Dipl.-Kfm. Dipl.-Psych. Georg Brabänder MA

Ambidextrous leadership and evidence-based management

Organisational context conditions for the design of innovative healthcare services

According to Roland Berger's hospital study from 2023, the future of healthcare in Germany will be networked, outpatient and AI-supported (1). Solutions need to be found for the shortage of specialists, complex clinical pictures, increased demands on healthcare services themselves and on the medical and ethical competences of service providers, as well as for continuous cost increases. Solutions are also being sought for the interoperability of outpatient and inpatient service provision systems, for the high documentation costs in hospitals and surgeries and for reducing billing complexity. The interests of patients, payers and service providers are also to be coordinated and the benefits of healthcare services evaluated. Above all, the collection and use of data from different sources of healthcare is a necessary prerequisite for the networked, interdisciplinary and multi-professional provision of innovative and personalised healthcare services. They also form the basis for efficient and effective management of the service itself and for research purposes.

Healthcare organisations caught between ambivalences

>> In addition, the Nursing Studies Strengthening Act will lead to the academisation of the nursing professions from 2025, which will allow appropriately trained nurses to be assigned medical qualifications. This is intended to promote interprofessional teamwork in healthcare organisations and assign more competencies to nursing (2) in order to be able to provide healthcare services more flexibly in terms of place and time and to make the nursing profession more attractive. This will make coordination between medical and nursing staff and the management of service-providing teams more challenging (3), as within the existing power imbalance, an expansion of the fields of activity will only meet with the approval of the medical profession where it leads to relief and there is no fear of loss of control.

Medical technology, pharmacological innovations and digital technologies should provide solutions for the diverse challenges in the healthcare system. These include existing applications such as robotics, augmented and virtual reality (4) and the digital twin (5). According to Gartner (6), artificial intelligence applications are emerging as a partner for continuous risk management and the optimisation of decision-making. The application of generative artificial intelligence in routine activities is also expected to lead to high leaps in productivity (7).

This means that the processes of knowledge generation and knowledge integration into existing and new routines are of central importance for the competitiveness of the organisation. The VUCA factors of volatility, uncertainty, complexity and ambiguity, which have become commonplace in describing today's business environment, are also increasingly becoming a reality for healthcare organisations (8). The sometimes conflicting requirements of different stakeholders lead to considerable organisational tensions in the management of healthcare organisations (9). These tensions are symptoms of change processes, but also have the potential to trigger necessary adjustments. The decisive factor here is how management deals with these tensions and how purposefully it can utilise the potential for activation. Tensions and ambivalences have always existed in organisations, but they are occurring more frequently and with greater amplitude, even in sectors that have been relatively secure up to now.

Ambidexterity as a management task

The sustainable competitiveness of a company - including a healthcare organisation - goes hand in hand with the ability to tap into new knowledge, develop innovations and/or quickly adopt them from research, while at the same time making the best possible use of the existing core business. This ability to combine opposing action strategies is referred to as ambidexterity and , in a medical context, originally refers to the ability to use both hands skilfully (11). Ambidexterity represents the dynamic ability of an organisation to adapt flexibly to continuous and disruptive changes, an ability of managers in particular, which is expressed in their own willingness to learn and the ability to constantly reconfigure the skills of their employees (12). The right combination of intensive utilisation of the existing (exploitation) and exploration of the new (exploration) is a complex capability that offers a competitive advantage that goes beyond that which can be achieved by any single activity.

At the strategic level, ambidexterity corresponds to a so-called hybrid form of strategy in which the two usually separate strategic alternatives - differentiation strategy on the one hand and cost leadership on the other - are combined. Structurally, the tension between a centralised, functionally closed exploit orientation and a more decentralised, open explore orientation can be managed by separate units, sequentially by separating the modes over time or contextually by implementing both modes simultaneously.

