Leadership in Norwegian hospitals: a qualitative study of clinical managers' pathways, identities, and influence strategies

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ABSTRACT

Clinicians have a central role in the design, implementation, and improvement of care, and they exercise a key role in treatment decisions with implications for overall budgets. Increasing expectations to health care, increased costs and a growing number of older patients with complex diseases have raised public awareness towards effectiveness and quality of care. Several authors and commentators have pointed to the need to involve doctors in management in order to control resource use and costs. There has consequently been an increased interest in recruiting clinicians to management positions in health care.

The overall aim of this study is to uncover conditions for successful engagement of clinicians in management. The thesis consists of three articles that seek to explore clinicians´ journeys into management and their experiences of becoming a clinical manager (paper I); how their professional background influences their identity and transition into a manager role (paper II); and how their professional background influences the strategies that they use to exert influence in hospitals (paper III).

The thesis is based on observations and interviews with 30 clinicians in two different health trusts in Norway. While the main interest was on doctors, nurses were also included in the study to provide a contrasting lens for analyzing and interpreting the findings.

We found that the career paths of clinical managers were characterized by coincidences and peer pressure to take the position as manager, rather than deliberate choices (paper I). A common experience among participants was insufficient preparation for the required tasks for their new position. Clinicians told that they had to learn management "on the fly", and experienced frustrations related to administrative work and challenges delegating work effectively. Doctors also experienced difficulties in reconciling the role as health professional with the role as manager (paper II). They maintained a professional identity and reported to find meaning and satisfaction from clinical work. The thesis also highlights some of the institutionalized rules and norms in hospitals, namely the perception that power relies on professional expertise and that clinical managers were more likely to draw on expert power than on formal position power (paper III). The managers´ professional background was both a resource and a constraint in this context; while nurses were mostly restrained from acting within an expert base, doctors believed that they had to draw on expert power to influence peers. Participants who were not able to influence higher-level managers sought to find informal workarounds.

The thesis suggests that theories on role and identity increase the understanding of how clinicians experience and perform the manager role and that psychological needs for autonomy, competence and relatedness might be instrumental in effective identity building

and role transition. Clinical managers who do not experience need satisfaction in their managerial role might become frustrated and instead seek satisfaction in the clinical and research aspects of their role. Decision makers and top managers should acknowledge the social structure that exists in hospitals and the limitations facing managers with different backgrounds, before implementing new management models and responsibilities. Clinicians entering management need training and preparation at an early stage, rather than having to learn important skills after becoming managers. Management programs should also acknowledge the sense of meaning and purpose imbedded in the professional role, and the sense of loss involved when clinicians enter into managerial positions.

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LIST OF PAPERS

Paper I

Spehar I, Frich JC, Kjekshus LE. (2012). Clinicians' experiences of becoming a clinical manager: a qualitative study. *BMC Health Services Research*, 12(421).

Paper II

Spehar I, Frich JC, Kjekshus LE. (in press). Professional identity and role transitions in clinical managers. *Journal of Health Organization and Management*.

Paper III

Spehar I, Frich JC, Kjekshus LE. (2014). Clinicians in management: a qualitative study of managers' use of influence strategies in hospitals. *BMC Health Services Research*. 14(251).

I refer to the papers by their Roman numerals.

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CONTENTS

INTRODUCTION

Growing expectations to health care, increased costs and a growing number of older patients with complex diseases have raised public awareness towards effectiveness and quality of care. There has consequently been an increased interest in recruiting clinicians to management positions in health care (Cragg, Marsden, & Wall, 2008; Day, 2000; Degeling, Maxwell, Iedema, & Hunter, 2004; Fulop & Day, 2010; Goodall, 2011; Jeon, Glasgow, Merlyn, & Sansoni, 2010; McKimm & Swanwick, 2011; Neogy & Kirkpatrick, 2009; Veronesi, Kirkpatrick, & Vallascas, 2012). International research initiatives have been formed, including the European Cooperation in Science and Technology Action: "Enhancing the role of medicine in the management of European Health Systems". In addition, a range of leadership development programs have been launched in the NHS, including "The Clinical Leadership Competency Framework" and "The Medical Leadership Competency Framework". The emphasis on recruiting clinicians into management is also seen outside of Europe, in countries such as Australia and New Zealand. There is a similar focus on recruiting and developing clinicians in Norway, and recommendations from the Office of the Auditor General of Norway state that clinicians should become more involved in budgets and strategic decisions in order to improve the economic efficiency of health care organizations.

In order to attract and develop future clinical managers it is important to understand more about their journeys into management, their experiences of the manager role and how they perform the role. It is also important to understand the context in which they perform the role. Current knowledge is limited by the use of traditional theoretical perspectives. Research on professions and health care has traditionally been grounded in a sociological or institutional school of thought, often taking a macro-level perspective. Some of the main topics include how health professionals have reacted and adapted to reforms in health care (Johansen, 2009; Mo, 2006; Skaset, 2006; Torjesen, 2007) and the competition between doctors and non-doctors to maintain and expand jurisdictions (Freidson, 2001; Kirkpatrick, Dent, & Kragh Jespersen, 2011). The current project seeks to challenge and complement some of the assumptions of sociological and institutional theories by introducing theory from the organizational psychological domain. For example, from a sociological perspective, clinicians take on the managerial role as a means of gaining power relative to other actors and professions. Factors such as internal motivation, need satisfaction and identity are rarely explored, although literature from organizational psychology suggests that these factors are important for the motivation to engage in new roles. There are gaps in the theoretical and empirical literature on how medical managers conceptualize management and undertake management roles. There is consequently a need to conduct

micro-level studies, and merging ideas from sociological and institutional perspectives with those from organizational psychology could therefore facilitate research in this area.

In the following, I present the context of the study. I will then present theories and research on key issues for the current project.

The Norwegian context

The Norwegian health service is predominantly publicly financed with an emphasis on equal access according to need. The municipalities provide primary health care services such as general practitioner clinics, while four regional health authorities provide specialized medical services. Norwegian health care organizations have implemented a profession neutral unity of command and a decentralized decision structure. The intention has been to increase accountability and to create what we may refer to as a "hybrid management model" that includes both medical and managerial perspectives. The manager is not only formally responsible for sub-specialized areas of medicine, but also has responsibility for larger areas of activities, including nurse-specific activities (Kjekshus & Nordby, 2003). Following debates in the 1990´s on how to strengthen accountability and professionalize management in hospitals, the Norwegian Parliament passed a law to establish unitary management at all levels in Norwegian hospitals through The Specialist Health Services Act. The act was carried into effect in 2001 (Ministry of Health and Social Affairs, 1999). A committee had been appointed by the Ministry of Social Affairs and Health in 1996 to evaluate the organization and management structures in Norwegian hospitals, and to suggest measures for improving these areas. Hospitals were at the time usually run by doctors and nurses in two parallel hierarchies. The committee argued that dual management created ambiguity about management responsibilities, as well as signaling that one profession (e.g. doctors) could not be subjected to the management of other professionals (e.g. nurses) (Spehar & Kjekshus, 2012). This latter argument was based on the assumption that patients should be viewed as "customers" who interact with health care organizations as a whole, instead of exclusively relating to specific professions (Torjesen, 2007). The committee, therefore, recommended that hospitals should introduce new management structures with an emphasis on managing organizational units as a whole.

Following the unitary management reform, hospitals were required to have profession neutral management on all levels in the management hierarchy. This paved the way for nurses and other clinicians to take on many of the new management positions that were created within the hospitals (Johansen & Gjerberg, 2009; Mo, 2008). Managers became responsible for all line employees, regardless of the managers clinical background.

This Norwegian management form departs from other countries, where the main responsibility for running clinical departments often lies with a doctor alone or with a doctor working alongside a general manager and a nurse (Neogy & Kirkpatrick, 2009).

The Norwegian context provides a unique opportunity to study clinicians in management, as it involves the novel and unusual situation where managers with a non-medical background are in essence given the same management tasks and responsibilities as doctors. This provides a contrasting lens for studying how doctors and non-doctors take on managerial roles.

Leadership and management in health care

Differentiating between leadership and management

While leadership is often understood as motivating or influencing others to produce change, management is usually described as achieving specific results by planning, organizing and problem solving (Yukl, 2010). Many authors have used these terms interchangeably, as these activities are usually integrated in formal management positions (Mintzberg, 1973). According to Hogan and Kaiser (2005), leadership is among the most important topics in the human sciences and "the key to organizational effectiveness" (p. 169). However, as several scholars, including Vance and Larson (2002, p. 165), have pointed out, "the search for a single definition of leadership appears fruitless", because the appropriate choice of definition depends on the aspects of leadership being considered. This also applies to the use of the word management. According to Drucker (1977, p. 47), the words *manager* and *management* are "slippery, to say the least".

Kotter (1990) has polarized the terms management and leadership, as illustrated in a book titled "Force for change: how leadership differs from management". Kotter´s (ibid.) argument is that leadership has always existed, while management arose as a response to the emergence of complex organizations, such as steel mills and auto companies. Management differs from leadership in that the latter produces movement and change, while management produces consistency and order through planning, budgeting, organizing, staffing, controlling and problem solving. Mintzberg (2009), on the other hand, argues that leadership is one of several roles related to a manager´s job, and that one cannot take out any of these roles because they are blended together. According to Mintzberg (1975), the classical view of a manager as someone who plans, organizes, coordinates and controls is inspired by the French industrialist Henri Fayol, who introduced these concepts as part of his description of the primary functions and principles of management in the book

Administration Industrielle et Générale (Fayol, 1949). Mintzberg´s (1975) premise has been that researchers need to study what a manager *does* in order to fully understand and define management. Based on this premise, and on his own and other researchers´ observations of managers and executives, Mintzberg has identified and described ten roles common to most managers and categorized them as either interpersonal, informational or decisional roles. He attributes the role as leader to an interpersonal role, which involves communicating with, training and motivating employees.

Although definitions of management and leadership differs in the literature, several management scholars support Mintzberg´s claim that management includes several functions, including those often associated with leadership. Drucker (1977), for example, describes five basic operations in the work of a manager: setting objectives, organizing, motivating and communicating, measuring and analyzing performance and developing people. Drucker goes on to write: "Every manager does these things – knowingly or not. A manager may do them well, or may do them wretchedly, but always does them". (Drucker, 1977, p. 55). While early definitions of management tend to fall into what Mintzberg (1975) has characterized as informational and decisional roles, later definitions tend to include interpersonal roles and functions. This could reflect a changing industrial landscape, in which soft skills such as motivation and communication are becoming increasingly important.

