new forms of medical management. On this basis we argue that if organizational circumstances and medical management arrangements in place are highly institutionalized, and if the sources of their legitimacy are not compromised, new roles and groups aimed at further developing medical management can end up being entrapped by the very same systems they must improve.

Finally, as "patterns of accommodation between medicine and management are more nation-specific than is frequently acknowledged" (Kirkpatrick *et al.*, 2009) it seems important to accompany the analysis of medical management arrangements and the sources of their legitimacy with the study of a nation's unique political, legal and historical context. This in-depth analysis is developed in this paper with reference to the case of Italy.

3. Methodology

The analysis that follows draws on both primary and secondary data sources. A review of the healthcare management literature was developed searching the electronic database EBSCO Business Source Complete Database for the following keywords: "clinical director", "clinical directorate", "hybrids", "medical management" and "Italy". Papers published in the last 20 years were included. The volumes of key Italian journals in healthcare management[1] published after 2005 were screened manually, and a snowball strategy was adopted to collect previous literature. The results of independent studies on the development of CDs based on surveys and documental analysis were analysed, as was national legislation on CDs.

The paper also draws on previous research published by the authors (Lega, 1999, 2002, 2008; Cantù and Lega, 2002; De Pietro and Prenestini, 2008; Lega and Prenestini, 2009; Poser and Prenestini, 2010; Sartirana, 2013) and on the findings of ten action researches conducted by the authors over the period 2002-2013[2] to support hospital independent trusts (3), general hospitals controlled by local health authorities (LHAs) (4) or teaching hospitals (3) in the design of CDs or in the development of the effective engagement of doctors in the new managerial roles. The hospitals were based in eight different Italian regions, researches were developed on site and included interviews and group discussions with hospital top managers, clinical directors and other senior medical and non medical managers and unit chiefs. One action research was longitudinal (2002-2012) and allowed to analyse the dynamic nature of the process of professionals' managerial role taking. The initial conceptualization of data was developed among the three authors, it was condensed, structured and theoretically contextualized by the first author and further discussed and enriched during feedback sessions with the co-authors.

The paper is organized as follows. Section 4 describes the features of the Italian system and their effects on the development of formal medical management roles. Section 5 describes the features of Italian medical management roles, while Section 6 discusses the impact of traditional medical management forms on the development of clinical director roles. In the final paragraph conclusions are presented.

4. The Italian health system

This section describes the main features of the Italian National Health System (INHS) – and in particular its hospital sector – to understand how it potentially favoured the development of clinical director roles. According to the framework proposed by Kirkpatrick *et al.* (2012) to explain the development of medical management roles in a healthcare system, we first describe the general characteristics of the INHS, then the nature and process of public management reforms and finally the nature of organizational settlements with the medical profession (Table I).

The INHS grants universal access to a uniform level of care throughout Italy. It is a regionally based system such that the 21 regional governments are responsible for ensuring the delivery of healthcare services. Resources are collected through general

taxation and are allocated from the central state to regions and from regions to LHAs. LHAs operate owned hospitals and act as commissioners of services for public hospital trusts (PHTs) and private accredited providers (PAPs); funding is given to the LHAs based on capitation and a DRG system for PHTs and PAPs. Patients have the right to choose between public hospitals and PAPs throughout the country. In the last few years the cumulative effect of the growing strategic planning at the regional level, the strong financial pressures, the development of the commissioning activity of regions and LHAs, and some degree of competition have created a push towards hospital managerialization (France and Taroni, 2005; Lega, 2005; Lo Scalzo *et al.*, 2009; Anessi Pessina and Cantù, 2011). This push, in turn, has led to calls for improved governance of hospital healthcare services which has brought about a need for doctors to be more involved in management.

This trend was supported by the public sector reforms of the last 20 years, inspired by the values of the new public management movement. At the beginning of the 1990s, the INHS was reformed, bringing about most of the managerial innovations described above. One of the most relevant changes was the set up of hospital top management teams that were empowered with management responsibilities, substituting the traditional role of hospital administrators. These teams, composed of a general director or CEO, an administrative director and a medical director (a doctor by law), were given the task of reducing the autonomy of unit chiefs and dismantling the existing managerial style deeply connected with informal and political logics. In the same years, other, broader public sector reforms were passed and strongly affected public healthcare providers (in particular the so-called "privatization" of the public employment relationship). In the late 1990s, regional governments also increased their legislative activity with reference to health policy and hospital organization (introducing, among others, norms concerning the directorate structure).

Finally, the features of the medical profession in Italy, such as the fact that Italy is among the OECD countries with the most doctors per capita (4.1 per 1,000 inhabitants: OECD data 2011) and that Italian doctors are hired and paid by the hospital and usually have open-ended contracts, seemed to facilitate the active involvement of doctors in management. Furthermore, the relatively marginal role – compared to other European countries – of medical bodies and societies, which do not have official decision-making roles in the system but rather lobby central and regional governments, hinders professional self-regulation which potentially might discourage doctors' involvement in management.

