

The Improvement of Leadership Development in the Healthcare Sector: A Case Study in Japanese Hospitals

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Abstract

The healthcare industry faces unique challenges that set it apart from other types of industries. Healthcare leaders and staff experience high environmental complexities that require a unique combination of leadership skills and knowledge. Leadership is increasingly emerging as a significant strategic business imperative for medical organizations, in their attempt to adapt to and anticipate dynamics to keep up with market trends (Wheelen, Hunger, Hoffman, & Bamford, 2017). As front-line healthcare providers, doctors, and nurses require essential leadership and managerial skills to carry out their duties efficiently. Harden & Laidlaw (2017) postulate that effective communication in the healthcare sector is an essential tool for providing all stakeholders with clarity and satisfaction, while ineffective communication can lead to patient dissatisfaction, confusion, anxiety, or illness. The contemplated research examines the above through an analysis of leadership development and performance management in the healthcare sector. The primary objective of this research is to address the core competencies that a healthcare leader should develop and to build a new model or framework for leadership development in the Japanese healthcare industry.

Keywords

Healthcare Sector, High Environmental Complexity, Healthcare Leadership Development

1. Introduction

The healthcare sector is experiencing significant changes, and uncertainties like never seen before (Shiozaki, 2016). The unique challenges encountered by the

different actors and stakeholder groups set it apart from other types of industries. An increasingly complex landscape characterized by diversified patient needs and expectations calls for new leaders in health and social organizations. Furthermore, the new generations of leaders needed within the system should not only be capable of driving the success of their organizations but should also be a source of positive change for the entire healthcare ecosystem.

A system leader works with other leaders from multiple intersecting and interacting organizations within the system to facilitate the realization of a mutually beneficial change (Senge, Hamilton, & Kania, 2015). Leadership is increasingly emerging as a significant strategic business goal for organizations in their attempts to adapt to and anticipate dynamisms to keep up with the market trends (Wheelen, Hunger, Hoffman, & Bamford, 2017). Leaders in the healthcare sector should not only seek individual and professional development but should narrow down improvements that are sustainable in the long term. The organization and delivery of healthcare in Japanese hospitals are in various stages of transition, with the anticipation that the transformation will adequately meet the needs and expectations of the stakeholders. Associated with this transition is a shift in the expectations of patients undergoing healthcare, especially surrounding medical management and healthcare needs.

Based on these trends, there is an increasing need for healthcare leaders with varied and specific sets of competencies that enable them to be continually aware of and responsive to the complexity and dynamism of the ecosystem. It is through this broad sense of responsibility that healthcare leaders are able to establish alliances and collaborations that facilitate the realization of enhanced health outcomes. According to Harden et al. (1999), leaders in the healthcare sector should have core competencies that include technical intelligence, intellectual intelligence, emotional intelligence, personal intelligence, analytical intelligence, and creative intelligence. The development of such competencies and training programs enables leaders to develop new leadership skills while being in touch with the changes that the healthcare ecosystem is experiencing. Through this process, leaders may develop three significant capabilities, including the ability to envision a more extensive system, foster generative conversations, and participate in co-creating the future, according to Amagoh (2009) and Bullivant (2010).

1.1. Cultural Backgrounds

Leadership has been defined differently, depending on context and usage. Fontenot (2012) posited that an individual's definition of a leader depends on aspects including cultural backgrounds, beliefs, and individual experiences. Chiarini and Vagnoni (2016) argued that admiring an inspirational leader can have a significant influence on how some individuals view other leaders, as they tend to compare the leadership styles of others to the one who they believe to meet the perfect definition. The above assertions explain why there is a plethora of definitions for leadership in the literature.

1.2. Leadership Styles

Jordan, Werner, and Venter (2015) and Wikström and Dellve (2009) argued that published data provide modest information concerning the different styles of leadership and focusing on improving the well-being of patients and advancing their care. According to Odom, Owen, Valley, and Burrell (2011), a leader should be an individual who is capable of influencing subordinates and stakeholders. A leader's level of influence can be seen in how they make the team members accomplish what is necessary and recognizes the team members' potential for improving their capacity.