As evident from the above description, it is important that researchers clearly define terms such as leadership and management in order to avoid conceptual confusion. In this project, I regard leadership and management as integrated and interrelated concepts, based on the premise that the activities related to both concepts are often integrated in formal management positions. Furthermore, I use the term "clinical manager" to refer to clinicians in formal management positions who may or may not retain a role in clinical work. This differs from the term "clinical leadership", which has been increasingly used in the NHS in an effort to increase accountability among clinicians and to encourage them to develop leadership behaviors, irrespective of whether they have formal management responsibilities or not (Swanwick & McKimm, 2011). As with the term "leadership", reaching a consensual definition of "clinical leadership" is difficult. Edmonstone (2005) refers to clinical leaders as those who retain a clinical role while also engaging in management related activities, such as strategic and collaborative work with health care managers and professionals. While this definition is closer to my own, it excludes clinicians who have become full-time general managers in hospitals and other health care organizations. I include these clinicians in my own definition. Also, Spurgeon, Clark and Ham (2011) point out that commentators often

use the term "clinical leadership" when they in fact mean "medical leadership". I use the term "clinician" to refer to doctors, nurses and other allied health professionals.

There is general agreement that leadership can be enacted with and without formal authority (e.g. Day, 2000). The NHS has actively attempted to promote distributed leadership. Martin and Learmonth (2012) notes that in NHS policy documents, leadership "is vested in an increasingly heterogeneous group of actors […] with frontline staff, patients and even the public themselves empowered to lead change" (Martin & Learmonth, p. 285). Management, however, is a term that is more often used in relation to formal positions and responsibilities. While almost "anyone" can become a leader regardless of formal position, there is an intuitive sense of a manager as someone in a specific management position. In this regard, my definition follows Mintzberg´s (1975, p. 54), who defines a manager as someone who is "vested with formal authority over an organizational unit". It could be argued that clinicians also manage on a daily basis, through planning, organizing and problem solving (Yukl, 2010). Mintzberg (2012) notes that physicians are involved in decision making that places them "squarely in the realm of management" (p. 6), for example when making decisions that affect the hospital, such as deciding to purchase expensive equipment. In addition, clinicians sometimes take on an informal role as a manager by coordinating tasks or changing shift schedules informally. The notion of informal managers is not necessarily controversial, according to Mintzberg (2012, p. 6), "as soon as we get past the notion that management is something practiced only by people called managers". While acknowledging that both formal and informal managers can be found, I prefer to use the word "clinical manager" over "clinical leader", as I believe that the former is intuitively easier to grasp.

Different logics

Hospitals have been described as organizations with competing institutional logics (Reay & Hinings, 2009; Witman, Smid, Meurs, & Willems, 2011). Logics can be understood as the belief systems and practices which are predominant in an organizational field and guide the behavior of actors within that field (Reay & Hinings, 2009; Scott, 2001). The term "mindset" has been used in a similar sense in the health management literature to denote the specific attitudes and dispositions of groups of actors (e.g. Guthrie, 1999). Specifically, hospital organizations have been characterized by a decoupling between the top management level and the clinical level (Borum, 2005; Kaluzny & Shortell, 1997; Meyer & Rowan, 1977). While the top management level is mostly founded on top-down models and the logics of economics and administration, the clinical level is dominated by informal leaders with a professional background in medicine, advocating the importance of

professional autonomy. Strategic decisions and budget processes are decoupled from clinical actions and decisions at the frontline level of the organization, resulting in significant distance between actions and expectations concerning activities, budgets, strategies, and quality of care.

Edmonstone (2009) points to the differences in mindsets between general managers and clinicians by differentiating between clinical leadership and managerial leadership. Clinicians treat individual patients and are socialized into having a micro-view focus on patient treatment and quality of clinical services through their medical specialization. In contrast, managers tend to take a macro-view focus on overall organizational needs. Moreover, clinicians tend to view leadership as something qualitatively different from management. While a manager, in their view, tends to exert power through formal authority and control, a leader supports and encourages the employees to keep developing their skills and experience. A leader has a natural authority and has been appointed, often informally, by the clinicians, while a manager has been appointed by non-clinicians.

The introduction of new public management (NPM) in health care has appeared to further increase the divide between the health professions and management. NPM inspired reforms were introduced in the late 1970s and early 1980s, beginning in the United Kingdom and some municipal governments in the U.S. that had suffered heavily from economic recession (Gruening, 2001). New Zealand and Australia followed shortly after, prompting more countries to put similar reforms on their agendas. Key characteristics of NPM include the introduction of market mechanisms, performance measurement, professional management and parsimony in resource use (Hood, 1991). Part of the rationale behind the introduction of NPM mechanisms in health care has been the perceived need to impose an effective regime of control on clinical decision making and resource use (Doolin, 2002). The assumption is that hospital clinicians (especially medical professionals) are responsible for decisions involving large resource implications during the course of providing patient care. NPM-inspired reforms in health care have met resistance from health professionals and doctors in particular (Spehar & Kjekshus, 2012). They see managers´ efforts to standardize the nature of clinical practice as attempts to contain costs and increase productivity, rather than improving the quality of care (Beckman, Suchman, Curtin, & Greene, 2006; Carlsen & Norheim, 2008). Monitoring procedures, for example, are perceived as excessive paperwork (Schlesinger, Gray, & Perreira, 1997; Waring & Currie, 2009) and as tools for controlling professional work (Darr, Harrison, Shakked, & Shalom, 2003; McDonald, Waring, Harrison, Walshe, & Boaden, 2005; Waring, 2007). Moreover, efforts to increase control over clinical decision making are perceived by doctors as detrimental to quality of care. In a cohort study of doctors working in Swedish public

hospitals, those who had found their clinical autonomy reduced due to financial considerations assessed the quality of care as significantly lower than those who had not experienced a reduction in autonomy (Forsberg, Axelsson, & Arnetz, 2001) A focus group study of Australian general practitioners found that they perceived financial accountability and clinical decision making as polar opposites (Lewis & Marjoribanks, 2003).

The introduction of NPM in health care may have nourished a negative perception of management among health professionals and strengthened the perception of an ideological divide. This divide is for example seen in how clinicians seek to outwardly distance themselves from the world of management (e.g. Harvey, Annandale, Loan-Clarke, Suhomlinova, & Teasdale, 2014). Commentators point out that doctors in management positions prefer not to associate themselves with the title "manager", wanting to be referred to instead as "clinical head of specialty, clinical lead, or some other title with the term clinical in it" (Ireri, Walshe, Benson, & Mwanthi, 2011, p. 24). Indeed, the word "leadership" is increasingly being used by the NHS in an effort to engage clinicians in management.

Table 1 summarizes some of the main ideal-type differences between a managerial and clinical mindset, according to the literature (Davies, Nutley, & Mannion, 2000; Edmonstone, 2009; Flynn, 1999; Freidson, 1994; Gray & Harrison, 2004; Mintzberg, 1979).

Table 1. Ideal-type differences between a managerial and clinical mindset.

	Managerial	*Medical/clinical*
Educational base:	Social sciences	Natural sciences
Loyalty:	Towards the organization	Towards the profession or sub-discipline
Patient focus:	Patients as a group	Patients as individuals
Regulation:	Formal authority, control	Informal authority, influence
Source of legitimacy:	Hierarchical position	Expertise
Success measure:	Efficiency, cost-effective	Effectiveness

Clinicians as managers

The term "hybrid management" – or sometimes "hybrid leadership" – is being increasingly used in the health management literature to describe managers who combine a professional background with managerial tasks and responsibilities (Llewellyn, 2001; Montgomery, 2001). The term reflects the idea of managers as translators and mediators between the different logistics of management and medicine (Edmonstone, 2009; Kragh Jespersen, 2005; Llewellyn, 2001; Schwartz & Pogge, 2000). The Oxford dictionary defines the word "hybrid" as denoting the offspring of two animals or plants of different species or varieties, or as something made by combining two different elements. According to the dictionary, the origin of the term can be traced back to the early 17th century and the Latin term "hybrida", referring to the "offspring of a tame sow and wild boar". The term "hybrid manager" implies that management and medicine (and perhaps more generally, management and health care) are counterparts. However, a common definition of the hybrid manager seems to be lacking, and it is unclear whether all individuals who combine different roles are hybrid managers, or whether there should be a specific qualitative difference between the roles. While authors and commentators tend to use the term to describe doctors who take on management responsibilities, some define it in more profession neutral ways. Hewison (2012, p. 862), for example, defines it as "roles that incorporate generic management activity and professional practice". Moreover, hybrid management is used to describe what an individual does in practice, rather than how she or he sees and defines themselves. Someone who combines professional practice with management responsibilities could for example be referred to as a "hybrid" in the literature, but in fact perceive her- or himself primarily as a clinician or a manager. The term reflects the tension between the two main logics in health care, suggesting that managers who are tasked with embodying both perspectives might themselves experience tensions and role conflicts.

Moreover, while the hybrid term suggests that there is a notion of two opposing perspectives (clinical versus managerial), Glouberman and Mintzberg (2001a, 2001b) complicate this picture by separating between the mindsets of "care" and "cure" in hospitals. The care mindset refers mainly to nurses, but also includes other health care workers who provide basic care. This mindset emphasizes a focus on the coordination of workflows and continuous care. The cure mindset refers to the medical community and is more action-oriented with a focus on periodic and specific interventions and making individual treatment decisions. Moreover, the two mindsets represent a difference in commitment. While doctors have traditionally been more committed to their profession and less to the hospital as an organization, nurses have traditionally been more committed to the organization. Gouldner (1957) used the concepts of "locals" and "cosmopolitans" to

describe differences in orientations and loyalty towards an employing organization (e.g. hospital) versus an external reference group (e.g. profession). Drawing on this conceptualization, Johansen and Gjerberg (2009) have described nurses as locals, and doctors as cosmopolitans. Studies suggest that doctors and nurses also approach the managerial position differently. Firstly, while nurses are usually full-time managers, doctors prioritize other activities, including research and clinical work. In 2012, 79% of the nurses in Norwegian hospitals reportedly spent all of their time on management-related tasks in the position as department manager, as opposed tto only 14% of doctors in the same position (Kjekshus & Bernstrøm, 2013). Secondly, Viitanen and Konu (2009) studied leadership roles used by middle managers in Finnish health organizations and found that nurses more often reported taking on a coordinator and facilitator role compared to doctors, who were more task-oriented. Additionally, Johansen and Gjerberg (2009) found that Norwegian nurses were more likely than doctors to view management as an attractive career track.

A question of professionalism?

Given the differences in mindsets, researchers have been interested in exploring clinicians´ motivations for engaging in management. Research in the sociological tradition has focused on how taking on formal positions of influence can serve profession-specific interests (Abbott, 1988; Freidson, 2001; Larson, 1977). This perspective emphasizes professional dominance and autonomy as key motives for engaging in management. According to the sociological perspective, professions engage in a struggle for self-governance and dominance against competitive forces. These forces include government regulations and other professions which compete to expand and maintain their jurisdictions. Similar trends have been observed in Norway, namely between doctors and the state and doctors and nurses (Spehar & Kjekshus, 2012). In line with these ideas, studies on clinicians in management positions have suggested that one of the key motivations for taking on the position was to strengthen or protect one´s own profession or sub-discipline from outside influence (Doolin, 2001; Hoff, 1999; Johansen & Gjerberg, 2009; Mo, 2008). The view of professionalism as a motivation for engaging in management is contrasted with how managers have been depicted in the more "generic" management literature, where they are usually portrayed as individuals who seek to become managers out of intrinsic motivation (Viitanen & Konu, 2009). Either perspective tends to take a narrow view on why clinicians engage in management. Studies have shown that clinicians can also be regarded as reluctant to engage in management (e.g. Boucher, 2005; Doolin, 2001), suggesting that there are a multitude of paths into management. According to Day and colleagues (2014, p. 79), individual managers develop along various trajectories. They argue that researchers should

examine these trajectories in order to learn from those who develop more quickly and effectively.

