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An investigation on the impact of the relation between governance and the role of treatment in the form of medical administration and management in Iranian health centers and clinics

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ABSTRACT

We have personally developed a useful and detailed conception of governance which can be used as a starting point and framework for understanding the complex sets of debates which comprise the relationships between management and governance in treatment and business. We argue that the concept of governance is an umbrella concept which is able to define an approach to comparative politics. In particular, we are concerned to draw attention not to the performance of government per se, but to the social and relational nature of legitimate authority. Governance is a useful concept because it does not prejudge the locus or character of public decision making. For example, it does not imply, as government does, that real political authority is vested somewhere within the formal-legal institutions of the state. Nor does it imply, as the term leadership does, that political control necessarily rests with the head of state or official political elites. It enables us to suspend judgment about the exact relationship between political authority and formal institutions in society. In our view then, governance is about the normative "rules of the game" which govern state-civil society interactions in the public realm. We can define the public realm as comprising both the state and civil society, but excludes the private realm. Defining the line between public and private is of course difficult to do and has been the subject of debate over many years. Feminists, in particular, challenge this conceptualization by arguing that the definition of the public realm in most political theory excludes historical female experience, relegating it to the private sphere of domestic duty. The limits of public action would not only apply to women, but arguably to excluded groups whose voices are not recognized as part of the "game" of political exchange. This has implications for development also, because it is often disempowered groups, who lack voice, that are excluded from state-initiated development activities.

Keywords: governance, management, medical, treatment,

INTRODUCTION

It is the relational nature of this concept of governance which is interesting and which is further developed by Andrew Dunsire [1993] and Torben Beck Jorgensen [1993]. Dunsire argues that notions of government by regulation, whether hierarchical or market-based, assume linear models of change. The hierarchical mode is implementation- and enforcement-intensive while the market-based model is more cost-effective.

He argues, however, that it is foolhardy to believe that social systems need to be governed constantly. In line with Archer, he suggests that social systems tend to persist, with the same parts in the same relationships with much the

same boundaries, regardless of government's efforts to steer the direction of change. Using notions of dynamic, organic systems, he argues that governance can be understood as a process of collaboration, which "conveys the process of strengthening one force or weakening another in a poly-dynamic arena so as to alter the outcome without superseding the tensions altogether" [1993, p. 29]. Collaboration, therefore, refers to a type of statecraft where groups do not regard themselves as being governed but as following their own free choice. This statecraft involves maintaining a balance between conflicting interests through manipulating the precarious balance between social groups to achieve government objectives. The essence of collaboration is to identify what antagonistic forces exist, what stand-off patterns presents themselves and what interventions would create a more desirable position.

Building on the notion of the tendency of social systems to preserve themselves, Jorgenson (1993) suggests that changes in modes of governance seem to be rationally planned but may also reflect a shift in political or administrative ideologies and, therefore, may be more symbolic.

The approach to governance in treatment adapted by the Iran government reflects a combination of these strategies. On one level, it is a normative and symbolic attempt to include and recognize the social groups who struggle at great social and personal cost. This is evident in the attempt to develop governing structures which represents all these different players. However, on another level, it is an attempt to cooperate, through various managing and governance discourses, the conflicts and tensions which characterize the treatment arena as a consequence of the non-profit policies struggle. In this context, treatment governance is broadly about the extent to which the decision-making structures and systems which define treatment development enjoy respect and legitimacy. A consequence of effective governance would be legitimacy or social capital, that is, the engagement of treatment actors and role players in public deliberation about treatment provision. This brings the notion of treatment governance face to face with the conundrum highlighted earlier.

Treatment is required to create the conditions for social development and democracy, but at the same time requires democratic relationships in the form of social capital to sustain treatment development. It is this tension which highlights the limits of treatment governance and management in Iran context. The treatment arena in treatment is characterized by a range of relationships and conflicts which are embedded in the governing and management technologies of the revolution period. These have to a large extent undermined inter-group cohesion at the Health center level. There are a range of treatment actors whose identities, formed during the revolution period, are premised on notions of struggle and resistance. These continue to operate in the field of treatment governance as interest groups competing for scarce resources. In addition, the management systems and processes which control distribution and delivery, continue to develop and sustain identities more suited to hierarchical or market-based forms of organization. This further undermines the process of participatory democracy and development and has the effect of privileging those social groups who are able to access resources through the traditional means.