As the financing of healthcare services in the German healthcare system generally does not allow any room for manoeuvre for additional units, the focus here is on contextual ambidexterity. However, the activity patterns of the two design alternatives of exploitation and exploration differ fundamentally. While exploitation concentrates on the utilisation of existing processes and requires cost optimisation, process and system control (tight coupling), exploration focuses primarily on flexibility, self-organisation and growth (loose coupling) (13).

Whichever structural model is chosen, ambidexterity is primarily a management task (14). Securing and developing this ambidex-

trous leadership quality is therefore one of the greatest levers for future corporate success (15). 'We define ambidextrous leadership as the ability to foster both explorative and exploitative behaviours in followers by increasing or reducing variance in their behaviour and flexibly switching between those behaviours.' (16)

Business research and studies almost universally point to a positive correlation between ambidexterity and business performance (17), so it seems worthwhile examining the transfer to healthcare organisations.

Ambidextrous leadership in healthcare organisations can be located among the leadership models as a combination of transformational and transactional leadership, given the special nature of healthcare and the conditions under which it is provided. Transformational leadership is particularly important in the healthcare sector because its consistent employee-orientation is an important, cost-relevant prerequisite for providing healthcare services at a high medical level and with ethical clarity (18). At the same time, hierarchy-oriented transactional leadership behaviour is also necessary to ensure medical responsibility for the treatment outcome and compliance with legal regulations and guidelines. This distinction between a transactional and transformational leadership style and their integration is the core of ambidextrous leadership (19), which is mediated in social interaction and communication processes depending on the context. The challenge for managers is then to balance conflicting interests and conflicts over available resources in the teams and departments providing the service by switching flexibly between an opening leadership behaviour and a closing leadership behaviour (20).

Ambidextrous leadership - reference point treatment pathway

Ideally, healthcare services take the form of treatment pathways. They consist of individual analogue and/or digital services (smart services) (21) and are provided by teams and individuals within healthcare organisations and with their networks, i.e. in a complex organisational context in compliance with legal rules, ethical principles and values. Among the central categories of the organisational context (structures, processes and organisational culture), which as intermediary target variables co-determine the outcome of the healthcare service (22), leadership is the most important element.

Treatment pathways can be understood as the complex service bundles that enable personalised healthcare services through the integration of patients, their generated and shared data. Digital solutions within treatment pathways enable the recording of patient-reported outcomes and experience thanks to sensor technology, networking and quantitative evaluation.

In line with the service-dominant logic, the potential of the individual sub-services can be utilised in such a way that they generate a patient-relevant, measurable additional benefit - a higher 'value-in-use' (23) - and efficient use of resources with patients as co-creators. This service-dominant logic approach can be used in the evaluation of treatment pathways as a meta-structure in which analogue and digital, qualitative and quantitative and - depending on the strategic orientation of the healthcare organisation - clinical-epidemiological and health economic aspects can be methodically integrated. The two processes of knowledge generation and knowledge integration, which primarily take place in the service-providing teams, are prerequisites for the exploitation of existing and the exploration of innovative healthcare services. With their assessment, evaluation and constructive criticism, these are the 'crystallisation point' (24) for innovation and continuous improvement. This is where common patterns of interpretation develop and the feedback loops for unlearning old routines and learning new ones take place.

These processes require the parallel practice of opposing leadership strategies (25). The design and implementation alternatives of the individual sub-services of a treatment pathway can be summarised in four leadership dimensions, each with two opposing leadership styles, open and closed leadership (26) (see Fig. 1)

1st dimension of delegation of authority: This refers to the distribution of decision-making authority. Increasing the scope of action through delegation enables identification with the task, new experiences and increased knowledge and strengthens self-efficacy, i.e. the inner conviction that difficult or challenging situations can be mastered well. Reducing the scope of action through direct leadership establishes rules that promote coordination and knowledge integration.