5. Medical management in Italy: the old and the new

As anticipated, the involvement of doctors in management tasks has always characterized the history of the INHS, especially at the specialty unit level, which the first law on hospital organization, passed in 1938 (RD 1631/1938), identified as the

National population (2012)	Overall health spending, USD PPP per capita (2012)	Total expenditure on health as % of GDP (2012)	Public expenditure on health as % of total expenditure (2012)	Practicing physicians per 1,000 population (2011)	Total hospital beds per 1,000 population (2011)
59,118,000	2,919.4	8.7	80.3	4.1	3.4

Source: OECD Health Data (2013)

Table I.
The Italian health system

fundamental component of the organizational structure. Italian unit chiefs were not only experienced professionals but have also always been in charge of formal responsibilities concerning both the organization of work and human resources (traditionally, doctors, nurses and healthcare assistants) and physical resources (beds, outpatient rooms, operating theatres, etc.). This responsibility has always been accompanied by the legal responsibility for monitoring, directly and indirectly, all of the clinical activities in the unit. After 1992 their role was enhanced with formal managerial responsibilities for achieving targets and controlling costs. In addition, the traditional wording *primario* (literally, primary physician) was substituted by *direttore di unita` operativa* (unit chief).

Moreover, a second element characterizing the INHS is represented by a class of doctors holding a specialization in "Hospital hygiene and organization", a medical discipline whose members have historically been in charge of the operational management responsibilities in hospitals. Their origin dates back to the first reform in 1938, when all Italian hospitals were required to have a medical director responsible for hospital management[3]. Over the years, this category of physicians (referred to as "hygienists") emerged as an independent medical specialization, taking care of hospital hygiene, hospital organization, medical archives and epidemiological analysis. Many residential courses were introduced over time, and the discipline is taught today in 32 medical schools. Despite this, hygienists' professional legitimacy was not always acknowledged in organizations as some practicing doctors doubted the competency of colleagues who abandoned – or never began – clinical work. Hygienists today make up for most hospital medical directors, and comprise the large majority of the 50 per cent of all CEOs with a medical background in Italy. They have also set up an active medical association (ANMDO) and, more recently, many of them contributed to the establishment of an association of medical managers (SIMM), modelled after the British Association of Medical Managers. In order to regain power and status this group has recently started acquiring new competencies in management fields as operations management, risk management, control of safety standards, implementation of EBM protocols and health technology assessment.

The healthcare reforms of the 1990s also prescribed the introduction of the clinical director role in order to answer two perceived needs. First, the necessity to reduce top managers' span of control, as the number of clinical units in hospitals had grown significantly because the appointment as unit chief had been used as the only leverage to reward clinicians on their career path. The span of control had further increased over the previous 20 years due to hospital mergers. Second, the necessity to effectively reduce costs and introduce a model of care closer to needs of older, chronic and more complex patients required a deeper clinical governance and a more incisive management of clinical services, which could only be performed by doctors on the shop floor able to manoeuvre within the "black box" of clinical processes. Clinical directors (labelled "department heads") were introduced as an intermediate hospital organizational level and were intended to embody a managerial role charged with fostering cooperation among different units in developing joint care pathways and evidence-based procedures and facilitate resource pooling to benefit from economies of scale and scope[4] (Lega, 1999, 2002; Lega and Prenestini, 2009). Therefore this role was also expected to take up some of the existing responsibilities of unit chiefs and hygienists, and also to contribute to top management activity by participating in hospital-wide strategy making. Italian clinical directors are defined by law as part-time roles, with doctors maintaining the leadership of the clinical units and usually some level of clinical activity. They are appointed by the CEO, often out of a shortlist of three

candidates elected by the doctors who work in the directorate. They hierarchically report either to the CEO or the medical director and participate in the Council of Clinical Directors, which is expected to work as the executive committee supporting the top management on issues of strategic planning, management and clinical governance. The law does not prescribe the introduction of any support for the clinical director from administrative staff, nurses or general managers, although regional legislation and hospitals statutes are free to introduce administrative staff or nurse managers (Cantù and Lega, 2002).