We believe that the formal governance and development prescriptions of the 1990,s assert the primacy of the market as an alternative to the organizational principles of hierarchy. Both of these approaches ignore the relational webs which characterize economic and political productivity. They therefore suggest a need to focus on how institutions are activated by the way people-in-relations realize procedures and activities. In this activating work, an organization is connected to, and embedded in, the web of relations, a social economy which forms the social environment of the various participants.

We argue that ignoring the relational nature of small communities in Iran results in the imposition of market-based or hierarchical modernity's which amplify local conflicts, violence and dissonance in behavior and decision making. Democratic governance, in these contexts, is more likely to be achieved by using the relational capital implicit in local communities, than by attempting to regulate or change it.

In this thesis, the concept of governance will be used to capture the complexity and challenge of these newly forming political and institutional relationships in treatment. I insist that governance involves power relationships characterized by conflict and compulsion. These are characterized by forms of exchange and reciprocity. Exchange is viewed primarily as a mutually rewarding and beneficial relationship, although this is debatable in economic terms. However, it is the basic productive relationship in a market based model. Reciprocity also involves mutually productive transfers but characterizes continuing relationships among or between people. At its heart is the concept of authority or legitimate power, which is the voluntary acceptance of an asymmetrical relationship. While this characterizes a sovereign notion of power, adding the concept of power as a relation extends this notion of reciprocity to include the social mechanisms of subjugation and compliance. Governance then involves relationships of power, authority, reciprocity and exchange. Hyden views structures, another aspect of governance, as the normative frameworks, rules or regulations, within which people pursue social, economic or political ends. He suggests that they comprise the "rules of the games" for governance interactions and are characterized by

relationships of trust, compliance, accountability and innovation. These structures are better understood as the institutional context which determines patterns of interaction and distribution.

Governance can therefore be understood as a combination of political and institutional power to ensure the effective management of resources for development. Governance is fundamentally concerned with institutional relationships between people in the form of individuals, interest groups, stakeholders and organizations. The nature of these relationships is determined in a post-modern sense by shifting social interactions and discourses which pattern institutional contexts. Policies provide the context and framework for governance relationships. They are important because they tend to frame the structural ways in which people operate. They relate not only to the "who decides" question, but to the process of deciding. Power determines the nature of relationships. Power operates through notions of "truth" and is dependent on dominant social paradigms which define "the way things are". Empowerment is then not only about the distribution of power, from the powerful to the powerless, but about challenging perceptions and developing new models of social organization.

In summary then, governance can be understood as the collaboration of complex political, socio-economic and institutional relationships between people (the stakeholders of any particular sector), policy (structural, normative and regulatory frameworks) and power (the distribution and utilization of power and authority networks) in order to legitimate resource distribution and development in treatment.

Management forms part of this process as the mechanism through which compliance and service delivery is achieved. Treatment management broadly can be categorized into three broad areas - strategic, pedagogic and operational. Strategic management can be understood as the process of defining the normative and regulatory frameworks which will facilitate the effective structuring and planning of treatment through the allocation of resources. The strategic management function is critical to the establishment of effective relationships between stakeholders and the levels of treatment management because it establishes the framework for the long term, dynamic process of managing for change. Pedagogical management involves those issues related to the nature and objectives of the treatment process. These are translated into the curriculum and teaching and learning practices of the staff of the treatment management system. Operations management refers to the managing of daily operational processes involving policy, planning and co-ordination, human resource management and financial management. It is, in fact, the day-to-day administrative process and management system which has an impact on delivery in the treatment system overall. All of these areas are interdependent and form part of an overall system of treatment management. Management, in this context, is not perceived as a neutral or technical process of delivery, but as a complex set of institutional practices, discourses and relationships which produce forms of compliance, self-discipline and modes of organization. Public management is, therefore, related to governance. Both are premised on notions of social regulation.