To sum up, themes such as clinicians´ journeys into management, their role and identity as hybrid managers and power in a healthcare context should be explored further in research on clinicians´ engagement in management.

AIMS OF THE STUDY

The overall aim of this study is to uncover conditions for successful engagement of clinicians in management, with the three specific aims to explore:

- Clinicians´ journeys into management and their experiences of becoming a manager.

- How professional background influences clinicians´ identity and transition into a manager role.

- How professional background influences the strategies that clinical managers use to exert influence.

THEORETICAL PERSPECTIVES

Leadership development in health care

Are managers born or made?

One of the earliest approaches towards studying leadership involved the trait approach, where researchers studied the traits that characterized people who emerged as leaders in formal and informal groups (Yukl, 2010). The theories that subscribed to this perspective were called "great man" theories because of their focus on identifying characteristics and qualities possessed by highly influential individuals (e.g. Mohandas Gandhi, Abraham Lincoln and Napoleon Bonaparte). It was believed that these leaders were born with certain traits that differentiated them from their followers. The trait approach was challenged in the mid-20th century by research that questioned the universality of leadership traits. In a major review of the literature, Stogdill (1948) found no consistent set of traits that differentiated leaders from non-leaders across different situations. The study marked a shift in the focus of leadership studies towards observable skills and behaviors (Northouse, 2012). While earlier perspectives viewed leadership as innate and largely fixed, the emphasis began to shift towards skills and behaviors that could be learned and developed.

Scholars now mostly agree that leadership and management skills can be taught and developed (Block & Manning, 2007; Blumenthal, Bernard, Bohnen, & Bohmer, 2012), and positive correlations between training and skills have been observed in various settings (Frich, Brewster, Cherlin, & Bradley, 2014). Mumford and colleagues (2000) found positive correlations between formal leadership training and leadership skills among U.S. Army officers, including creative thinking and the ability to solve complex problems. Crethar, Philips, and Brown (2011) found that doctors, nurses and allied health professionals in Australia reported improvements in their leadership skills and knowledge after having participated in leadership programs. Improvements included a better understanding of political issues and the ability to draw on a wider range of leadership approaches in dealing with others. Busari, Berkenbosch, and Brouns (2011) reviewed studies on management training for doctors and found that all of the studies reported an improvement in doctors´ knowledge concerning management issues, according to subjective and objective assessments.

Developing clinicians as managers

Boucher (2005) studied the factors that influenced clinicians´ decisions to become managers. The author found that their motivations varied, but that the transitions into the manager role often involved little or no preparation. These findings are consistent with findings in other studies on doctors who become managers and suggest a lack of formalized and structured career paths for management in health care (Dickinson, Ham, Snelling, & Spurgeon, 2013; Ham, Clark, Spurgeon, Dickinson, & Armit, 2011; Klaber & Bridle, 2010). Neogy and Kirkpatrick (2009) argue that preparation for management roles through education and training is one of the key factors in influencing the engagement of doctors in management. The authors conducted a study of doctors in formal management positions in various European countries and how they were prepared for management positions (Denmark, France, Germany, Italy, Netherlands, and United Kingdom). While some countries offered training for doctors in management positions, there were few shared standards, and few countries had formal requirements for management training. Leadership programs were generally lacking at undergraduate and postgraduate levels. Ham and Dickinson (2008) reported from a more extensive study on Australia, Denmark, Finland, Germany, Netherlands, New Zealand, Norway, Sweden and United Kingdom. The results largely mirrored those found by Neogy and Kirkpatrick (2009). Denmark was noted as having the most structured approach to preparing doctors for management roles (Ham & Dickinson, 2008; Neogy & Kirkpatrick, 2009). Denmark has introduced mandatory leadership training for doctors in specialty training and medical specialists are mandated to demonstrate core competence in various roles, such as medical expert, collaborator, leader and administrator (Ham, 2008). The latter roles include knowledge about management of resources, financial management and personal leadership. Training is offered through a ten day course in "Leadership, administration and collaboration", provided by the National Board of Health and the Danish regions (i.e. the public hospital owners).

With the exception of Denmark, the studies above reinforce Clark´s (2012) argument that much of the leadership development directed towards preparing doctors for management positions has been "remedial, episodic and ad hoc" (p. 442). The limited focus on preparing clinicians for positions of management stands in contrast to some health care organizations in the U.S., most notably Mayo Clinic and Kaiser Permanente. These organizations are recognized for their approach towards recruiting, supporting and developing doctors as managers (Berry & Seltman, 2008; Dickinson et al., 2013), with Kaiser Permanente specifically having been used as a comparison point for the NHS (Ham, 2008; Kirkpatrick, Malby, Neogy, & Dent, 2007). The organizations´ approaches include the creation of planned pathways into management, with a focus on identifying and

recruiting potential managers from within the organization, continued development and maintenance of management skills, and a clear "exit strategy" for managers so that they may return to the clinic.

In Norway, doctors in postgraduate (specialist) training are required to take a mandatory five day course (30 hours) in administration and leadership and pass a test at the end of the course. Topics include leadership, change management, health legislation, financial management, patient safety, ethics and handling the press.

The regional health authorities jointly offer a national top management program over four months to senior managers of all professions. The curriculum covers issues such as strategic and financial management and the role of the health services in society. Candidates are recommended by their local health trusts based on having demonstrated talent for leadership and having ambitions for a management career in hospitals.

Additionally, a new subject centered on evidence-based health care, leadership and quality improvement ("KLoK") was introduced in 2011 as part of the medical school curriculum in Oslo (Frich, Gran, Vandvik, Gulbrandsen, & Hjortdahl, 2012). The program stretches over six of the twelve semesters of medical school and offers training through lectures, seminars, course assignments and a simulation exercise. Learning outcomes focus on knowledge, skills and general competence, and include being able to describe the functions and tasks of managers at different levels of the health services and being able to describe leadership challenges related to quality improvement and organizational change.

Focus on competencies

Scholars and commentators have increasingly argued that management training and awareness needs to begin early in medical schools (e.g. Barzdins & Barzdins, 2013; Blumenthal et al., 2012), and become incorporated into the medical curriculum (e.g. Busari et al., 2011). There have consequently been new advances towards introducing leadership and management themes in medical schools, with an increasing number of regulatory bodies and government agencies involved in developing national competency frameworks (Clark & Armit, 2010; Reeves, Fox, & Hodges, 2009; Stephenson, 2009).

A recent example of such a competency framework can be found in the NHS. The *Medical Leadership Competency Framework* (MLCF) was jointly developed by the NHS Institute for Innovation and Improvement and The Academy of Medical Royal Colleges, beginning in 2006. The framework was intended to describe the competencies doctors needed to become more involved in the planning and delivery of health care and to inform the design of leadership programs and curricula (Spurgeon et al., 2011). It describes three

main roles for doctors: practitioner, partner and leaders. The framework consists of five domains: demonstrating personal qualities, working with others, managing services, improving services and setting direction. Each dimension has four elements which are further divided into four competency outcomes (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010). A similar model – the *Clinical Leadership Competency Framework* – was subsequently developed for nurses and allied health professions. Both models were later integrated into a single NHS Leadership Framework in order to create a common approach to leadership development (NHS Leadership Academy, 2011). Two dimensions applying to individuals in senior management positions were added to this framework: creating the vision and delivering the strategy.

Other competency frameworks are being developed and updated in Canada (Frank, 2005) and Australia (Sebastian et al., 2014), under the abbreviations CanMEDS and Health LEADS, respectively. These frameworks also involve a focus on competencies in management, collaboration and leadership as part of the medical curriculum.

A common theme of these and similar frameworks for leadership development is the focus on competencies. Although the use of the word competency varies, it usually refers to the knowledge, skills, values and behaviors believed to affect an individual's performance (Hartley & Benington, 2010). In this thesis, I use the terms competency, skill and capability interchangeably.

What is missing from leadership development programs?

Reeves et al. (2009) note that competency models offer wide appeal because they help to establish common standards and provide observable indicators that can be measured. However, they and other authors (e.g. Bolden, Wood, & Gosling, 2006; Edmonstone, 2014; Hewison & Morrell, 2014) have criticized the competency based approaches in health care. One part of the criticism is that leadership frameworks tend to focus on individual competencies. There is little consideration of context, even though several authors have argued for the importance of considering leadership and leadership development in relation to context (Edmonstone, 2014; Hartley & Benington, 2010; Hewison & Morrell, 2014). Edmonstone (2014) describes the differences in terms of "leader development" and "leadership development", and argues that leader development is flawed without also focusing on leadership development.

Another critique, not confined to health care, is that competency approaches tend to limit reflection, intuition and experience (Bolden et al., 2006; Talbot, 2004). Day and Sin (2011) argue that there is a lack of focus on developmental processes in the leadership

development literature. Moreover, there is an assumption that the effect of leadership development is based solely on specific and observable skills and behaviors. This assumption ignores the role of knowledge structures and mental models related to identity. According to scholars, processes related to identity can be viewed as mechanisms that underlie the development of leadership skills and competencies (Day, Harrison, & Halpin, 2009; Lord & Hall, 2005). For example, Day and Sin (2011) conducted a longitudinal study of university students who were placed into teams and tasked with designing and implementing a service-learning project. The authors measured the students´ self-identification as leaders several times across the study and compared it to an external observer´s rating of their effectiveness as a leader on different occasions. Results indicated that a stronger identification as a leader was associated with more positive external perceptions of a student´s leadership abilities. According to Blumenthal and colleagues (2012), residency training programs need to teach nontraditional skills, such as self-reflection and self-awareness. Developing such programs necessitates studies on how clinicians transition into and identify with the manager role.

Motivations and incentives to engage in management is another aspect that has been given little attention in leadership development initiatives in health care. Spurgeon et al. (2011) note that competency frameworks such as the Medical Leadership Competency Framework are not enough in themselves to motivate clinicians to become managers. Organizations need to create climate or culture where doctors are encouraged to become managers. Ham and Dickinson (2008) argue that the focus on education and development of doctors as managers needs to be linked to appropriate incentives and clear career structures. Fitzgerald and colleagues (2006) have requested more research on the motivations and rationale of clinicians who want to continue in a management role. While there have been discussions of external incentives, there has been little focus on internal motivation. Neogy and Kirkpatrick (2009) note that intrinsic motivations are harder to account for.

In summary, most scholars agree that leadership and management skills can be developed and nurtured, and leadership and management training is increasingly being introduced into medical curricula at the undergraduate and graduate level. There has traditionally been a lack of leadership development and career structures for clinicians in management in most countries, and there is a need to understand more about clinicians' journeys into management and their experiences of becoming clinical managers.