2nd dimension of timing: It distinguishes between time-limited, efficiency-orientated with a focus on quick decisions and fast action, and elaborative and deliberate with a focus on quality. This dimension is particularly important for healthcare services, as decisions often have to be made under a high degree of uncertainty and the basis for decisions may not be clear.

3rd dimension of knowledge interpretation: This dimension refers to the way in which existing knowledge is interpreted as certain, provisional or uncertain. Employees are encouraged to rely on their own existing knowledge or to actively seek new knowledge externally. This requires a psychological security in the team with the confidence to be open with ignorance and mistakes.

4th dimension of communication orientation: This dimension refers to whether either more consensus orientation, confirmation of the status quo and harmony or more dissent, differing opinions and different levels of knowledge should be sought.

These four dimensions, on which opposing leadership styles can be practised, are in a complementary relationship in that they describe four paths on which separate contributions can be made to overcoming complexity through knowledge generation and knowledge integration. By combining and balancing opposing styles, the negative developments associated with a one-sided implementation of a leadership style can be compensated for and the positive effects can be cumulated (27). Digitalisation concepts and applications of artificial intelligence can contribute to a higher speed of analysis, decision-making and implementation in all dimensions and thus have a positive effect on the possible combinations of leadership styles. Open management styles work towards know-

Ambidextrous leadership in the design of the treatment pathway

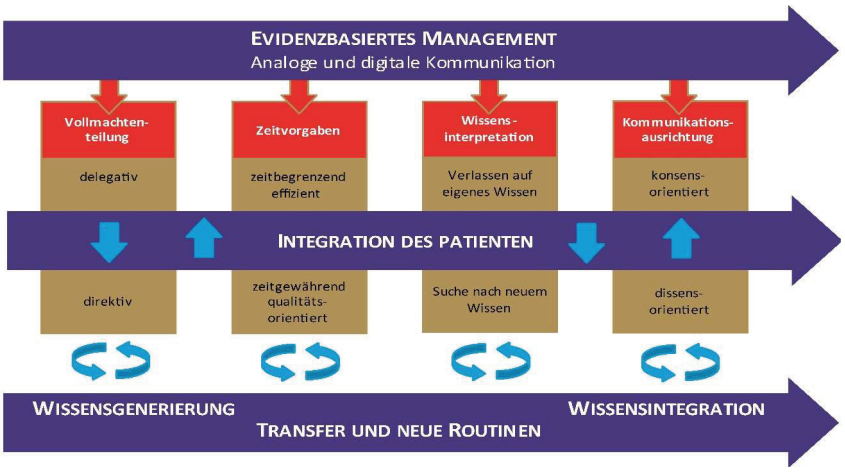


Fig. 1: *Ambidextrous leadership in the design of the treatment pathway, own illustration based on Geber/ Kearney 2011*

ledge generation through their direct and indirect effects, while closed management styles work towards knowledge integration, i.e. transfer and new routines.

However, the development of such contextual ambidexterity is challenging, as conflicts are to be expected due to uncertainties in the fields of 'routine or experiment' and 'control versus freedom' and in the area of resource distribution between doctors and nursing staff. It is advantageous to act in a results-orientated manner and to have shared assessment standards (28).

Evidence-based management: shared decision-making principles

A key feature of the healthcare sector is that healthcare services are provided by professional groups that have undergone a long process of training and human capital refinement with the right to self-administration and professional autonomy and are endowed with the creation of an extensive monopoly for medical services. If such expert organisations are 'industrialised', this can be experienced as a restriction, disrespect or insult (29). There is generally an aversion to hierarchical organisational charts and leadership in healthcare organisations; instead, it is more about supporting the intrinsic motivation of the experts.

A growing body of evidence provides evidence that leadership training in healthcare organisations is still limited in terms of employee leadership and self-management (30). Leadership decisions usually have systematic weaknesses in decision-making and information behaviour that arise in the assessment of risks and probabilities. They are based on three areas of psychological theory (31): 1. theories about the world in relation to the consequences of complex decisions, risk assessment and the perception of responsibility 2. theories about others with ethnocentrism and prejudice 3. theories about oneself with the illusion of superiority, inadequate judgement of one's own performance and overestimation of oneself.