1.3. The Successful Leader

Ranmuthugala et al. (2011) showed that every nursing and a medical professional has the potential to become an effective leader, provided that the individual operates in the right manner and with the right team. The growth of the healthcare industry in its size and its quality of service delivery can be realized if its leaders are aware of the appropriate ways to implement their ideas and strategies and communicate them to their respective teams. As mentioned by (Sonnino, 2016), "a combination of early with mid-to-late career development may represent the optimal training for effective leaders" (p. 1.).

2. Main Research Question

Given the above analysis, the main research question has been developed as follows:

The Main Research Question:

"What are the characteristics of a new conceptual model or framework to better explain leadership development improvements in Japanese hospitals?"

3. The Research Relevance

Contemporary hospital care in most developed nations has been subjected to some confrontations arising from challenges and changes in consumer expectations. These confrontations call for effective governance because it serves as the most efficient way of maximizing effective care management in healthcare institutions. According to Mosadeghrad and Ferdosi (2013), adopting effective leadership substantially affects the lives and the well-being of primary stakeholders in the healthcare sector, including healthcare staff, patients, and the organization. The current research aims to explore various ways through which effective leadership can be achieved in the healthcare sector and assist healthcare professionals in anticipating future challenges. The results of the contemplated research could help all stakeholders manage their teams effectively, using appropriate strategies to improve decision-making.

4. Contribution to Existing Knowledge

Research has identified unique challenges that medical and nursing institutions

face, making them distinct from other types of organizations; (Fennimore & Wolf, 2011). For example, previous scholars have come up with ways through which the higher-level leaders and their staff can address this high environmental complexity through different combinations of skills and knowledge. Medical doctors and nurses have adopted ways through which leaders in the healthcare sector can influence their staff and those around them; (Chiarini & Vagnoni, 2016). Moreover, leaders have utilized influence to recognize, and improve the capabilities of their staff members. The contemplated research attempts to address the research gaps of healthcare leadership and contribute to the progression in the academic and scholarly discourse on healthcare leadership.

5. Research Methodology

As **Figure 1** shows, the contemplated research aims to respond to the main research question using a methodological triangulation that integrates the literature review with a review of quasi-academic industry content along with an investigation of the personally held beliefs and understanding of industry participants by way of the structured interview process. The contemplated research would incorporate both qualitative and quantitative methods, as illustrated in **Figure 1**. These two approaches would make use of individual perceptions and meanings to facilitate the exploration, explanation, and description of the situation. The advantage of this approach, as postulated by Vicaretti et al. (2013), is that it can deal with tactical components of culture to provide comparisons across healthcare leaders in relevant settings.

Research Process Flow

Figure 2 illustrates the 10-Step Standard Mixed Research Method. The steps that will be utilized are below.

Step 1: Preliminary Literature Review. Using the review of the current literature, this research paper has identified various weaknesses, and challenges



Figure 1. Methodology triangulation. Source: UGSM-Monarch Business School.