Identity and role

Although there is no universally accepted definition of identity, two notions of identity have been particularly influential in relation to studies of occupations and

organizations. The first is based on social identity theory (SIT), developed by Tajfel and Turner (1985). According to SIT, individuals classify themselves and others into various social categories or groups, based on prototypical characteristics of the groups´ members (Tajfel & Turner, 1985). This serves a cognitive function by ordering the social environment and enabling individuals to define and locate themselves within that environment. It also creates a sense of oneness or belongingness to specific groups (Ashforth & Mael, 1989). The second conceptualization is based on identity theory (Stryker, 1980), which has roots in symbolic interactionism (Mead, 1934). Here, identity is composed of the meanings (e.g. attitudes, beliefs and values) individuals attach to the different roles that they inhabit. A role can be understood as a position in social space with an accompanying set of expectations towards the role holder. Roles may be articulated officially, for example in the form of a job title, or less formally through representations such as "parent" and "child". When individuals internalize the role - i.e. adopt the role as a component of the self - a new identity (or "role identity") is established (McCall & Simmons, 1978). According to Stryker and other authors (McCall & Simmons, 1978; Stryker & Burke, 2000), individuals differ in terms of the degree of commitment to a particular role identity. Specifically, they have conceptualized the self as organized by a salience hierarchy of identities. The more prominent an identity is in this hierarchy, the stronger it is believed to influence an individual´s actions (McCall & Simmons, 1978). In addition to guiding behavioral choices, salient role identities might also serve as cognitive schemas that influence the interpretation of events and provide meaning for the self (Stryker & Burke, 2000). From this, it follows that roles can be understood and enacted differently, according to the individuals´ salience hierarchy. Other researchers have interpreted the relationship between role, identity and behavior somewhat similarly. Identity has for example been proposed to play a part in role attachment, or the degree of intensity of involvement in a given role (Sarbin, 1954; Sarbin & Allen, 1968). At one end of the spectrum (i.e. low degree of identification with the role), role behavior occurs with a minimal degree of involvement and effort. At the opposite end of the spectrum (i.e. high degree of identification with the role), the role is performed with a high degree of involvement and effort.

There are some notable differences between the two theoretical perspectives. SIT was originally developed to understand the psychological conditions of intergroup discrimination, while identity theory has focused on how occupying a particular role guides specific, individual behaviors (Stets & Burke, 2000). Stated differently, identification within SIT is studied in relation to collectives or groups, while identification within identity theory is studied in relation to roles. These concepts tend to intertwine, however, and Stets and Burke (2000) write that roles and groups are not easily separated, neither empirically nor analytically. There are also similarities. Both perspectives embody a notion of a structured

society. Social categories precede individuals in the sense that individuals are born into a society which is already structured. In this sense, they both nod to a sociological position, in which social structures are believed to affect cognition and behavior (Stets & Burke, 2000). Also, both perspectives see individuals as having several identities which make up the self (Ashforth & Mael, 1989; Stryker, 1980) and that people differ in how strongly they identify with a particular identity.

In this thesis, I subscribe to ideas from both perspectives. Specifically, I am interested in how clinical managers define themselves in terms of belonging to social groups or collectives, and how "strongly" they identify with their different roles. The SIT perspective is relevant in understanding how identities are categorized in relation to each other and as opposites. While clinical managers occupy several roles (e.g. researcher, man, woman) I am mainly interested in the roles (and identities) as a professional (here denoted as doctor and nurse) and manager. I also draw on the notion of a salience hierarchy of identities, and thus find that concepts from both theoretical perspectives complement each other. Indeed, Stets and Burke (2000) argue that both perspectives overlap on several important dimensions and that combining the two theories could be fruitful for gaining a more integrated view of the self. Ideas from both theoretical perspectives have been combined previously by other scholars (e.g. Ashforth, Harrison, & Corley, 2008). In the following, I will relate the concepts of identity and role more specifically to clinicians´ professional background.

The socialization process in medicine - i.e. the way in which doctors learn to behave according to the specific norms of the medical profession - has received much attention in the literature (Hafferty & Franks, 1994; Luke, 2003). Doctors often have similar socializations into their professional role, where they develop a strong professional identity and sense of solidarity and community (Freidson, 2001; Gray & Harrison, 2004; Pratt, Rockmann, & Kaufmann, 2006). This socialization process is also referred to as "the hidden curriculum" (Hafferty & Franks, 1994), in contrast to the more formal curriculum in medical education. Doctors internalize norms about collegial manners, loyalty and power hierarchies through the hidden curriculum, resulting in the development of a "common" professional identity. Borrowing the concept of "habitus" from Bourdieu (1992), Witman and colleagues (2011) write about the medical habitus, which refers to doctors´ internal model of social reality. Through interviews, focus groups and observations of doctors in a Dutch university hospital, they identified and related four dispositions to the medical habitus: clinical, scientific, professional and collegial. Summarized, these dispositions involve a focus on clinical autonomy (personal control over diagnosis and treatment), putting the patient first, taking personal responsibility, being updated on current research

and treating colleagues as equals. These dispositions are also seen to underlie the clinical mindset, as depicted in Table 1.

The result of this socialization process (i.e. the resulting strong identity as a "doctor") could be relevant for understanding the transition between medical and managerial roles. Ebaugh´s (1988) role exit theory proposes that individuals who move into new roles "tend to maintain role residual or some kind of 'hangover identity' from a previous role" (Ebaugh, 1988, p. 5). Ebaugh (1988) studied exits from various roles, including religious, political and occupational roles. The author found that the more involved and committed individuals were to their former role, the more role residual tended to manifest itself into the new role. Doctors who exited the medical role continued to identify strongly with that role - more so than nurses.

Research suggests that clinicians need to develop and draw on different identities in order to perform effectively as managers in hospitals (Iedema, Degeling, Braithwaite, & White, 2004). According to Patti and Austin (1977), if a clinician "clings indiscriminately to the clinical mindset, his/her ability to internalize the knowledge, values, and skills needed for management is likely to be seriously impaired" (p. 269). Retaining a primarily clinical mindset could for example negatively influence the motivation to learn and practice important management skills, such as financial and strategic skills. Moreover, if individuals experience conflict between identities due to different demands and expectations, they might attempt to resolve the conflict by emphasizing the identity that is subjectively most valued and important (Ashforth & Mael, 1989; Stryker & Burke, 2000). Ashforth and Meal (1989) point to an example from Adler and Adler (1987) who conducted a longitudinal study of college basketball players. Over time, the basketball players experienced increased conflict between their academic and athletic roles. They resolved this conflict by identifying more strongly with the role as athlete, which involved reducing their academic efforts accordingly.

Harvey and colleagues (2014) point out that little consideration has been given in the literature to the identity of managers in hospitals, especially below the top management level. This mirrors a general trend within the sociology of professions literature, in which issues of identity and role transitions have been relatively neglected (Currie, Finn, & Martin, 2010). Specifically, there is a lack of literature about how clinicians experience the transition from a clinical to a managerial role, and how their identity develops in this process. The literature also fails to analyze the factors involved in facilitating the development of a managerial identity. Given the importance placed on identity in successful

role transition, this encouraged us to study identity and role transitions in clinical managers in paper II.

Power in a health care context

Hospitals as professional bureaucracies

Hospitals have been sites of continuous struggle for power and influence over resources, jurisdictions and tasks (Abbott, 1988; Reay & Hinings, 2009). Abbott (1988) portrayed hospitals as an interacting system of professions, in which various professions compete to maintain and expand their jurisdictions. Doolin (2002) describes hospitals as "institutions with their own inherited ideological appeal and complex power relations constituted around various expert knowledge" (p. 381). This description is in line with Mintzberg´s (1979) portrayal of hospitals as professional bureaucracies. These types of organizations rely on highly trained professionals and are characterized by an inverted power structure, where front-line staff has more influence over daily decision making than those in formal management positions. Furthermore, hospitals are characterized by an informal hierarchy dominated by professional affiliations, in which medical knowledge is privileged over nursing and managerial knowledge (Finn, 2008; Martin & Waring, 2013).

There are several examples in the literature of how policy efforts aimed at redistributing responsibilities and power have failed after running up against existing professional hierarchies and jurisdictions. Charles-Jones, Latimer and May (2003) describe how general practitioners in England responded to policy efforts to redistribute clinical work in primary care in a way that maintained their status and position in the professional hierarchy. Martin and Waring (2013) interviewed nurses and other staff in two UK operating theatre departments who were given formal responsibilities as team leaders and theatre coordinators by their hospitals. The authors found that the participants´ ability to practice leadership was constrained by the established norms in the hospitals. Specifically, they lacked the power and legitimacy to influence more powerful actors, such as surgeons and anesthetists. Participants instead sought to act as intermediaries by encouraging more powerful actors to negotiate between themselves. Participants were able to enact the role more effectively when their attempts to influence were directed towards subordinate members of their teams, such as operating department practitioners and those of the same professional discipline.

Defining power

Kurunmäki (1999) states that actors within health care have different chances of winning or losing, "depending on their relative power" (p. 96). There have been several attempts at defining and operationalizing power. Yukl (2010) describes power as a flexible concept that can be used in a variety of ways. It involves "the capacity of one party ('the agent') to influence another party ('the target')" (p. 199). The agent can refer to an individual, a group or an organization, and the target can refer to a single person or multiple persons. "What" the agent influences can also vary. Northouse (2012) defines power as "the ability to affect others´ beliefs, attitudes, and courses of action" (p. 7).

Power is often conceptualized in terms of authority. According to Yukl (2010), authority is associated with particular positions within an organization or a social system, and involves certain rights, prerogatives and obligations. Yukl´s (ibid.) definition is somewhat narrow, because it primarily associates authority with formal positions in management and ignores other sources of authority. Max Weber (1864-1920) had a somewhat broader approach through his tripartite classification of authority. Weber distinguished between three ideal types of authority: charismatic, traditional and legal. He argued that historical relations between rulers and the ruled had usually contained these dimensions. Although this classification was primarily intended for understanding political leadership, similar conceptualizations have been featured in more recent accounts of power.

Another conceptualization regards power as primarily imbedded within structures, as opposed to being embedded within individuals. Kanter´s (1977) theory of structural power evolved from a study of work environments in a large American corporation. Structural power refers to an individual´s ability to access and mobilize resources, information and support from her or his position within the organization. Access to resources refers to the ability to acquire the necessary materials, funding, supplies, and personnel needed to meet organizational goals. Information refers to the technical knowledge, expertise and data required to perform one's job. Support refers to the feedback and guidance received from peers, supervisors and subordinates.

A related question is *how* individuals seek to influence others´ beliefs, attitudes and courses of action. The literature suggests that there are different sources of power and that these might affect the strategies individuals use to achieve influence. French and Raven's (1959) typology of power is among the most widely used and is still used today. While their original model has its limitations, such as a lack of refinement and development of central concepts, it provides a useful angle for differentiating between different types of influence strategies. French and Raven (ibid.) defined social influence as changes in the attitudes,

beliefs or behaviors of one person (the target of influence), resulting from actions of another person (the influencing agent). Social power is defined as the potential or ability of the influencing agent to bring about such change by using available resources. The authors identified five different bases of power from which an individual may exert influence over others: legitimate, reward, expert, referent, and coercive. A sixth power base, informational power, was later added (Raven, 2010). A description of each power base is provided in table 2.