This results in a lack of consideration of the possible consequences, the assessment of risks and the perception of responsibilities, as well as errors of reasoning in the process of problem solving, such as a failure to recognise interactions and control loops (32).

A basis for valid evaluation standards in the organisation can be achieved by transferring the principle of evidence-based medicine (EBM), which has proven itself in medicine, to management processes and decisions. This means:

- 'Validating decision-making and measures on the basis of existing scientific findings or at least on the basis of verified data and making them effective ,
- developing findings on concepts and instruments and discussing them critically in a broad circle and
- to make this knowledge available for management practice, education, training and research.' (33)

All available sources of evidence should be utilised and communicated transparently when making management decisions regarding the above-mentioned management dimensions. Various sources are available to derive evidence for leadership decisions:

- Scientific evidence: scientific studies and published results, e.g. on leadership and organisational theories.
- Organisational evidence: As there cannot be scientifically based findings for all internal organisational problems, the findings that are obtained within the organisation using scientific methods can also be used as fact-based, organisation-specific knowledge as a source .
- Experiential knowledge: Experiential knowledge can be established by observing previous management decisions and their results if it is based on the systematic evaluation of practices and routines (for comparison, 360-degree feedback) (34).
- Stakeholder values and expectations: How leadership decisions are evaluated by stakeholders has a major impact on the organisation. Stakeholders should therefore also be regarded as holders of expert knowledge (35).
- Results from the use of analytics systems can help to shed light on the unknown, enrich decisions with data and thus introduce constructive doubt (36). 'In the 21st century, one of the most important leadership abilities will be to act as an orchestral conductor, to have humans and algorithms working together in symphony.' (37)

Leadership success is the result of evidence-based decisions (38) that are based on a combination of evidence-based knowledge and theoretical knowledge as well as regular adjustment loops.

Potentials and challenges

Knowledge generation is supported when new approaches are tested and options are thoroughly analysed, the capacity to absorb

new knowledge is increased and the spectrum of perspectives is broadened through heterogenisation. Open leadership behaviour includes doing things differently, questioning established approaches and creating space for independent thinking and action. This enables medical and nursing staff to experiment and generate knowledge, particularly through the comprehensive integration of the patient. Conversely, the closing behaviour of managers includes the definition of specific guidelines that promote coordination, quality assurance and corrective measures and thus promotes knowledge integration, which also includes the de-implementation of inappropriate partial services or methods (39).

This 'systematic waste disposal' (40) in the form of a regularly used methodology leads to the release of resources for innovative services. Balancing management activities on the basis of the aforementioned evidence and their analogue and digital communication strengthens the transparency of decisions as well as credibility and trust in management and reduces information asymmetry and resistance to change.

As healthcare services are usually highly standardised and routine for quality and cost reasons, there is a risk of path dependencies, the mechanisms of which can be interrupted by the evidence-based change from open to closed leadership behaviour and vice versa, as well as the associated activities (41). This is primarily achieved with discursive approaches, in which reflection can be used to gain insight into the dependencies and the mechanisms that cause them (42).

The expansion of the fields of activity for nursing may only meet with limited approval from the medical profession. The strategic anchoring of evidence-based management action can contribute to a harmonisation of cultures, especially if evidence-based management is embedded in the quality and risk management strategy.

It is to be expected that ambidextrous leadership with its balancing of opposing leadership styles will lead to tensions and stress among managers, as the clarity and accuracy of cause-and-effect relationships is increasingly being called into question due to the growing complexity of healthcare provision. The key concept here is contingency: 'Know that it can be one way, but it can also be another.' (43) Managers require a high level of analogue and digital communication skills as well as strong self-management skills in the core areas of self-responsibility, self-awareness and self-development (44). Self-control and self-regulation skills are particularly crucial. In addition to the cognitive abilities of the leader, they prove to be a further micro-foundation of dynamic abilities (45) with positive effects on the strategic change of organisations.