However, the first directorates were not set up until 1995, and the diffusion took almost 15 years. In general terms, an early stage can be identified, lasting until the end of the 1990s, in which the development of CDs was slow: CDs were set up mainly in large independent hospitals, sometimes on an experimental basis, and the grouping of clinical units was often designed according to clinicians' preferences, most often on a specialty-based rationale, rather than according to organizational strategies of integration of care (Lega, 2008). To accelerate departmentalization, law decree 229 of 1999 was passed, making the reorganization according to the CD model compulsory for all hospitals. Yet most independent studies carried out between 2000 and 2004 (Senato della Repubblica, 2001; Cicchetti and Baraldi, 2001; Cantù and Lega, 2002; Bergamaschi and Fosti, 2002; ANAAO, 2004; Cicchetti *et al.*, 2009) reported that, although the number of hospitals that had implemented departments increased dramatically in the following years, the development of CDs and clinical director roles was far from being incisive in healthcare organizations. In most cases, these individuals were not managing directorate resources or acting as clinical unit coordinators accountable for achieving directorate targets (Bergamaschi and Fosti, 2002). Similar findings are provided by Poser and Prenestini (2010) and by a recent study by Morandi *et al.* (2011) based on a 2006 survey of over 1,800 CDs, which reports that most of the directorates introduced after 1999 have not developed effective clinical governance tools, such as departmental guidelines, clinical pathways, telemedicine, systems for appraising clinical outcomes, departmental budgets and training programmes.

6. Accounting for the reasons behind clinical director roles' poor development

This section explores the influence of existing doctors-in-management on the scarce engagement of Italian clinical directors in their role. First of all, the involvement of clinical unit chiefs in management turned out to be a major obstacle for the effective development of clinical director roles. Unit chiefs were accountable for the use of resources and were legally responsible for the organization of all clinical activities performed by the professionals working in the unit. Furthermore their role had even been strengthened during the healthcare reforms as they had been provided with new financial management responsibilities. Therefore their role was supported by a number of rules and coercive mechanisms, and they could manipulate rewards and sanctions to influence colleagues' behaviours. In short, using Scott's (2001) phrasing, they had a strong regulative legitimacy. But they also remained the "masters" of the hospital, with responsibility over training, knowledge transfer and professional development of their colleagues. They were highly respected professionals who deserved the followership of the doctors and nurses working in their units. As a consequence, they usually held a recognized professional legitimacy. Finally, Italian hospitals had always been based on clinical units, and unit chiefs had historically been provided with strong autonomy in clinical activity. The rules of accountability were clear and – to paraphrase the famous Griffiths report – if Florence Nightingale had

carried her lamp through the corridors of the INHS she would have quickly found the people in charge. Many professionals considered this model comprehensible, as responsibilities were clearly defined, and meaningful, as it had always worked. As a consequence there was a good degree of agreement about the fact that the existing medical management model was an effective way to run the hospital, it had cognitive legitimacy.

Second, there was the medical specialty in hygiene and hospital organization, the discipline that had historically developed a boundary-spanning role in dealing with managerial and organizational issues from a medical perspective. They also had legitimacy in the system, from both a regulative, professional and cognitive perspective. This medical management group was a recognized medical specialty, and as the devolution of managerial power to clinical directors was seen in many cases as a threat to the future of the specialty, they often favoured inertia rather than change.

As a consequence, the Italian hospital sector historically had favoured the development of a strong medical management model. Such a model was highly institutionalized, as existing doctors-in-management roles were considered appropriate, usually had a strong professional status and were backed by a strong regulative system. This model was stable and proved resilient to change when an alternative order (the clinical director model) was introduced. Resistance to clinical directors therefore did not come primarily from practicing physicians, but from professionals who were already medical managers. Therefore clinical director roles, aiming at further developing medical management, in facts became the object of what might be called an "institutional entrapment" due to the strong legitimation of those systems they were meant to improve.

Also, it must be added that the hospital top management itself was very cautious in setting up governance structures, incentives and management tools to support the effective involvement of clinical directors in their role (Lega, 2008). The delegation of functions to intermediate layers was seen by some CEOs as a danger to the legitimacy and effectiveness of their own role, and often top managers directly managed the relationships with unit chiefs, therefore delegitimizing the formal authority of clinical directors. Furthermore, although the mandate of a CEO by law is five years, on average – according to most recent studies (Anessi Pessina and Cantù, 2011) – CEOs remain in the same hospital for an average of approximately three years, and this span of time has often been perceived by CEOs as too short to truly invest in building a class of clinical directors to delegate decision making and responsibilities. Therefore, there was little "sharing of minds" between CEOs and clinical directors, and the top managers preferred to take autonomously strategic decisions leaving their implementation to hygienists or unit chiefs. As a consequence the stability of the existing medical management model was favoured also by non medical managers, and especially top managers. Rather than implementing the law by empowering and supporting clinical directors, they often supported the resilience of the existing order, preventing the institutional change.

7. Conclusions

"Of course, if *they* do not involve us in decision making we just ask for the latest 'toy' […] but if they did, we would be able to contribute to forging the vision, the positioning of this hospital".