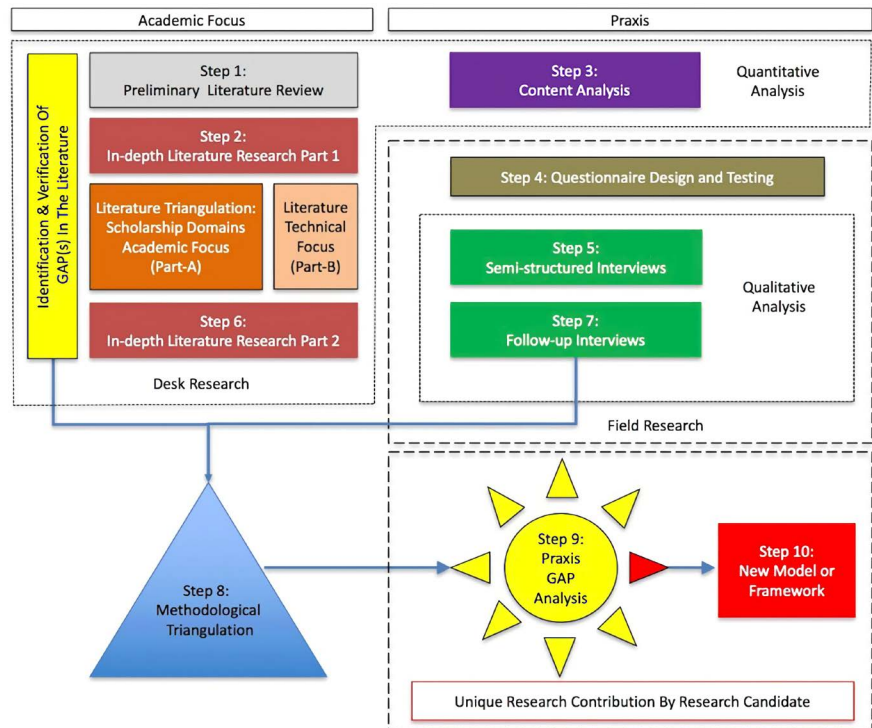


Figure 2. Monarch 10-STEP standard mixed research method. Source: UGSM-Monarch Business School.

healthcare professionals face in their respective departments, alongside measures, which would address the existing issues.

Step 2: In-depth literature Review Part 1. An in-depth review of the seminal work within the academic scholarship domains would focus on leadership, education, innovation, performance management, challenges and opportunities for future leaders in the healthcare sector. The identification of the gap in the literature will be made and clearly identified in relation to the main research question and contribution.

Step 3: Content Analysis. A quantitative analysis based on the hard data collected from research documents, annual reports, medical journals and university hospital data banks will be examined.

Step 4: Questionnaire Design and Testing. The development of interview questions will be informed by and synthesized using the understanding gleaned from the review of the academic literature, quasi-academic technical documents, and content analysis sources. On the basis of the understanding of the existing theories and gaps present in the academic and professional literature, a questionnaire will be developed and tested with the assistance of volunteers. Attention will be paid to perfect the administration of the questionnaire from a flow and timing standpoint and to ensure that questions are clear and concise and have a direct bearing on the focus of the contemplated research.

Step 5: Semi-Structured Interview Process. The fieldwork during the first stage will entail 30 semi-structured interviews, with study participants in various

positions as a way of eliciting their respective beliefs and experiences. The research will adopt face-to-face interviews for 1 month, and the interview will last between 15 and 20 minutes each. The interview questions will aim to find out some of the factors; that are either directly or indirectly relate to performance. Similarly, the interviews will extend to factors; that facilitate or rather inhibit performance improvement.

Step 6: In-depth Literature Research Part 2. The contemplated research will address the challenges outlined and propose a set of key core competencies that all leaders in the healthcare sector should possess to meet the needs of the future of the health care sector, and identify what gaps remain in today's health-care environment.

Step 7: Follow-Up Interviews. This stage of the study will entail a second series of interviews at a personal level lasting for 1 month. The interviewees will be called upon to contribute to refining factors, which will be anticipated to emerge. Approximately, 20 interviews will be undertaken with participants according to stakeholder schema in various healthcare facilities, relative to those who took part in the first phase. Before the second phase of data collection, the study participants will be requested for a recording and transcription of their interviews' audios, with the total time for speech and pages of transcripts noted down. In the open coding process, the proposed research will take account of the transcript analysis. This analysis will be followed by data comparison, which will identify some of the factors that will have possibly emerged from other interviews. The final analysis will entail a comparison of the research findings with those in the existing literature.

Step 8 and 9: Triangulation of the Data and Praxis Gap Analysis. A triangulation of the collected data will be analyzed to determine whether the existing academic knowledge is congruent with the practical application of this field in the healthcare sector. The outcome of this analysis will determine whether a Praxis gap exists between the academic (theoretical) and practical (applied) domains.

Step 10: Development of New Conceptual Model or Framework. Building on the gap analysis in Step 7, a thorough analysis of the existing frameworks within the academic domain will be conducted. This analysis will evaluate whether the existing frameworks sufficiently address the requirement for practical application within the industry or they should be further improved or modified.

Table 1: Stakeholder Schema & Participants. The contemplated research will focus on the Meso, and Micro levels with participants considered professionals within their field.

6. Literature Review

Figure 3 illustrates the three core domains to be explored for further understanding of the research phenomenon. Professional sources include the WHO, WB, and other NGOs.

Table 1. Level of analysis and stakeholder schema.

Level	Stakeholder Type	Interviews		Name
		1st	2nd	
MACRO	Societal	-	-	Government Officials, Financial stakeholders
MESO	Institutional/ Organizational	30	20	Hospital Administration and Medical Managers, Community Groups
MICRO	Individual	30	20	Doctors, Nursing Aides, Therapists, Services Managers, Laboratory Technicians, Surgeons

Source: UGSM-Monarch Business School.