Conclusion

The ambidexterity concept offers a helpful perspective and useful elements for describing how healthcare organisations can deal with digital transformation, how they can generate and integrate new knowledge and break out of familiar routines. Contradictions and conflict dynamics in the distribution of resources, ethical issues and perceptions of responsibilities can thus be clarified and lead to greater transparency

With the help of increasing digitalisation and the application of artificial intelligence right down to routine processes, the individual analogue and digital sub-services of a treatment pathway can be presented transparently and management decisions can be aligned accordingly.

The main challenges are the strategic specification of evidence-based management decisions and the self-management skills of the individual manager. The multidimensionality of the approach illustrates the problems of one-sided leadership and the advantages of ambidextrous leadership. This results in justified prospects for better leadership decisions. <<

Literature

1. Auschra, C./Gersch, M. (2022): Theorie der Pfadabhängigkeit. In: Monitor Versorgungsforschung, 15. Jg., 03/22, S. 54-56.
2. Avolio, B.J./Bass, B.M. (2015): Developing Potential Across a full Range of Leadership TM: Cases on Transactional and Transformational Leadership. Psychology Press New York.
3. Bauer M. (2022): Kommt das Metaversum auch ins Gesundheitswesen? URL: https://www.hcm-magazin.de/kommt-das-metaversum-auch-ins-gesundheitswesen-308206/. Letzter Aufruf am 23.01.2024.
4. Berchtold, P./Schmitz, C. (2008): Einmal anders: Was kann Management von der Medizin lernen? In: OrganisationsEntwicklung, 1/2008, S. 16-22.
5. De Cremer, D. (2020): Leadership by Algorithm. Harriman House Petersfield.
6. Duwe, J. (2018): Beidhändige Führung, Springer Berlin.
7. Ehmer, S. (2019): Ambiguität – Mut zum Sowohl-als-auch. Mehrdeutige Situationen brauchen mehrdeutige Antworten. In: Supervision. Mensch. Arbeit. Organisation. 37. Jg., 4, 2019. S. 24-26; Externbrink, K./Dormann, C. (2015): Führen und Entscheiden: Evidence-based Management, In: Felfe, J. (Hrsg.): Trends der psychologischen Führungsforschung. Hogrefe Göttingen, S. 429-439.
8. Foglia, E. et al. (2019): What drives hospital wards' ambidexterity: Insights on the determinants of exploration and exploitation? In: Health Policy, 2019, 123, S. 1298–1307.
9. Formica-Schiller, N. (2021): Künstliche Intelligenz und Blockchain im Gesundheitswesen. Elsevier München.
10. Gärtner, C. (2019): Ambivalenzen und Dilemmata in digital transformierten Arbeitswelten. In: Supervision. Mensch. Arbeit. Organisation. 37. Jg., Nr. 4, S. 10-17.
11. Gartner: Strategische Technologie Trends 2024. URL: https://www.gartner.com/en/articles/gartner-top-10-strategic-technology-trends-for-2024. Letzter Aufruf am 23.01.2024.
12. Gebert, D./Kearney, E. (2011): Ambidextre Führung. Eine andere Sichtweise. In: Zeitschrift für Arbeits- und Organisationspsychologie, 2011, 55 (N. F. 29) 2, 74 – 87.