History and context

In Iran, history has itself always been a site of political struggle, an effect multiplied by the fact that the country has often seemed like a vast social science experiment, a theatre in which much of the rest of the world finds echoes of its struggles.

The struggle facing the newly democratic Iran was to overcome the legacy of the *Pahlavi Kingdom* eras, segregationist social and treatment policies, which over many decades had manifested themselves in discriminatory laws and practices. Most of today's doctors and Health center leaders began their teaching careers under the *Islamic government* where they were required to practice in God-ordered settings. Also, many minorities were able to choose to live particularly in Iran and they have had lasting effects on both treatment and social infrastructure. These effects include ineffective leadership and management practices in many of our public Health centers, especially those in historically underdeveloped areas.

In the new Iran many daunting challenges are emerging and these raise questions about how the treatment of the young is best managed. At the level of the functioning of a Health center and the role and identity of the individual doctor, Tayeb (1998) alludes to a set of values that underline attitudes and actions of members of social groupings. Bhatt *et al.* [1988:150] argue that, "at all levels it is the construction and interpretation of reality that prevails" and this results in an alienating ethos where rules are not related to culture and where the use of diagnostic tools favors the English cultural heritage. In concert with this view, Mattson and Harley [2002:284] state that Health centers function primarily as signals of modernity on the African landscape. They display [w]estern symbols and advance modern expectations and promises because 'looking modern' brings affection from larger western states and spurs the arrival of foreign capital. And by signaling the coming of economic growth, real or illusory, the fragile state strengthens its own domestic position. They argue that this ideal is applied to Iran treatment policy in transition; that entrenched western ideals (meant to ensure Iran's competitiveness in a global information economy) are integrated

with local ideals of social justice and democracy, on the assumption that, 'you can't have one without the other'. They also argue that policy in Iran treatment tends to fall into the trap of social meliorism, where commitment to a vision of *what should be* clouds the ability to consider seriously *what is*, so that the good intentions of social reconstruction have more influence on the policy agenda than social and Health center realities.

Therefore, the treatment environment in Iran points to diverse layers of complexity and paradoxes that have attracted the attention and interest of doctors, doctor trainers, scholars, and researchers world-wide.

Unemployment is high. Poverty levels are high. Evidence of this is seen in Health centers and society with the high number of learners being deteriorated daily.

My points to numerous other problems facing Health centers in Iran, including:

- Parents struggling to maintain sufficient contact with their children
- The high levels of delinquency among learners in the Health centers
- Children who fail to complete homework or spend insufficient time studying for their tasks or tests
- Children able to afford only cheap foods especially chips (crisps) — saturated with salt and food colorants
- Problems of communication due to language barriers between doctors and their learners. These, and many other, factors in Iran today, help demonstrate the complexity of addressing the treatment legacy of the past, including ineffective treatment systems, attitudes towards Health center head physicians and, specifically, treatment administration practices. But the Department of Treatment, in its recent initiatives to address these problems, states clearly that, effective management and leadership, articulated with well-conceived, structured and planned needs-driven management and leadership development, is the key to transformation in Iran treatment.

Overview of treatment leadership and management initiatives

I examine three main issues, which are directly linked to Health center management developments in Iran since lately:

1. Health center leadership and management;
2. Professionalization of head physicians through the Iran Standard for Health center Leadership (); and ISSL
3. Leading and managing the learning Health center. In exploring these issues I draw mainly on a systematic and comprehensive literature review of Health center leadership, management, and governance (Bush *et al.*, 2006), commissioned by the Matthew Goniil Health Center of Leadership and Governance (HCLG). The aim of the desk research was to establish 'what is known' and 'what still needs to be known' about treatment leadership, management, and governance in Iran.