Most research has searched for the causes the poor development of hybrid medical manager roles at the individual level, by exploring the clash between management and professionalism. Yet a contextualized understanding of the antecedents at the organizational

level, and particularly the behaviours of existing medical managers and non medical managers, provides a more thorough picture of the reality. This quote from a clinical director of a large Italian tertiary hospital shows only one of the many cases in which professionals are willing to engage in management, but the organization, namely top managers and existing medical managers, does not provide them, through delegation and involvement, the context to do it. And that explains why also doctors – and clinical directors – with a high-managerial potential do not perform their hybrid role and just continue claiming the latest "toy" (i.e. the most recent, expensive technology).

By adopting an institutional perspective this paper shows that in contexts in which doctors in management roles exist and are provided with legitimacy deriving from legal norms, historical settlements between professions and taken for granted arrangements, medical management becomes institutionalized, stability prevails and the occurrence of change is extremely unlikely. As a consequence, the introduction of "modern" medical management roles in hospitals, which has been one of the component of most recent health policy reforms, should take into account the differences between contexts in which doctors-in-management did not exist and situations in which medical management arrangements flourished. These findings introduce a novel perspective which gives a contribution to the literature on hybrid roles not only by showing the relevance of the nation-specific context in the development of doctors' engagement in the managerial role, but also pointing out that the development of new medical management roles such as clinical directors can be seriously hampered precisely in those systems in which medical management is already well established and benefits from strong legitimacy. Furthermore, also individuals that might be expected to support the engagement of clinical directors, i.e. the hospital CEOs, can contribute to this resilience.

Our research also answers the call to investigate the dynamic of "doctor subgroups which have gained status and power relative to other subgroups through recent reforms and reorganizations" (Numerato *et al.*, 2011), and to deepen the understanding of the relationship between clinical directors and hospital top management (Marnoch *et al.*, 2000; Hoff, 2001; Forbes *et al.*, 2004; Mo, 2008). The findings can also contribute to broader research on hybrid roles in other professional public services. For instance similar problems in coping with professional and managerial different roles and identities have recently been found in academics who are appointed head of department (Floyd and Dimmock, 2011), and many professionals in schools or social services in most western countries are struggling with comparable challenges (Kirkpatrick *et al.*, 2005). The antecedents at the level of the individual and at the level of the professional group are important but should probably not be overemphasized. Rather than considering it only as a background control variable research should explore more the organizational context and its influence in providing (or not) the opportunity for professionals to effectively enter the new managerial roles.

This study has some limitations, mainly regarding the relatively scarcity of literature on the topic. Some of the findings might not apply to all Italian healthcare organizations or regional contexts. Moreover, although the action researches in which they were involved exposed the authors to all key professional profiles (top management, clinical directors, unit chiefs, hygienists and nurses), hospital top managers were slightly over-represented, which might have partially affected the study results. Nevertheless, these initial findings may help develop more pertinent hypotheses and propositions for further inquiry using primary data sources.

The study also provides useful insights for health policy making and management in countries aiming at strengthening medical management. Policymakers should be

careful in introducing hospital reorganizations and new standardized roles without considering if and how the individuals who should be the sponsors of change are going to engage in it. If hospitals' top managers do not believe in doctors-in-management, and are not willing to invest in them by delegating power and responsibilities and by supporting them with dedicated staff, doctors' managerial role taking will not occur. And if potentially competing professional groups of doctors in management already exist, a careful process of re-definition of their professional identity should be supported, and alternative development pathways and incentives should be provided to them.

Notes

1. Mecosan, Mondo Sanitario, Organizzazione Sanitaria, Politiche Sanitarie, Sanità Pubblica e Privata.
2. 2012: assessment of the perceived directorates' effectiveness – LHA Bologna; 2010: reconfiguration of the hospital network – Trento; 2009: designing of the multi hospital network "A.O. Ospedale di Circolo" di Melegnano"; 2009: reorganization of new hospital Niguarda of Milan according to "intensity of care" model; 2008-2009: reorganization and development of clinical directorates at LHA of Bologna; 2008: reorganization and clinical directorates development at orthopaedic teaching hospital I.O.R. in Bologna; 2008: reorganization and development of clinical directorates at teaching hospital San Martino of Genoa; 2007: reorganization and development of clinical directorates at teaching hospital of Udine; 2007: reorganization of LHA of Udine; 2005-2006: reorganization of the Foligno Hospital; 2004-2005: reorganization of LHA of Bologna; 2003: organizational development at Lucca LHA.
3. The Italian expression used by the law is "curare il buon governo dell'ospedale".
4. Although the department (as we intended) were established only in 1992, the idea of grouping specialties in order to reduce the clinical and organizational fragmentation and costs had already been proposed – although never realized – in the previous reforms of 1968, 1976, 1978 and 1985.

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