13. Gebert, D./Börner, S. /Kearney, E. (2010): Fostering Team Innovation: Why Is It Important to Combine Opposing Action Strategies? In: Organization Science, Vol. 21, 2010, Nr. 3, S. 593-608.
14. Gleissner, W./Piechota, S. (2012): Psychologische und ethische Facetten von Managemententscheidungen: Ein Plädoyer für Evidenzbasiertes Management. In: Controller Magazin, Nr. 3, Mai/Juni 2012, S. 80-87.
15. Graf, A. (2019): Selbstmanagementkompetenz in Organisationen stärken. 2. Auflage, Springer Wiesbaden.
16. Haring, M./Gersch, M. (2022): Organisatorische Spannungen. In: Monitor Versorgungsforschung, 06/22, S. 45-47.
17. Helfat, C.E./Peteraf, M.A. (2014): Managerial cognitive capabilities and the microfoundations of dynamic capabilities. In: Strategic Management Journal, Vol. 36, Nr. 6, S. 831-850.
18. Hibbeler, B. (2011): Ein chronischer Konflikt. In: Deutsches Ärzteblatt, Jg. 108, 41, S. A2138A2144.
19. Hodel, M. (2019): Führung von Experten an Hochschulen: Bedingungen für evidenzbasiertes Führungshandeln. In: Kels, P./Kaudela-Baum. S. (Hrsg.): Experten führen. Springer Gabler Wiesbaden, S. 69-91.
20. Joiner, K.A./Lusch, R.F. (2016): Evolving to a new service-dominant logic for health care. In: Innovation and Entrepreneurship in Health, 2016, S. 25-33. DOI: 10.2147/IEH.S93473.
21. Knape, T./Hufnagel, P./Rasche, C. (2020). Innovationsmanagement unter VUKA-Bedingungen: Gesundheit im Fokus von Digitalisierung, Datenanalytik, Diskontinuität und Disruption. In: Pfannstiel, M.A./Kassel, K. /Rasche, C. (Hrsg.): Innovationen und Innovationsmanagement im Gesundheitswesen. Springer Gabler Wiesbaden, S. 1–23.
22. Konlechner, S.W./Güttel, W.H. (2009): Kontinuierlicher Wandel mit Ambidexterity. In: Zeitschrift Führung und Organisation, 78. Jg., 01/2009, S. 45-53.
23. Lück, B. (2023): Wie Unternehmen das Potenzial von generativer KI nutzen können. URL: https://www.bigdata-insider.de/generative-ki-fuehrungskraefte-hoffen-auf-produktivitaetsspruenge-a-d0c4cdd179d44b042d6c93943ef68324/. Letzter Aufruf am 23.01.2024.
24. Luedi, M.M. (2022): Leadership in 2022: A perspective. In: Best Practice & Research Clinical Anaesthesiology 36/2022, S. 229e235. Doi.org/10.1016/j.bpa.2022.04.002. Letzter Zugriff am 23.01.2024.
25. March, J.G. (1991): Exploration and Exploitation in Organizational Learning. In: Organization Science, Vol. 2, Nr.1, 1991, S. 71-87.
26. Meckel, M./Kienbaum, F. (2022). Die qualitativ bessere Chefetage. Handelsblatt vom 04./05./06.03.2022(45), S. 64.
27. Norton, W.E./Chambers, D.A: (2020): Unpacking the complexities of de-implementing inappropriate health interventions. In: Implementation Science, Vol. 15, Nr. 2, 2020.
28. O'Reilly, C.A./Tushman, M.L. (2008): Ambidexterity as a Dynamic Capability: Resolving the Innovator's Dilemma. In: Research in Organizational Behavior, 28, 2008, S. 185-206.
29. Probst, G./Gomez, P. (1991): Die Methodik des vernetzten Denkens zur Lösung komplexer Probleme. In: Probst, G./Gomez, P. (Hrsg.): Vernetztes Denken, 2. Aufl., Gabler Wiesbaden, S. 3–20.
30. Pschyrembel (2013): Klinisches Wörterbuch, 264. Auflage, Berlin Boston 2012, S. 68.