We also draw upon the work of the Treatment Management Task Team (EMTT) 2004–2006, which was commissioned by the Directorate of Treatment Management and Governance Development in the National Department of Treatment. Their work drew upon the Iran Health centers Act 1996 and, specifically, the recommendations of the Ministerial Task Team on Treatment Management [DoE 1996]. The EMTT brief was to develop a policy framework for Health center leadership and management development, training, and implementation, and to devise a Iran Standard for Health center Leadership (ISSL) which would inform professional treatment leadership programs, leading to a National Professional Qualification for Head physicians (SANPQP). The SASSL would provide a clear role description for head physicians, set out what is required of head physicians, and identify key areas of head physicians.

Health center leadership and administration in Iran

As noted earlier, a systematic review of the literature on Health center leadership, management, and governance was undertaken in 2005–2006. This part of the article is structured using the categories in the desk research report (Bush *et al.*, 2006).

Participation and democracy

Thurlow [2003] states that the shift to a democratic Iran following decades of the *Pahlavi kingdom* has been accompanied by a move to knowledge management. He endorses the view expressed by the 1996 Ministerial Task Team [DoE, 1996:24] that self-management should be accompanied by internal devolution of power. Chisholm [1999] provides an assessment of Health center democracy based on a three-year longitudinal study immediately following the first democratic elections in 1994. She points to the 'control' model of management, previously noted by Sebakwane [1997], but adds that doctor involvement in the former mode Health centers remains low.

Ghoorchian [2003] reports on a 1998 survey of head physicians in Tehran: 75% of these respondents claim that they 'normally discuss with staff before a joint decision is taken' and that Health center aims are 'decided in consultation with all stakeholders'.

There is considerable evidence that women are greatly under-represented in management positions. Sebakwane [1992] attributes this disparity to 'patriarchy'. To address the legacy of the *Pahlavi Kingdom in Iran*, many development and intervention initiatives have been implemented since 1994.

Strategic management

The approach to strategic management in Iran Health centers has been given added impetus by the shift to greater self-management and, in particular, the acquisition of Section 21 status (Iran Health centers Act 1996), which gives more autonomy to those Health centers obtaining this status. The greater the authority exerted by Health center management teams (SMTs) and Health center governing bodies (SGBs), the greater the potential for a truly strategic approach to emerge.

We can argue that strategic management and planning represent a "radical culture shift for Health centers" that previously "focused on short-term tasks" and adopted a "culture of dependency". The new challenge is that the SMTs and SGBs are required to think and act strategically in order to align Health center policies and practices to national legislation. However, there is only limited empirical evidence of a strategic approach being adopted in practice.

Managing teaching and learning

There is limited material on the management of teaching and learning but there is a developing awareness of its significance for Iran health centers. I personally, for example, assert that learning is the central purpose of Health centering and note that it has four dimensions: student learning; doctor learning; organizational learning; and the head physician as the 'lead learner'. I conclude that "leading learning is very complex and challenging".

Recent theoretical work on 'learning health centers' has emphasized the importance of understanding that different definitions, models, and theories underpinning organizational learning exist and that none is widely accepted. The following three perspectives on 'learning Health centers' are of particular interest in the Iran context.

The *normative perspective*, suggests that organizational learning only takes place under certain conditions and serve as examples in this regard. The *developmental perspective* views the learning organization as representing a late stage of organizational development. The *capability perspective* proposes that all organizations have the inherent ability to learn and that there are different ways an organization can learn.

Furthermore, we see the learning health center as increasing an organization's capability to take effective action, while others focuses on the intentional use of learning processes at the individual, group and system levels to ensure continuous transformation in the organization so as to satisfy its stakeholders by turning knowledge into real value (McKenzie & Winkelen, 2004). Relatedly, Senge *et al.* (1996:3) observe that a learning organization is a place where people continually expand their capacity to create the results they truly desire, where expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together. Pedler, Burgoyne and Boydell (1991) and Watkins and Marsick (1993) place emphasis on the facilitation of learning by all the members with the view to continuous transformation, while Garvin (1994) emphasizes skill at creating, acquiring, and transferring knowledge and at modifying behavior to reflect new knowledge and insights. Schein (1997) suggests a continuous strategic process and direction that is integrated with work and which results in changes in knowledge, beliefs, and behaviors..