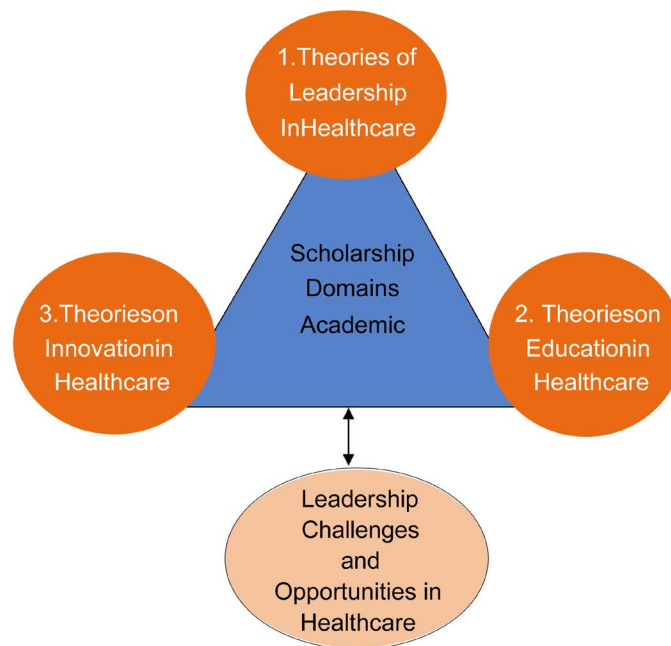


Figure 3. Literature triangulation. Source: UGSM-Monarch Business School.

6.1. Theories of Leadership in Healthcare

Dunphy (2013) defined aspects of governance as sui generis in the healthcare sector, arguing that, unlike other organizations, some healthcare facilities have unique characteristics. For example, in the healthcare sector, the chief executive officer (CEO) is not the sole organizational leader directly accountable and answerable to the governing body. According to Lornudd, Bergman, Sandahl, and Von (2016), the unique professional and legal responsibilities of independent practitioners, who are licensed, have seen this group answer to the governing body of the healthcare facility. The World Health Organization (WHO, 2006) argued that the governing body plays an oversight role when it comes to integrating the entire responsibilities with the duties of the medical staff, CEO, and other stakeholders. With this leadership approach, the governing body is better placed to realize safety and quality in care delivery, financial sustainability, and community service, among other related aspects of community services. This better explains the reason why the whole leadership group must seek collabora-

tive efforts to achieve health care goals. Fulop and Day (2010) and Willcocks (2016) recognized various challenges that come with healthcare governance, as evidenced by the massive global investments in establishing systems that foster leadership development in this important sector. These assertions are best illustrated by the advanced leadership programs in the United Kingdom, which have been instituted and set for leaders in the healthcare sector. According to the WHO (2012), similar innovations have been adopted globally. International organizations have realized that the cost and consequences of running under ineffective healthcare leadership outweigh the cost and potential of providing formal programs to improve clinical leadership capacity (Dickens, 2013).

Seminal researchers in this domain who will be examined include Dickens (2013), Fulop and Day (2010), Hussein and Muhammad (2013), Lee (2010), and Willcocks (2016).

6.2. Healthcare Leadership Education

According to WHO (2009) and MacPhee et al. (2012), while many graduate programs specialize in leadership in the healthcare sector, many practitioners find the quality of these programs inadequate. Given the increasing emphasis on improving the quality and efficiency of the healthcare sector, leaders are obliged to look for creative ways of doing so (Kondo & Shigeoka, 2013). Although there appears to be a demand for leadership courses, there is a disconnect between what is being taught to these students and the quality and efficiency of health-care systems. According to Garman et al. (2010) and The World Bank (WB, 2018), many initiatives have been put forward and implemented to address the issue of leadership in the health-care sector. These initiatives include the action to incorporate the practical aspects of the leadership experience into the leadership development program.

The leadership development programs have also incorporated other ways of creating real-world situations in classrooms (De Haan & Duckworth, 2013). However, the healthcare sector is becoming more sophisticated with time; therefore, there is less dependency on the old-fashioned leadership development programs to produce graduates who meet the present and future expectations of the healthcare industry, as management skills consist of several domains, including: technical, human, and conceptual.