The power bases may be grouped in different ways. Northouse (2012) and Yukl (2010) separate between two major types of power in organizations: position power and personal power. Position power refers to the power an individual derives from a formal position or status in an organizational system, and embodies French and Raven´s (1959) notions of legitimate, reward and coercive power. Yukl and Falbe (1991) suggest that power in large organizations is associated with particular positions within the organization. This assumption is not necessarily transferable to hospitals and other professional settings, where informal leaders can be more influential than formal leaders. Personal power embodies the notions of referent and expert power. These individuals can often be considered as role models and are viewed as knowledgeable, considerate or likeable (Northouse, 2012).

Table 2. French and Raven´s (1959) bases of social power (see also Raven, 2010).

Legitimate	Reward	Expert	Referent	Coercive	Informational
Based on the belief that a person has the right to expect compliance and obedience from others. Often related to a formal title, e.g. manager, supervisor.	Based on a person´s ability to compensate another for compliance, e.g. through compliments or monetary rewards.	Based on a person´s superior skills, experience and knowledge.	Refers to a person´s perceived attractive-ness, worthiness, and right to respect from others.	Originates from the belief that a person can punish others for non-compliance.	Refers to how information is used and shared, e.g. kept for oneself or shared with certain people. Also refers to the arguments used by the influencing agent.

Chemers (2014) suggests that organizational context and culture plays a role in managers´ choice of influence strategies. Research indicates that expert power might carry more importance in a health care setting than other types of power (Witman et al., 2011). As noted earlier, the medical profession has been described as more powerful than any other

group in health care (Finn, 2008; Watkins, 2004). Conceptualized as an informal hierarchy, doctors with their medical knowledge are situated at the top, with nurses and other allied health professions situated below, and general managers at the bottom. Expert power could in this context be regarded as medical knowledge and expertise.

In this thesis, I agree with Northouse´s (2012) definition of power as the ability to influence others' beliefs, attitudes, and courses of action. This definition is in alignment with French and Raven´s (1959) conceptualization of power. French and Raven´s (ibid.) framework complements Northouse´s (2012) definition by addressing the agent´s *capacity* or *ability* to influence. I am mainly interested in power at the individual level, i.e. individual clinical managers' power. An important aspect of this is that there are different sources or bases of power that affect the individual´s ability to exert influence. In paper III, we conceptualized a clinicians´ professional background (doctor, nurse) as a source of power. In this regard, the framework developed by French and Raven is relevant (1959), firstly because of the conceptualization of bases of power, and secondly for its notion of expert power, which we related to having a medical background.

MATERIAL AND METHODS

Setting and participants

I used a purposeful sampling strategy (maximum variation) with the intention of identifying and recruiting participants who could facilitate the exploration of our research themes. This approach allowed me to deliberately include a broad range of participants and to include key participants with access to relevant sources of knowledge (Mays & Pope, 1995). First, I wanted to include both men and women in the study. Second, I sought to include participants from medical and surgical divisions. Authors have found a prestige hierarchy among medical specialties (Album & Westin, 2008; Norredam & Album, 2007) and I suspected that professional specialty could influence how clinicians perceive their role as professionals and how they enact the managerial role. Third, I sought to include two health trusts of different sizes and functions, as I suspected differences in the conditions for management in larger versus smaller hospitals and departments. I selected one health trust that primarily had a local function (serving several municipalities across four counties), while the other had large national and teaching functions in addition to a local function. The latter health trust had a five-level hierarchical management structure, consisting of the executive director of the organization, division managers, department managers, section managers and unit managers. The other had a four-level structure (excluding the unit management level but otherwise similar). Fourth, I sought to include both department and section managers. While both can be described as middle managers, department managers usually have responsibility for a larger organizational unit. Lastly, I wanted to include both doctors and non-medical health professionals in the study.

I contacted division and department managers and gave them information about the study. I then asked for permission to contact potential participants directly through email and phone. In some cases the superior suggested potential participants or forwarded my request directly to the participants, who then contacted me. Potential participants were identified through organizational charts, through recommendations by colleagues and supervisors and by asking participants to suggest potential people that I should talk to. The participants came from four hospitals spanning across two health trust in southeastern Norway. Further characteristics of the participants are shown in appendix A.

Interviews and observations

Interviews were used as the main data source for the three studies in this thesis. The interview guide was developed on the basis of theoretical studies and revised based on data

from two pilot focus group interviews with 20 clinicians who participated in an executive program in health administration. They did not participate in any of the subsequent interviews or observations. The interviews and observations were conducted from March to December 2010. Observations were carried out on the same day as the interviews and lasted from three to eight hours. I observed the participants in formal management meetings as well as in informal sessions, e.g. during lunch. One participant was followed over the course of two consecutive days. I was dressed casually. The observation of participants served several purposes. One purpose was to familiarize myself with the context. Another purpose was to generate insights and ideas that could lead to new and relevant interview questions. In addition, data from observations allowed me to validate data from the interviews. Field notes were written down and kept for later analysis.

In practical terms, there are essentially two main strategies for taking field notes: writing down the most salient or noteworthy observations, or systematically describing everything that happened during a specific period of time (Emerson, Fretz, & Shaw, 1995; Wolfinger, 2002). I attempted to write down as comprehensive field notes as possible. This included the describing the clothes of participants, the time of day that each event occurred, and my own thoughts about these events. According to Wolfinger (2002), this method "has the advantage of forcing an ethnographer to recreate events in the order they really happened [and] can aid in the recall of details that might otherwise have been forgotten" (p. 91). Also, what initially appears salient for a researcher could change over time. A systematic or comprehensive approach does not limit the researcher to an initial idea of salience or noteworthiness.

The interviews were conducted in the offices of the participants. They were usually scheduled in the middle of the day or near the end of the day. Although I relied mainly on interviews and observations to collect data, internal organizational documents and newspaper articles served to supplement data collection and analysis. Participants also provided me with relevant documents, such as meeting agendas and minutes from meetings.

Data saturation

In qualitative research, data saturation refers to the point at which no new information or themes are observable in the process of data collection. In a review of literature on data saturation in qualitative research, Guest, Bunce and Johnson (2006) found that the literature did a poor job of operationalizing the concept, offering no practical guidelines for estimating sample sizes or determining when saturation has been reached. Malterud (2012) has criticized the usefulness of the saturation concept, based on the argument that explorative studies do not seek to achieve a complete description of every

aspect of the study phenomenon Malterud (ibid.) argues instead that it is more important for the researcher to establish a sample that provides rich and diverse accounts of what the researcher seeks to explore, contributing to new understanding of a phenomenon. As mentioned previously, I sought to establish a rich and varied sample through a purposeful sampling strategy. Data was continuously analyzed and assessed, both by me individually and in discussions with my supervisors in order to determine when interviews and observations no longer provided new significant codes, themes or insights.

Analysis

An overview of the data collection and analysis process is illustrated in figure 1. I transcribed all of the tape-recorded interviews in verbatim. I and my supervisors read ten transcripts independently and developed a coding frame for the analysis. I coded all of the transcripts and used the qualitative research software NVivo8 to facilitate the organization of data and analysis.

The analysis was based on "systematic text condensation", in accordance with the principles of Giorgi's (1985) phenomenological analysis, which has later been modified by Malterud (2012). The analysis followed the following four steps: (1) reading all of the material to obtain an overall impression and identifying preliminary themes; (ii) identifying units of meaning and coding for these (i.e. moving from preliminary themes to codes); (iii) condensing and summarizing the contents of each code group; and (iv) generalizing concepts and descriptions pertaining to the specific theme for each study.

Field notes were analyzed independently for emerging themes and then assessed against findings from the interviews, with specific interest on observations that could validate, contradict or add additional insights to the interview data.

I summarized the findings and analysis in a separate document for each manuscript, which I used as a basis for writing the manuscripts. My supervisors also read the documents and contributed in revising the final categories and content. I also wrote a memo for each participant in the study. The memo included demographic information, specific observations and issues emerging from the interviews and observations, and information on the relationship between participants (e.g. supervisor, subordinate). I consulted the memos during all stages of the data analysis and used them as tools for informing the analysis and for providing contextual information for text excerpts and quotes.

Figure 1. Overview of data collection and analysis
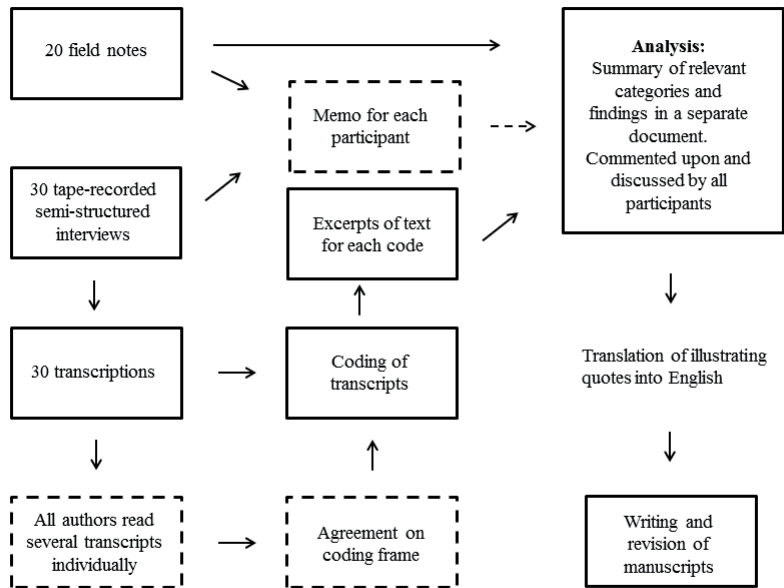
Ethical considerations

Approval to conduct the study was granted by the Norwegian Social Science Data Services (appendix D). I obtained written consent to participate in the study from all study participants. Information about the study and written consent was sent by email, so that participants would have time to read through all of the necessary information before we met. I also gave them the documents in person. Participants were told that they could withdraw from the study at any time, without giving a reason. They were also told that data from interviews (transcripts) and observations (field notes) would be anonymized. In order to secure the participants anonymity after the interviews were conducted, the audio files were stored on a memory stick with a built-in security code, placed in a locked desk drawer. The participants were given a reference number for the transcribed interviews, and the list matching the reference numbers to participant names was stored separately, in a locked file cabinet.

For ethical reasons, and because I did not view it as a clear necessity for reaching the study aims, I did not participate in clinical consultations with patients. I was, however,

present at morning meeting where patients were discussed. I did not record any patient names or other personal information.

Another research ethical issue, which is seldom mentioned in the literature, relates to the "exhaustion" of research participants - in the sense of discouraging individuals from participating in future research projects. As the number of individuals in hospital management positions is rather limited, the same individuals are likely to receive numerous requests to participate in different studies. One of the potential participants I contacted rejected to participate in the study, stating that he had already been involved in numerous past studies, and that he was tired of receiving requests for new studies. Francis and colleagues (2010) note that samples that are larger than needed could be regarded as a waste of participants´ time. I believe that the implications of this project justified the use of the participants' time and effort.