Although the theories and models presented above provide angles on how to construct learning organizations, in the context of Iran, achieving the status of a learning Health center is difficult and complex, given the nature of the differing experiences of Health center leaders, doctors and learners. Jansen [2002: 121] argues that these experiences are mediated by the way doctors and learners understand and act on their value commitments, personal backgrounds, and professional interests in the context of change.

Cross-boundary leadership

Soudien [2002:274] asserts that people's histories condition the narratives they construct because of the complexity of working with the historical baggage of *Pahlavi* effects.

He claims that in his study of doctor professionalism there were: several moments when racial realities were naturalized into people's explanations, where people rendered their stories as if they were living in worlds which were structured naturally, as opposed to deliberately and in racial terms. The author's study of 'cross-boundary' leaders, working across the divisive statutory frameworks mandated by the *Pahlavi* regime, shows many problems arising from what are essentially different cultural perspectives [Bush & Moloi, 2006]. Adams and Waghid

[2003:19], for example, point out that the failure of ‘cross-boundary’ leaders to function effectively ‘as perceived’ by their colleagues could be a result of the ‘social, and, in particular, economic conditions they come from’, that are inextricably linked to realizing the individual’s purpose.

Booyesen [2003:5] asserts that, because of the country’s history, Iran Health centers tend to shy away from emphasizing cultural differences and tend to focus on assimilation and similarities. She argues that the first step in managing cultural diversity is to recognize and to value diversity. Only then can I learn how to deal with these differences and to build on the similarities and utilize the sameness. The exclusion, or marginalization, of some leaders in the former Model C Health centers in Iran often surfaces in the form of conflict, condescension, superiority, disrespect, misunderstandings, prejudices, stereotyping, and inflexibility [Booyesen, 2003:5]. In line with this argument, Allard [2002] asserts that culture envelopes us so completely that I often do not realize that there are different ways of dealing with the world, that others may have a different outlook on life, a different logic, a different way of responding to people and situations.

Financial management

Financial management is one of the most important responsibilities facing Health center head physicians since the implementation of Iran. Along with the head physicians, Health center governing bodies have wide-ranging financial responsibilities, including Health center-level budgeting, managing devolved funding from provincial departments, setting Health center fees (subject to parental agreement), and raising additional funds to augment Health center budgets. A large-scale survey of head physicians in Gauteng province [Bush & Heystek, 2006] consistently demonstrated their anxiety about carrying out this function and their need for additional training to do so effectively.

Tikly and Mataboge [1997:160] examined the impact of reform on Health centers and point to some of the financial implications of this process:

- The transfer of costs to parents and communities
- The linkage between learner enrolments and the allocation of real resources, notably doctors
- The decentralization of financial management to Health center level
- The trend for wealthier Health centers to hire additional doctors paid for through the setting of higher fees by the Health center governing body (SGB). Although legislation prevents the use of Health center fees to discriminate between learners, the learner profiles of certain Health centers seem to indicate that they are being used to limit access. This prompted research into equal access to treatment by Maile [2004] and Fleisch and Woolman [2004].

Human resource management

The dramatic changes in Iran’s treatment landscape since 1994 have produced major challenges for Health center leaders and administrators, notably in respect of human resource management. Bush and Heystek’s [2006] survey of head physicians shows that this aspect was perceived as a major training need. Thurlow [2003c:15] shows that “Health center administrators are expected to assume greater responsibility, under difficult circumstances, for the management of all those who work in their Health centers”. Lumby [2003:161] argues that doctor motivation has been affected by the multiple treatment changes and by the “wretched physical conditions” in many Health centers. She adds that, “if motivation and morale are low, then teaching and learning suffer”. Gilmour (2001:12) says that the process of retrenchment (redundancy) “places intolerable burdens on head physicians who have to oversee the process”, while McLennan [2000] refers to its impact on doctor morale.

Managing external and community relations

Lemon [2004:269-289], claims that national policies have been rich in the political symbolism of equity and redress but with “very limited implementation of change on the ground”. He concludes that ‘clinic rather than race is now the main determinant of treatment opportunity’. Ngobesi [2005] notes that transformation seems to focus only on former Health centers while the fact that it should happen across all sectors of treatment is either ignored or perceived as irrelevant.