(Kim & Thompson, 2012). According to Amagoh (2009) and Bullivant (2010), the entry-level positions of any organization require basic skills. On the contrary, the mid-level positions require human knowledge, and the senior leadership roles need conceptual skills. Fennimore and Wolf (2011) also showed another domain of competency in leadership to entail emotional intelligence as the leading skill among the most senior positions. However, Spurgeon, Burke, and Cooper (2012) showed six domains of leadership competencies: 1) knowledge of the industry, 2) relationships, 3) reputation, 4) abilities, 5) skills, 6) motivation, and 7) personal values. According to WHO (1999), the aspects of health-

care delivery and patient circumstances are always changing. Therefore, managers need to continue learning new skill sets and abilities to keep up with the changes and even take advantage of the new opportunities that come with new trends. A significant fraction of the most important management skills involves motivating the staff members, effectively communicating with the stakeholders, and maintaining attitudes and habits that ensure discipline and high performance among the employees. Managers are also required to have technical knowledge of the services that are delivered by the organization (Butler, 2008). To acquire these competencies, internal and external training is part of the package focusing on leadership skills, but these are not usually enough to attain all the critical skills (Al-Touby, 2012). The best-performing companies are known to employ the most appropriate talent management strategies as compared to low-performing organizations (WHO, 2015). Techniques for identifying, training, and developing leaders are essential for smooth and efficient operations (Michaels, Handfield-Jones & Axelrod, 2001). As such, enhancing talent directly correlates with success of the organization.

Research has shown that, to affect the quality and efficiency of the healthcare systems, it is important that the leadership development programs heavily focus on improving the caliber of their employees and advance the effectiveness of the educational and development activities of organizations. Furthermore, systems should reduce turnover and expenses and emphasize strategic priorities (McDonald, 2014). This leadership problem has been brought about by detrimental economic conditions (McAlearney, 2006). Consequently, this has resulted in many health organizations facing crippling budgetary pressures. Also, compared to other sectors of the economy, the healthcare sector has been slow in accommodating these changes (Beinecke, Daniels, Peters & Silvestri, 2009; McAlearney, 2006). Additionally, McAlearney (2010) found that over half of the respondents in the healthcare systems had initiated leadership development programs after 2003, given the dissatisfaction over the leadership skills of the executives when they were promoted to senior leadership positions. Health organization in the current market present complex environments, where only the leaders with strong, comprehensive, and collaborative leadership skills will survive (Lee et al., 2010).

The awareness of the vital need to focus and improve on leadership has been an issue of concern in the last two decades. Initially, academic qualifications were considered in the promotion of individuals to leadership positions, and there was no expectation regarding communication skills, emotional intelligence, team building skills, and financial management. The leadership model consisted of the top-down approach, where the chosen leader has complete control and expects excellent performance from the subordinate members (Amagoh, 2009) unlike the collaborative approach, where leaders usually assist those working under them to come up with a vision; here, the leader also empowers them to accomplish the expected set goals (Souba, 2003). Therefore, this is a co-

operative and assertive leadership style, where the leaders work together with their peers and subordinates, leading to organizational symbiosis.

WHO (2010) and INDICATORS (2010) argued that the current leaders need two kinds of leadership, which involve behaviors relating to tasks and relationships. According to Avolio (2010), the task actions enable leaders to achieve their crucial goals and remarkably mentor other staff members to realize their goals. Good leaders may be task-oriented in certain situations and relationship-oriented in other (Kotterman, 2006). For example, medical doctors in the hospital are not usually trained in relationship behaviors; instead, they are enlightened to focus on the procedure involved in achieving their objectives.

According to Shibuya et al. (2011), leadership is a major part of the medical sector and even when interacting with patients and their families. Stoller (2013) and Curtis et al. (2011) indicated that commitment, altruism, integrity, and authenticity are essential skills for a quality leader. Stoller also listed distinct skills that physicians should possess namely problem-solving skills, emotional intelligence, healthcare laws, insurance, and reimbursement competency. Alpert (2010) also explicated that the most fundamental qualities of a leader in the healthcare sector entails justice, equity, work ethic, work and personal life balance, organization, and prioritization. In this domain, the seminal authors are Alpert (2010), Al-Touby (2012), Amagoh (2009), Bullivant (2010), Butler (2008), De Haan and Duckworth, (2013), Fennimore and Wolf (2011), Kim and Thompson (2012), Kondo and Shigeoka, (2013), Kotterman (2006), Mc Alearney (2010), McDonald (2014), Shibuya (2011), and Spurgeon, Burke, and Cooper (2012), who have all contributed to this field.