RESULTS

Clinicians´ experiences of becoming a manager

In paper I, we aimed to explore clinicians' journeys towards management positions in hospitals and their experiences of becoming managers. Participants recounted personal characteristics that they believed had predisposed them towards engaging in management. They described themselves as outspoken, responsible and inclined towards seeking new challenges. However, they had not initially anticipated a career in clinical management and spoke of their journeys towards becoming managers as characterized by external and internal pressure. A recurring pattern in these stories was that the participants´ initial entries into management was characterized by informal ways of recruitment, often by persuasion from their supervisor (i.e. the manager to whom they reported), who was retiring from the position as manager and needed someone to take her or his place.

Participants recounted a feeling of pressure to apply for the position, following encouragements from their supervisor. Some experienced added pressure because of previous actions or decisions they had made. For example, one of the participants had taken a management course at a business school in order to increase her managerial competence after being asked to become a manager assistant at her section. Shortly thereafter, a section management position opened up and her supervisor strongly urged her to apply for the position. Although she was reluctant to do so, she was eventually persuaded by her supervisor who brought up the fact that she had previously taken the management course. In another example, a doctor had attempted to prevent someone else from being chosen for a vacant management position and eventually ended up applying for the position himself, although this was not his original intention. Another doctor held the view that it was important that doctors engage in management. When asked by his retiring supervisor to take over the soon-to-be vacant position as department manager, the doctor, who was personally uninterested in the position, eventually chose to do so on based on wanting to live up to his own beliefs.

We found that participants were unprepared for the reality of the management position. Participants spoke of being thrown into the position without being sufficiently prepared for the task. They recounted feelings of loneliness and being left for themselves to learn relevant management skills, such as language and procedures related to HSE (health, safety and environment) and budgeting and finance. Participants also told about frustrations related to increasing administrative workloads, lack of organizational support and being unable to delegate work effectively. Some participants were unsure of what tasks they could

delegate, while others expressed guilt for burdening their assistants or managers below in the hierarchy, who they perceived as already being overwhelmed with work. Others sought to maintain a complete overview of their unit, including personally overseeing as many assignments and emails as possible. More experienced managers told that they had learned to delegate tasks and responsibilities, rather than attempting to do everything themselves.

Transitioning into the managerial role and identity

In paper II, we aimed to investigate how clinicians' professional background influenced their transition into the manager role and identity as clinical managers.

Doctors described conflicting feelings and experienced difficulties in reconciling the role as health professional with the role as manager. Some told that they had gained an increased acceptance of financial restraints. This change in mindset brought ambivalence, as illustrated by a doctor who told that he was unsure of whether he had changed for the better. Doctors also described a sense of loss involved in the transition from a clinical to a managerial role, which involved reducing the time spent in the clinic. They derived satisfaction from clinical work, which provided them with a sense of autonomy, competence and acknowledgement from patients, staff and colleagues. Moreover, doctors conceptualized the manager role from a medical perspective. This involved the belief that managers needed to have legitimacy and authority among staff based on professional, as opposed to managerial, skills and knowledge.

Nurses recounted a faster transition into the managerial role and described it as a positive transition from being a clinical nurse. Although they told that they were proud of their nursing background, they were committed to the managerial role. They did not retain clinical commitments, although some helped out with simple patient related activities in specific situations, for example in the case of sickness absence among staff. Nurses spoke of this in terms of helping out and supporting their staff, rather than demonstrating their clinical skills and competence. They communicated to their staff that they relied on them for making the proper clinical decisions.

Psychological needs appeared as a recurring theme in the interviews and observations. Doctors and nurses who spoke positively about the managerial role told about the ability to influence decisions and the freedom to plan their own workdays. They described the role as enjoyable and meaningful, and spoke of themselves as being manager first and professional second. They spoke of their work as "fun" and stated that management had become more enjoyable as they had gained more experience and become more competent in management. Participants who were negative or ambivalent towards the

managerial role emphasized having little freedom in the role and a lack of social support. They described themselves as professional first and manager second. Some spoke about wanting to prioritize activities that they were more competent in and perceived as more interesting, namely clinical and academic activities. They considered activities in which they had less experience and competence, such as budgeting and finance, to be less rewarding.

Power and influence strategies

In paper III, we aimed to explore the strategies clinicians employed to achieve power and influence in hospitals. Drawing on role as resource theory (Baker & Faulkner, 1991; Callero, 1994), we suggested that professional roles (i.e. being a doctor or nurse) may act as facilitators or barriers to action. We differentiated between the strategies that managers used to exert influence upwards in the management hierarchy (towards their immediate supervisor or top management in general), and the strategies they utilized to exert influence downwards within the organization.

Participants spoke of having to "fight" over resources and recounted struggles for their arguments to be heard by higher-level managers. Managers with a nursing background argued that medical doctors could more easily gain support for their views. Nurses who were section managers spoke of advantages of having a doctor as the department manager. They believed that doctors had stronger credibility in the system, which in turn could ensure more positive outcomes for their own department and sections with regard to budget and resource allocations. Nurses reported that they sometimes deliberately avoided disclosing their professional background when dealing with higher-level managers. They could also use a doctor as their agent to achieve a strategic advantage.

Managers who were not able to influence or persuade higher-level managers could resort to what they referred to as "sabotage", for example through taking on certain tasks while ignoring other duties. This could serve as a way of becoming noticed and proving a point. Managers could also circumvent the system. Some had found informal workarounds, such as contacting IT-support directly on their private mobile phones instead of going through the formal and compulsory, but slower, centralized helpdesk.

We did not identify horizontal strategies in the observations or in the accounts given by the managers in our study. The managers appeared to mainly focus on their own department or professional sub-discipline and sometimes spoke of other departments or hospitals within the same health trust as "competitors".

With regard to exerting influencing downwards in the organization, doctors told of the importance they placed on being perceived as competent clinicians. They believed that this was important for maintaining respect and credibility among peers, and for influencing other doctors. Doctors therefore sought to demonstrate their skills through participating in clinical work. Because the time used on clinical work interfered with other managerial duties, participants mentioned that one strategy could be to specialize in a particular niche in their professional field. This would allow the manager to maintain some clinical credibility while also being able to tend to her or his management responsibilities. While doctors attempted to be medical role models, nurses spoke of being a role model in more general terms. Nurses also sought to be perceived as facilitators, rather than clinical role models. They could for example tell the doctors in the department that they would shield them from having to do excessive paper work, so that the doctors could prioritize other activities, such as doing research.

Moving above the micro-level perspective on managers´ use of influence strategies, the results also reflect the authoritative coordination mechanisms found in hospital settings, and how managers in this setting are influenced by such mechanisms. Specifically, the managers conveyed an awareness of the role and status of medical knowledge in the hospital hierarchy (both upwards and downwards in the hierarchy) and adjusted their influence strategies accordingly. They sought to influence peers by drawing on expert, informational or referent power (French & Raven, 1959), rather than through their formal authority as a manager. The results also suggest an important difference in doctors´ and nurses´ access to social power. Nurses were restricted from drawing directly on expert power (understood as power rooted in medical knowledge and expertise), so they sought instead to draw on this type of power indirectly, for example by using other doctors as their agents or by "hiding" their own professional background.

DISCUSSION

An overall aim of this thesis is to uncover conditions for successful engagement of clinicians into management. Our results underscore that health care organizations need to acknowledge the social and professional expectations of clinicians, and facilitate the transition into the managerial role through establishing systems for developing clinicians as managers. Our results suggest that institutional norms that equate medical expertise with managerial authority call for explicit reflection. The study suggests that our theoretical understanding of clinical management may be advanced through incorporating micro-level perspectives on managers and management.

Figure 2. The results of this study in terms of its overall aims and implications.
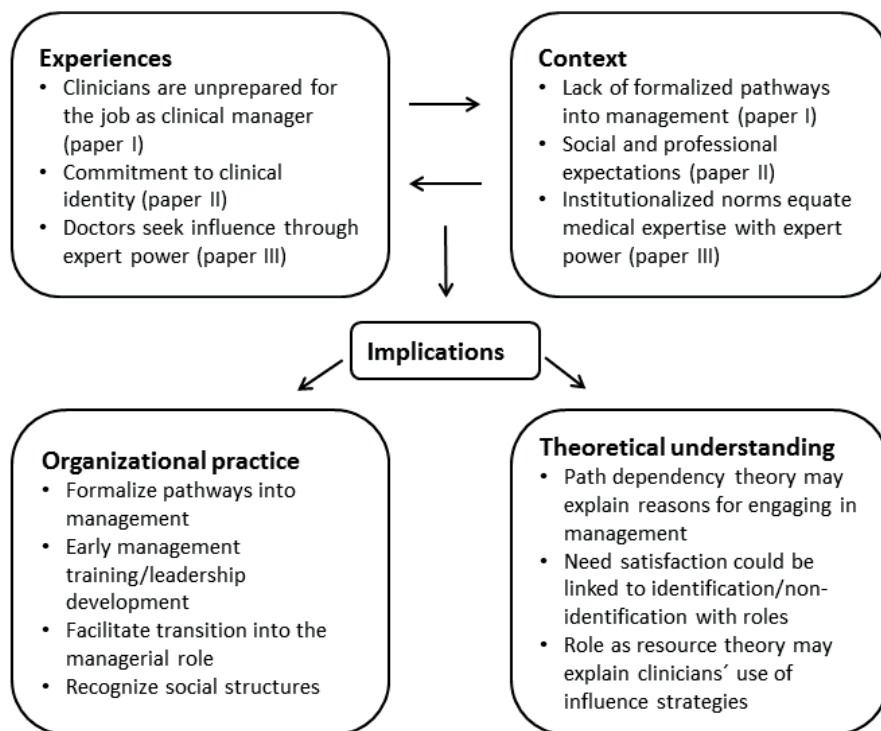
Balancing identities

Our study highlights the importance of understanding identity and role transitions in clinicians who take on management responsibilities (paper II). Our findings suggest that doctors experienced difficulties in reconciling the role as health professional with the role as manager. They maintained a professional identity and reported to find meaning and satisfaction from clinical work.

Are clinicians in management positions successfully bridging the gap between medicine and management? Underlying both the hybrid manager and the unitary manager approach is the sense of clinicians as "bridges" between different worlds, namely a managerial and clinical world. The findings in our study challenge this assumption. Paper I demonstrates that managers in our study experienced frustration in their role as managers, and paper II and paper III underscores that doctors continue to maintain a strong medical identity and use their professional role while exerting influence. We also found that managers with a nursing background sought alternative ways of influencing decisions upwards and downwards in the organization (paper III).