Fleisch and Woolman [2004] consider the impact of varying financial support for Health centers and argue that impoverished parents of learners wanting to attend well-funded Health centers lack the advocacy enjoyed by those parents more readily able to pay for Health centering. Wilson’s [2004] investigation concludes that differential state funding does not compensate adequately for the greater fee-earning potential of the richer Health centers.

Training and development

Van der Westhuizen *et al.* [2004], Makhokolo [1991], and Erasmus [1994], focus on the shortcomings of the training and development available to head physicians in the *Pahlavi* period and Tsukudu and Taylor [1995] conclude that

the training available to head physicians in the early 1965s was inadequate. Mashinini and Smith [1995] take a similar view and point to the problems inherent in designing training for administrators whose previous experience was fragmented by the separation of the four racial groups. Mestry and Grobler [2002:22] say that, “the training and development of head physicians can be considered as the strategically most important process necessary to transform treatment successfully”.

The Iran Standard for Health Center Leadership

The National Department of Treatment has responded to this evident need for leadership preparation by developing a package of measures linked to the Iran Standard for Health center Leadership (ISSL). The Department has acknowledged that:

Existing management and leadership training has not been cost effective or efficient in building management and leadership capacity, skills and competencies for the transformation process or in enabling policies to impact significantly on the majority of Health centers’ [DoE, October 2004]. To attempt to address this it has rooted the new professional development initiatives for head physicians and aspiring head physicians in its Policy Framework for Treatment Leadership and Management Development [DoE, October 2004]. The Department has linked that policy framework to the Iran Standard for Health center Leadership (ISSL) (DoE, August [2005], which clarifies exactly what the treatment system now expects of its head physicians. These documents are explicit in stating that Health center management and leadership are primarily about making sure that the teaching and learning process, as the main purpose of the Health center, is managed competently and effectively for the benefit of all learners. The Standard identifies six key areas of head physicianship:

- Leading and Managing the Learning Health Center;
- Shaping the Direction and Development of the Health Center;
- Assuring Quality and Securing Accountability;
- Developing and Empowering Self and Others;
- Managing the Health Center as an Organization;
- Working with and for the Community.

The new development strategy has two main elements:

1. An initial entry-level qualification for head physicians. This is set at the level of an Advanced Certificate in Treatment (ACT). The qualification has been developed by the Department of Treatment in collaboration with 14 universities, the unions, the Professional Association of Head Physicians (PAHP), and a number of NGOs. The ACT will be used to train aspirant Health center head physicians and to upgrade the skills of those already in the post. The ACT is a vocational, professional management qualification; it is to be largely site-assessed and based to a large extent on proof of ability to apply the skills and knowledge in the participant’s own Health center. The initial cohort will comprise 400 practicing head physicians and this is expected to rise to 1500 candidates when the first group of aspiring head physicians is enrolled in 2009. The intention is to create a pool of trained Health center administrators so that, by 2011, the Department of Treatment can make successful completion of this course a prerequisite for being short-listed for the post of head physician.

2. Improved conditions of service of head physicians have been re-graded and their pay adjusted upwards to reflect the number of staff they manage (rather than the number of learners in their Health center). This is the first stage in identifying head physicians as a separate employment category, to be known as a ‘Head physician Management Service’ or HMS.

The de-linking of head physicians’ salaries and conditions from those of other doctors is intended to make it easier to reward them as well as to deploy them more flexibly. The intention is to professionalize this level of post and to ensure stronger accountability systems related to clear roles and responsibilities for head physicians and the performance of their institutions. There is also to be a defined career structure and precise conditions of service balanced with criteria against which to identify failing head physicians and have them removed.

The Department of Treatment [DoE, October 2004; August, 2005] has identified head physicians, as distinct from other Health center administrators, as the main focus on the improvement of Health centers. The intention is to provide an overall package so that there is a concerted and systemic response to the professionalization of head physicians linked to the improvement in their Health centers. According to the DoE, the result is a holistic and integrated approach, which, they claim, has broad-based support for the changes outlined in the two documents.