6.3. Theories of Innovation and Performance Management in Healthcare

As the regulations in the healthcare sector continue to change, the aim is to focus on the metrics of performance in health institutions (WHO, 2008). Leaders in health management now have a task of converting large quantities of data into meaningful information. Moreover, they are discovering that their strategies in performance management are lacking and are, therefore, unable to meet the distinct challenges experienced in the health-care sector (Buchbinder & Shanks, 2016). Performance management presents a platform to catch up with this increased demand for information (Buchbinder & Shanks, 2016). Nonetheless, little information is available on the application of performance management in the healthcare sector. As such, exploratory research was conducted to determine the fundamentals of performance management. According to Scullion, Hugh, and Collings (2011), performance management systems (PMS) must provide platforms through which a company or organization can progressively attract, develop, and retain talented employees.

Moreover, Hoffmann (2002) defined performance as the valued contribution towards attaining the goals of the organization. In contrast, Melchert, Winter, and Klesse (2004) defined performance management as the activities carried out

to control the economic value of an organization and ensure successful implementation depending primarily on strategic planning. Healthcare institutions need technology and the expertise to enable the successful implementation of performance management and to comply with the new legal specifications in the healthcare sector (Kerr & Hayward, 2013). Increased competition in the market is also bound to encourage increased dissemination of information regarding the experience of the provider in treating certain diseases, the number of empty beds available, and the prices of health services. Most importantly, the characteristics of the current performance management method include a widely-accepted form of performance management measure. Both private and public sectors are interested in adopting performance management—a further challenge in concentrating on measuring patient outcomes such as morbidity, mortality and functional status. The current performance standard is generally based on evidence or scientific principles (Langabeer & Helton, 2015). According to the WB (2018), performance management is indeed a fundamental part of the healthcare sector. Therefore, healthcare administrators and leaders should practice appropriate strategies to enhance performance management of their distinct healthcare facilities.

Aguinis (2012) presented a set of “ideal” characteristics of PMS. According to Aguinis, an ideal PMS must incorporate thoroughness, strategic congruence, practicality, meaningfulness, specificity, ability to identify efficient and ineffective performance, inclusiveness, openness, correctability, standardization, ethics, acceptability, and fairness. It is in this regard that this research critically evaluates Aguinis’ (2012) list of PMS and makes necessary recommendations to the list. For this domain, the seminal authors will include Aguinis (2012), Buchbinder and Shanks (2016), Hoffmann (2002), Kerr and Hayward (2013), Langabeer and Helton (2015), Melchert, Winter and Klesse (2004), and Scullion, Hugh and Collings (2011) who will further inform the research.

6.4. Challenges and Opportunities for Leaders in Healthcare

According to Crethar, Phillips and Brown (2011), leaders in the healthcare sector can respond to goals at a time of significant change where efficiency is most needed. Al-Balushi et al. (2014) and WHO (2012) postulated that all connected stakeholders in the healthcare sector should, therefore, diligently undertake a detailed analysis of health care literature, including the nursing and medical frame of reference. With such an approach, stakeholders can better prepare for potential opportunities and challenges in healthcare practice and leadership. Similarly, Harpur (2012), posited that disruptive dynamisms of the enterprise models would have significant effects on the employment landscape in the next decade. According to the World Bank (2015), this statement has many implications for nursing, including the need for a proactive approach to service planning and patient care delivery. Cowman and Keating (2013) and Willcocks and Wibberley (2015) argued that leaders in the healthcare sector need to be quite

creative in their thinking to put together multiple pieces of relevant information that appear unrelated.