Doctors in our study described the transition from a clinical towards a managerial role in terms of a sense of loss. According to Snell, Briscoe, and Dickson (2011), clinicians need to understand and accept that there will be a shift in how they are perceived by others when they become managers and take on broader organizational responsibilities. Their decisions will not be popular with everyone, and they can expect to receive less praise than what they are accustomed to from working with patients. Stated differently, doctors can expect a change in the experience of social recognition and support. Other studies mirror the results from our own study in terms of exemplifying the positive experiences imbedded in the clinical role: Bååthe and Norbäck (2013, p. 488) note that Swedish doctors receive "a good dose of daily recognition from their patients" while Snell et al. (2011, p. 956) note that Canadian doctors "routinely receive a lot of praise from their patients". In addition, our results suggest that clinicians also receive positive reinforcement from coworkers.

Hybrid managers?

Our results may inform discussions on management models in health care. A unitary manager is someone who oversees the entire organizational unit (e.g. department, section). If unitary management is to be embodied within one individual, it follows that the "ideal" unitary manager is a hybrid, i.e. someone who may bridge the gap between a managerial and clinical logic and access the entire spectrum of power bases (French & Raven, 1959).

Based on the findings of this study, one may argue that only doctors have the potential to be "complete" managers, as they are the only professionals that can access expert (medical) power directly. Ideally, doctors may adjust their management style when dealing with different professions, for example by varying between an authoritative (professional) and "soft" (interpersonal, profession-neutral) style. Nurses and other managers are less free to vary their management style and are as such not "complete" managers in an ideal, unitary sense. However, as this study also found, doctors tend to emphasize a medical logic. It is unclear whether they are actually successful in bridging the gap between management and medicine.

In the wake of this project, I believe that it is appropriate to problematize both the use and the relevance of the hybrid manager term for describing clinicians who combine a clinical and a managerial role. A "hybrid" refers to something new or unique, and it is unclear whether someone who combines a clinical background with formal managerial responsibilities should be labelled as new or unique. According to Berg (1996), doctors have preferred to view management as the continuation of their own physician role. The use of the hybrid term could be seen as problematic, as using the term implies (and maintains) the idea of a polarization between the medical (or more broadly: "health") discipline and management. Numerato and colleagues (2012) note that managerialism and professionalism are often framed as contradictory in the literature and in doctors´ own views. However, the authors point out that the interplay between management and professionalism tends to result in a merging between these two logics rather than in hegemony or resistance. In their view, conceptualizations of the management/clinician dynamic tend to overemphasize a conflictual model. It is possible that the term "hybrid" does the same. While other concepts could be used instead, such as "holistic manager", these also carry certain assumptions. In conclusion, researchers should reflect on the assumptions related to the use of the term "hybrid manager" when employing the term themselves.

Doing management in a hospital context

Our findings suggest that clinical managers were more likely to draw on expert power than on formal position power (paper III). Professional background was both a resource and a constraint in this context; while nurses were mostly restrained from acting within an expert base, doctors believed that they had to draw on expert power to influence peers. Participants who were not able to influence higher-level managers sought to find informal workarounds.

Our findings highlight institutionalized norms that seem to exist in hospitals, namely the perception that power lies in expertise. In this context, doctors have a wider range of power than nurses. However, as illustrated in our findings, expert power was not given "once and for all", rather, it could be lost if not cultivated. Doctors experienced a need to use or uphold their expert power. It could be argued that the emphasis managers place on expert power in health care settings serves to restrict their own behavior. Yukl (2010) claims in relation to expert power that it "is not enough for the agent to possess expertise, the target person must recognize this expertise" (p. 209). Over time, the manager´s expert knowledge will be put to the test. While artifacts, such as diplomas, can symbolize expertise, a more convincing way to demonstrate expertise is by visibly solving problems, making decisions, providing advice, and "successfully completing challenging but highly visible projects" (ibid., p. 209). Yukl´s (ibid.) argument is exemplified in our results by doctors who attempted to maintain and demonstrate their power as experts. Nurses who were already restricted from accessing expert power did not attempt to demonstrate or maintain such power. The results from our study is in line with Martin and Waring´s (2013) argument that the ability to "do leadership" in a health care setting rests on alignment with existing organizational norms and power hierarchies.

Edmonstone (2014) suggests that power relations have been largely neglected by policy drives to engage clinicians in management in health care. It could perhaps be argued that the use of the word "power" itself is problematic from a policy perspective. There is an intuitive understanding of someone winning and others losing when power is used. This becomes even more prominent if one describes actors as more or less powerful. This is perhaps one of the reasons for why health care reforms, such as the unitary management reform in Norway, have appeared to ignore the idea of certain professions being more «powerful» than others. At the same time, understanding power relationships within health care can increase our understanding of how clinicians perform the manager role. For example, participants in our study attempted to align their influence strategies to existing power hierarchies. Professional background influences access to power in a health care setting. Doctors have access to a larger variety of power bases, but expectations and norms regarding expert power influences the strategies they use, such as seeking to demonstrate their medical expertise. Lack of power also influences action. For example, when actors perceive themselves as powerless they may try to use others as their agents, or even attempt to sabotage or circumvent the system. Power, then, is a very real concept, but it is inadequately reflected within policy and reform initiatives.

Currie and colleagues (2010) write that policy-makers fail to understand the social structures that exist in professionalized contexts. According to Martin and Waring (2013),

policy drives to engage clinicians in management are not achieved through changes in management structures and responsibilities in isolation from the context in which these responsibilities are to be enacted. Our study suggests that these social structures will be reflected in how managers attempt to "do management". The results of this project could also inform policy makers by highlighting the importance of understanding underlying norms and power relations.

Developing clinicians as managers

Our findings suggest that the career paths of clinical managers are characterized by coincidences and peer pressure to take the position as manager, rather than deliberate choices (paper I). Not being sufficiently prepared for the task was a common experience among participants. Clinicians told that they had to learn management "on the fly", and experienced frustrations related to administrative work and challenges delegating work effectively.

The accounts given by the managers in our study illustrated how initial decisions and actions steered them towards a specific path where they experienced pressure to take on management responsibilities. These accounts are in line with path dependency theory, which emphasizes the importance of past actions, as actors are often tied (or "locked-in") to previous decisions which are hard to reverse. The concepts of path dependency and lock-in originate from the economic history literature (David, 1985), but have been applied to various fields, including health care (Burau & Vrangbæk, 2008; Kirkpatrick, Jespersen, Dent, & Neogy, 2009; Wilsford, 1994). According to Gunderman (2009), developing leadership and management competencies in clinicians before they assume key management positions has been an underrated priority. Our study points to some competencies, such as financial issues, budgets and human resources management, in which clinicians need prior training and preparation.

Mintzberg (2004) argues that practical experience as a leader and manager should precede classroom training. However, as shown in paper I, the career trajectories of clinicians who become managers have largely left them ill equipped for management responsibilities. A central feature of these trajectories has been the lack of knowledge about management related themes, such as budgets and human resources management. While Edmonstone (2014) has criticized the focus on developing individual competencies, I would argue that some individual competencies are necessary, and that clinicians need to be prepared for the management role.

A precondition to engaging clinicians into management positions is a formalized and structured career path towards management, in which clinicians are offered necessary training and preparation in advance. Such programs may be internal or external, or a combination of both (Hartley & Benington, 2010), and one may focus both on developing leadership and followership (Dickinson et al., 2013; Ham, 2008).

While traditional approaches to leadership development have focused on developing specific and observable skills, there is also a need to focus on identity and psychological needs. According to self-determination theory (Deci & Ryan, 2000; Ryan & Deci, 2000), humans are inherently directed towards activities that satisfy basic psychological needs, namely the need for autonomy, competence and relatedness. Activities that satisfy these needs will facilitate intrinsic motivation (i.e. doing the activity out of enjoyment and interest in the activity itself), while activities that undermine or thwart these needs tend to orient the individual away from the activity. Similar relationships have been suggested by other researchers. Kanter (1977) claims that people will display different behaviors depending on whether certain structural factors related to power and growth opportunities are in place. Individuals who do not have access to structural power (as described earlier in the theory section) and growth opportunities (e.g. opportunities to increase knowledge and skills) will experience feelings of frustration and isolation. They will be less committed to the organization and tend to seek out peer groups outside of the organization for encouragement and support.

There appears to be an implicit assumption in much of the management literature that management positions are attractive and appealing, and that those seeking to become managers do so out of intrinsic motivation and interest (e.g. Conger & Fulmer, 2003). As shown in paper I and II, and by other scholars (Ackerly et al, 2011), this assumption may not be valid in the health care setting. Often, there has been a focus on incentive structures and remuneration, but we also need to focus on the internal motivation of clinicians in management positions.

The future for clinical management

One issue with the unitary management model is its focus on individuals, since notions of shared or distributed leadership are increasingly becoming more influential in health care (Spurgeon et al., 2011; Swanwick & McKimm, 2011). The latter approach underscores the distinction between leaders and leadership and argues that the use of leadership is not restricted to people who have been formally appointed as leaders. The practice of leadership is thus not solely tied to the formal organizational hierarchy, and all

members of the organization, not just those in formal management positions, can assume a leadership role. Examples include leading an emergency situation. Leaders are emergent, not pre-defined. A focus on leadership as an organizational capacity contrasts the assumptions of the manager as a single individual who is able to bridge the gap between the managerial and clinical logics, and we may focus more on developing hybrid management capacity in organizations, not necessarily linked to a single individual leader.

Methodological considerations

Reflexivity

A qualitative researcher will inevitably influence study participants by his or her physical presence, social background and preconceived ideas and notions. Rather than attempting to control for these variables, the researcher aims to acknowledge them and discuss how they might influence the study design, data collection and data analysis (Finlay & Gough, 2003). I wrote down my experiences from each of the interviews and observations in a note book. This included notes on how I might have influenced the participant and how participants and other people reacted to my presence. I approached the study with a master´s degree in psychology. I did not have any prior experience from clinical work or from work in hospitals or other health care organizations and was not invested in any particular outcome of the study.

Participants and other professionals in the hospitals would often ask me explicitly about my professional background. I explained my role as a doctoral student at the University of Oslo and emphasized that I had no formal affiliation or role in the hospital or health trust. I emphasized that I was a researcher within social sciences. I explained the aim of the study and said that participant´s accounts and experiences could be helpful in improving leadership training for clinicians and the organization of health service in general. Participants were also told that the information they gave me would be treated with confidentiality, and that they would not be identified with their own names or the name of their department or hospital. In my opinion, the fact that I did not have a professional background from medicine or nursing was an advantage in eliciting participants´ trust, as I was not perceived as a representative of a competing profession. A researcher with a nursing background might be perceived by doctors as someone who is invested in a positive portrayal of the nursing profession and vice versa. Having the same professional background as the participant might not necessarily be an advantage either, if, for example, the researcher´s subspecialty differs from that of the participant. In the field of health care, where both inter- and intra-professional competition is prevalent, having a neutral

background could be an advantage in gaining participants´ trust. A disadvantage was that I did not have access to profession-specific language and idioms, or to hospital-specific terms and abbreviations. I wrote down new expressions whenever they arose, and either asked the participant to explain it to me, or looked it up on the Internet later. As time progressed, I came across several of the same expressions in interviews and observations and had developed a fair grasp of the most common expressions towards the middle of the study.