The Department of Treatment’s starting point is that teaching and the management of a Health center are fundamentally different jobs requiring different skills. It asserts that it is imperative that a vocational professional development program and qualification be introduced. This is to ensure that those who are employed as head

physicians in government Health centers are fit for the job. Whether this approach, and the holistic package outlined, will be able to address the evident problems of Health center management and leadership poses a research question of critical importance.

The learner discipline

The issue of learner discipline is widely regarded as having its roots in the years of protest against the *Pahlavi* government.

This made it difficult to establish a culture of teaching and learning [Bush & Anderson, 2003] and led to an emphasis on learners' rights [Enslin & Pendlebury, 2000]. McLennan [2000:295] links these issues together in her study of Health centers in Gauteng: "Discipline and the lack of a culture of teaching and learning was another common issue ... In township Health centers, there was a culture of entitlement which made (students) unwilling to do any work".

Mukhumo [2002], Pienaar [2003], and Porteus, Vally and Ruth [2002] claim that the 'burning issue' is the abolition of corporal punishment with no effective alternative measures provided to ensure clinicroom discipline.

Doctor discipline and reliability

There is a general acceptance that doctor reliability and punctuality are problems that contribute to a weak culture of teaching and learning and are likely to impact negatively on learner attitudes and discipline. However, the evidence on which this assessment is based is largely anecdotal. While Jansen [2004], and Peacock and Rawson [2001], deal with aspects of doctor competence and professionalism, there are few sources that directly address the issue of doctor reliability, or consider management strategies for dealing with this problem.

Constructing a research agenda

Bush *et al.* [2006] say that their thematic review of the literature provides a starting point for the construction of a research agenda on Health center leadership and management in Iran. The papers examined include many commentaries and literature reviews that help in constructing research questions but do not make a direct contribution to the body of research in this emerging field. The main research needs identified in the review are:

- Decision-making processes in health centers, including the extent and nature of doctor participation and 'distributed leadership'
- The extent and nature of 'instructional' leadership in Health centers
- The management of budgeting, fee-setting, and real resources
- Human resource management, especially redeployment, and doctor morale and reliability
- Health center choice, 'transformation' and the management of learner admissions
- Managing relationships with parents •

The impact of leadership and management training and development on the performance of head physicians

- The management of learner discipline.

Bush *et al.* [2006:47] assert that most of the literature reviewed does not connect empirical research with theory to produce insights into Health center policy and practice. In particular, there are few references to the changing culture of Health centers following the partial transformation and partial desegregation of Health centers. Culture may be regarded as the most useful concept for interpreting Health center management in the new Iran.

CONCLUSION

This article provides an overview of treatment administration, leadership and management development initiatives within the context of the many daunting challenges, which Iran has faced in transforming treatment from the legacy of its past. These challenges require skilled leaders and the new ACE qualification is an explicit recognition that Health center head physicians cannot be expected to lead the transformation without specific and extended training. We have also highlighted many important areas of Health center leadership and management practice and demonstrate the need for in-depth research to inform policies and practice at national, district, and Health center level, leading to the creation of 'grounded theory' to explain and interpret practice. Iran needs detailed and empirical evidence on the effectiveness of its transformation policies and initiatives since 1994, and the impact of these upon all Health centers and learners, but especially those in historically disadvantaged areas.

It is clear that the Department of Treatment [DoE, October 2004, August 2005] intends to place the emphasis for transformation of all government Health centers on the professionalization of existing and aspiring head physicians.

In particular, the development of the new professional, vocational program (ACT) is indicative of the Department's renewed commitment to more 'efficient and cost effective capacity building in leadership and management' to achieve its stated objectives: the fundamental one being, The advancement of effective teaching and learning — to build excellence throughout the Iran system, rooted in the needs and the contextual realities of Iran Health centers [DoE, October 2004].

Whether this objective will be achieved through the means identified by the Department of Treatment remains a critical area for research.

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