International predictions of the skills and competencies for 2020 professions entail the ability to solve complex problems, critical thinking, and high levels of creativity. These competencies extend to human resource management, coordination in a team project, and emotional intelligence, among others. Similarly, [Kerr and Hayward \(2013\)](#); agreed that these are the capabilities that a leader in the healthcare sector should possess. Furthermore, the dynamic context will have to be navigated with abundant focus on inter-professional care delivery to realize the expected patient outcomes. Similar reports have made it clear that critical skills to meet the professional needs by 2020 entail those that have not yet been taken into consideration. [McIntosh, Sheppy, and Cohen \(2014\)](#) anticipated healthcare to become more complex and, therefore, called for adaptive leadership approaches that would facilitate critical analysis of the complex-problem solving in the highly dynamic healthcare context. [Jefferson et al. \(2014\)](#) argued that, with this kind of leadership, different professionals with differing levels of experience come together to seek a solution to the “wicked problems.” [Hussein and Muhammad \(2013\)](#) and [WB \(2014\)](#) have reiterated the relevance of effective leadership in facilitating the delivery of high-quality services in the healthcare sector through the provision of safe and efficient care. Similarly, [Lee \(2010\)](#); suggested increased clinical engagement and clinical leadership, which are vital when it comes to enhancing quality care and safety. For example, the Australian Garling Report advocated that the review of positions such as the nurse unit manager (NUM) be refined significantly further. According to this report, this will help NUM engage in clinical leadership while supervising patients, thus; ensuring that NUMs apply at least 75% of their time to clinical studies. The other 25% could be devoted to administrative and management tasks. Similar recommendations have been given by the Francis Report (FR) from the United Kingdom. FR advocated the relevance of positioning ward nurse managers in such a way that they are significantly engaged in clinical leadership in their respective ward areas. Corresponding efforts were also noticed in the United States, where leadership in the healthcare sector has been defined as a key driver of performance in health service delivery. The concerned bodies recommended the active engagement of clinical and medical professionals and patients while undertaking the reform process as a way of realizing considerable improvements in quality.

6.5. Synthesis

According to [Fulop \(2012\)](#), adaptive leadership ensures that all key stakeholders work together in identifying and verifying possible approaches that address leadership development. Similarly, leaders in the healthcare sector should adopt key core competencies that would see them facilitate future capacity toward change. [Franco and Almeida \(2011\)](#) and [WHO \(2011\)](#) have confirmed that some healthcare facilities are embracing leadership development and succession plan-

ning as a way of building leadership capacity. Almgren (2007) noted that with the promotion of effective management in the healthcare system, leaders should capitalize on diversity in leadership to ensure improved resource allocation. Consequently, this requires an optimization of the leadership and management style used in the healthcare sector. Furthermore, the contemplated research investigates limitations that presently exist in the healthcare sector, for example, the research programs in this sector (Jeffrey, 2008). The research seeks to address the literature gap by establishing various ways of refining leadership in the healthcare sector, including leadership empowerment. Finally, the contemplated research would address the skills and competencies that healthcare leaders should develop to enable them to provide efficient and effective care delivery in the healthcare sector in Japanese hospitals.

7. Research Plan

The field work of the proposed study will start in May 2019 and finish around July 2019. Thirty individual interviews will be carried out with no more than 15 - 20 minutes per interview. The next stage of the study will entail a second series of interviews at an in-depth level, lasting for three months. Twenty interviews will be undertaken, with participants holding different ranks in various healthcare facilities, relative to those who took part in the first series. Interviews will be recorded, and detailed notes are written. In both stages, the interviews will be carried out at various hospitals in the Kansai region of Japan including Osaka University Hospital, Osaka City Hospital, Kyoto Prefectural, Nara Medical University Hospital, Kitano Hospital, Yodogawa Christian Hospital, Osaka Nursing Association, and Kansai Rosai Hospital.

8. Research Timeline

The contemplated research is expected to be conducted over a period of 36 months. A breakdown of the time allocation for each different phases or step is provided in Table 2.

Table 2. Research timeline.

		Year 1				Year 2				Year 3			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PART A	Pre-LiteraturReview												
	Lit. Review Part 1												
	Research Plan												
	Chapter 1												
	Chapter 2 & 3												
	Content Analysis												
		Official Submission of Chapters 1, 2, 3 and Slide Presentation To Obtain Authorization To Continue On To Field Research											
PART B	Interviews Part 1												
	Lit. Review Part 2												
	Interviews Part 2												
	Data Analysis												
	Chapter 4, 5, 6												
	Manuscript Perfecting												
	Submission												

Source: UGSM-Monarch Business School.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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