31. Rasche, C./Braun von Reinersdorff, A. (2016): Krankenhäuser als Expertenorganisationen. In: Pfannstiel, M.A./Rasche, C./Mehlich, H. (Hrsg.): Dienstleistungsmanagement im Krankenhaus. Springer Wiesbaden 2016, S. 1-23.
32. Rölker-Denker, L. et al. (2019): DNVF-Memorandum III – Methoden für die Versorgungsforschung, Teil 4 – Kapitel 2 – Methodische Ansätze der OV: Zielgrößen, Datenquellen, Datenerhebung und -analyse. In: Das Gesundheitswesen, 2019; 81: e72-e81.
33. Rosing, K./Frese, M./Bausch, A. (2011): Explaining the heterogeneity of the leadership-innovation relationship: Ambidextrous leadership. In: The Leadership Quarterly 22, 2011, S. 956-974.
34. Rousseau, D.M. (2006): Is there such a thing as „Evidencebased Management?" In: Academy of Management Review 2006, Vol. 31, Nr. 2, 256–269.
35. Scheinpflug R. (2017): Personal aber – Eine Schlüsselfunktion im Umgang mit Komplexität. In: Scheinpflug, R./Stolzenberg, K. (Hrsg.): Neue Komplexität in Personalarbeit und Führung. Springer Gabler Wiesbaden, S. 41-67.
36. Schreyögg, G. (2013): In der Sackgasse. Organisationale Pfadabhängigkeit und ihre Folgen. In: OrganisationsEntwicklung, Nr.1, 2013, S. 21-30.
37. Stegmaier, P. (2023): „In Zukunft ambulanter und technologiegetriebener." In: Monitor Versorgungsforschung, 05/23, S. 26-27.
38. Stöger, R. (2016): Die Toolbox für Manager, 2. Auflage. Schäffer-Poeschel Verlag Stuttgart.
39. Töpfer, A./Brabänder, G. (2022): Smart Services in der Medizin und ihr Potenzial für eine Patient Centricity. In: Bruhn, M./Hadwich, K. (Hrsg.): Smart Services, Band 1. Springer Wiesbaden, S. 364-415.
40. Töpfer, A./Maertins, A. (2017): Transformationale Führung: Beitrag der Führungskompetenz zur nachhaltigen Wertsteigerung. In: Albrecht, D.M./Töpfer, A. (Hrsg.): Handbuch Changemanagement im Krankenhaus. 20-Punkte Sofortprogramm für Kliniken. 2. Auflage, Springer Berlin, S. 571-586.
41. Vogler, C. (2023): Paradigmenwechsel dringend erforderlich. In: Monitor Pflege, Nr. 01/2023, S. 6-8.
42. Warta, K. (2013): Innovation kommt um die Gruppe nicht herum. In: Warta, K./Zajec, K. (Hrsg.): Innovation! Was kann die Gruppe dafür? Österreichischer Arbeitskreis für Gruppentherapie und Gruppendynamik Wien, S. 11–28.

Author's declaration

The author declares that there are no conflicts of interest.

Citation

Brabänder, G.: 'Ambidextrous leadership and evidence-based management - Organisational context conditions for the design of innovative healthcare services',, in: „Monitor Versorgungsforschung“ (03/24), S. 84–89. http://doi.org/10.24945/MVF.03.24.1866-0533.2603

Dipl.-Kfm. Dipl.-Psych. Georg Brabänder MA **ORCID: 0000-0001-9699-9303**
ist niedergelassener Psychologischer Psychotherapeut in Homburg/Saar und Vorstand der Gesundheitsgenossenschaft Homburg/Saarpfalz sowie externer Doktorand bei Prof. Dr. Bernhard Schipp, Lehrstuhlinhaber für Quantitative Verfahren und geschäftsführender Direktor des Ökonomischen Zentrums der TU Dresden. Weitere Tätigkeitsfelder: Coaching von Führungskräften aus Gesundheitsorganisationen und Aufgaben im Bereich Qualitätsmanagement und Qualitätssicherung bei der KV Saar. Kontakt: georg.brabaender@t-online.de