Admittedly, prior relations to and knowledge of participants and their workplaces could have been an advantage, especially with regard to understanding the relevant terminology, as well as organizational routines and structure. However, the observational part of the study helped to counter the latter challenges, and the fact that I was not associated with a particular profession (or management), could have helped establish my role as an external researcher without invested interests in any particular outcome.

I was theoretically influenced by psychological theories of motivation and job engagement. I might have held a preconceived notion of individuals as internally motivated to engage in various activities. Writing literature reviews, participating in research groups and having frequent supervisor meetings offered me a broader understanding of different interpretations and analytical frameworks. I had one supervisor with a background in political science (main supervisor) and another supervisor with a specialty in neurology (co-supervisor). Discussing and presenting my work to my supervisors and colleagues from different disciplines also helped me to expand my theoretical and analytical horizon. In addition, feedback from conference presentations provided alternative and sometimes unexpected interpretations. After one presentation, two researchers commented that my use of the term "clinical leaders" was confusing, as it was unclear whether I was referring to formal or informal leaders. They suggested that I might avoid this confusion by referring to "clinical managers" instead. After discussing this with my supervisors, I chose to use the term "clinical managers". We also agreed on the importance of explaining our understanding of the term explicitly when communicating our research, in order to avoid any conceptual confusion.

Internal validity

There are several strategies that can be used to promote validity in qualitative research, and I will in the following cover the strategies that were used in this project. First, a qualitative researcher can engage in self-reflection by thinking about her or his biases and predispositions and how they might influence the research process and conclusions. My approach to this has been described above. Second, a researcher should discuss her or his work with peers; not only peers who are involved in or familiar with the research, but also

what Lincoln and Guba (1985) call "disinterested peers", i.e. researchers who are not involved in the same research. This has also been discussed above. I also received feedback from "disinterested peers" through various conference presentations. Third, a researcher may use triangulation, i.e. combining multiple research methods. The fact that I was able to combine interviews with observations strengthens the findings and insights. In qualitative interviews, participants' accounts are used as an indirect source of social reality; reality is mirrored through participants´ description of their experiences. Observations enabled me to generate a partially independent view of these experiences, and as such an independent view of respondents´ social reality (Erlandson, Harris, Skipper, & Allen, 1993). Another issue to consider is that individuals will often try to present themselves in the best possible way to an interviewer. By observing participants throughout their work day I was able to validate, contradict, or expand on accounts given in interviews. Observations of participants confirmed the accounts that they gave in interviews. Participants also told me that they had acted just like they would on a normal workday. I let participants choose suitable dates for observation. I cannot rule out the possibility that participants deliberately chose a date in which they would appear in a more positive light, for example by avoiding dates where negative events were likely to occur. However, I witnessed on different occasions that participants were being openly criticized by their staff in meetings, suggesting that participants did not shy away from inviting me to "tough" meetings.

While observations confirmed the accounts given in interviews, I did notice a discrepancy on one occasion. A department manager with a nursing background told that she was happy about having a doctor as a section manager, because she could consult him when she needed input or advice on medical issues. She encouraged me to interview the manager. When I later interviewed him, he told that he found her frequent requests for advice to be disrupting to his own work. This could suggest that the department manager had either embellished the truth or that she held another perspective of the situation. However, I did not pursue this issue further.

Lastly, Lincoln and Guba (1985) mention discussing one´s interpretations and conclusions with the participants or members of their community (member checking), in order to verify or nuance one´s interpretations. For example, a participant can clear up a misunderstanding or provide additional information. I originally wanted to invite participants back to focus group interviews. Due to time restrictions I was not able to include this as part of the study. I did, however, ask participants about issues that I had picked up from previous interviews or observations and that I was unsure of. This included factual issues, such as asking about the organizational structure, theoretical perspectives and

hypotheses, and accounts that other participants gave in their interviews. I also asked some participants follow-up questions by phone.

External validity

This study was conducted in a Norwegian hospital setting, but I believe that the findings and insights are transferable to clinical managers in other countries. First, doctors hold a unique knowledge and power base within health care. Even if the management structure in health care differs across countries, doctors share a similar base of knowledge and enjoy a similar status in society. Nurses enjoy less autonomy, status and income in their clinical roles. Second, doctors tend to undergo a similar socializations process, where they develop a strong professional identity and sense of solidarity and community. Nurses generally have a shorter education and are less likely to undergo a similar socialization process. Third, and related to the above, doctors have undergone a long education, with many choosing to specialize in specific disciplines. Experiences of autonomy, relatedness and competence can be expected to be higher in these roles than in managerial roles, where they have had less education and experience. A fourth argument is that similar trends to those described in the medical sociology literature, such as competition for jurisdictions and power, also apply to Norway.

CONCLUSION

Implications for policy and practice

- Health care organizations should formalize pathways into management for clinicians.
- In addition to teaching general management skills, management courses should address issues related to role and identity and acknowledge the sense of loss involved in transitioning from a clinical to a managerial role.
- Policy makers and top managers need to better understand the social structures and norms that exist in hospitals, especially with regard to issues of power, before considering new management models in hospitals.

Implications for theory

- Path dependency theory, which is usually applied to a macro level of analysis is also applicable to a micro level of analysis, and may help to explain why some clinicians take on managerial roles, even if they are not initially motivated to engage in such roles.
- Aspects from the identity and need satisfaction literature may improve the understanding of how clinicians transition into the role as manager. Specifically, clinicians could be motivated to engage or disengage from different identities based on whether these fulfill psychological needs.
- The notion of social bases of power helps to understand the strategies that clinicians use to exert influence in hospitals, particularly in the sense that they are restricted from accessing certain types of power.

Prospects for further research

- More comparative research is needed in order to address questions such as: What facilitates or frustrates clinicians' enactment of the managerial role? What are similarities and differences between countries, health systems and managerial structures?
- There are gaps in the literature concerning psychological factors such as need satisfaction, job satisfaction and burnout. Future studies could investigate need satisfaction and its role in the engagement and disengagement from managerial roles. Key questions include whether clinicians experience more need satisfaction in

clinical or managerial roles, and whether there are differences between doctors and other health care professionals. Studies could incorporate a quantitative design to measure the degree of experienced need satisfaction in different roles. Longitudinal studies could investigate how doctors´ well-being and job satisfaction change as they move in and out of managerial roles.

- One may study whether there are differences between doctors who choose to become managers and those who decline offers for management positions. This would be helpful for identifying potential managers at an early stage. For example, are those who seek to become managers less satisfied with their job as a clinician? Are "negative" or "positive" motivations more prevalent (e.g. wanting to leave current job versus interest in management)?

- Although the grouping of doctors into a single entity is often done in the health management literature, it could potentially ignore important intraprofessional differences. Distinctions such as doctor/nurse and doctor/manager are useful for conveying differences in ideas and perspectives, but might also simplify analyses and discussions. Future studies could explore identification and influence strategies among clinicians with different specialties, which in turn could nuance findings from this and similar studies.

- New and relevant knowledge about clinicians in management may be found in the interplay between macro and micro level perspectives, since structure and agency are intertwined. The study of clinicians in management thus calls for a contextualized analysis, and cannot be isolated from its institutional, cultural and normative surroundings. Researchers need to be aware of the context and account for the existence of contextual forces when exploring and analyzing findings taken from a health care context.

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APPENDIX A – Participants

Characteristics of participants (N = 30)	No	%
Gender		
Female	17	(57)
Male	13	(43)
Age		
36-45	9	(30)
46-55	12	(40)
56-65	9	(30)
Management level		
Department	17	(57)
Section (includes nine first-line managers)	13	(43)
Mean age		
Doctors	55	
Nurses	49	
Other clinical background	40	

APPENDIX B – Invitation letter to participants [in Norwegian]

U N I V E R S I T E T E T
I O S L O

AVDELING FOR HELSELEDELSE OG HELSEØKONOMI

[Helseforetaket]

v/ [Navn på potensiell deltaker]

Dato:

Postboks 1089 Blindern,
NO-0317 Oslo
Norway

Lars Erik Kjekshus
Førsteamanuensis, dr. polit
E-post: l.e.kjekshus@medisin.uio.no
Tlf (dir): 2307 5306

Tlf: 23 07 53 00
Faks: 23 07 53 10

Forskningsprosjektet "Klinisk ledelse – en studie av ledere og ledelsesmodeller ved norske sykehus"

Avdeling for helseledelse og helseøkonomi ved Universitetet i Oslo har et pågående doktorgradsprosjekt som undersøker ledelse i norske sykehus. Hensikten med prosjektet er å tilegne mer kunnskap om nye ledelsesmodeller og sykehusledelse i skjæringsfeltet mellom toppledelse og ledelse av klinikken. Hovedfokus er særlig avdelings- og seksjonslederes oppfattelse av egen rolle og jobbsituasjon. I denne anledning fremstår avdeling for forebyggende medisin som et særlig interessant forskningsområde.

Forskningsprosjektet vil primært bli utført av doktorgradsstipendiat Ivan Spehar. Ivan Spehar har en organisasjonspsykologisk bakgrunn og inngår i en større forskningsgruppe ved Avdeling for helseledelse og helseøkonomi, som studerer temaer knyttet til endringer og ledelse i helseorganisasjoner.

Doktorgradstipendiaten vil ønske å foreta dybdeintervjuer med nøkkelpersonell samt observere personal- og ledelsesmøter over en dag. Dette vil rent konkret foregå ved å følge bestemte avdelings- og seksjonsledere i møtevirksomhet og i kontakt med andre ansatte.

Tidspunkt vil kunne avtales med den respektive deltakeren. Utgangspunktet for prosjektet er nærmere beskrevet i vedlagte doktorgradsskisse.

Prosjektet følger NSDs regler for håndtering av data. Prosjektbeskrivelsen er godkjent av personvernombudet ved NSD og er underlagt strenge forskningsetiske verdier, som blant annet innebærer at deltagelse er frivillig og at alle data behandles konfidensielt. Deltakerne kan når som helst trekke seg fra studien, uten nærmere begrunnelse. Det vil benyttes lydopptaker ved intervjuene, som kun prosjektets kontaktpersoner har tilgang til. Lydfiler fra intervjuet overføres umiddelbart til en sikkerhetsbeskyttet datamaskin uten Internett-tilgang, og slettes ved prosjektets slutt. I transkriberingen av intervjuene vil deltakeres navn byttes ut med et referansenummer. Opplysninger om navn og referansenummer vil oppbevares separat fra datamaterialet, og listen vil makuleres etter prosjektets slutt. Deltakerne vil fremstilles anonymt i presentasjonen av resultatene, og det vil ikke bli gitt spesifikk informasjon som kan spores tilbake til den enkelte deltaker eller helseforetak.

Vi opplever [navn på avdeling/seksjon] som et svært aktuelt observasjonsområde for denne studien, og håper at det kan være interessant å delta i studien. All datainnsamling vil avsluttes ved utgangen av 2010 og oppsummeres i en rapport som sendes til deltakerne. Resultatene vil også kunne danne grunnlag for videre arbeid med utvikling av lederkompetanse i sykehus.

Beste hilsen

Lars Erik Kjekshus

Prosjektleder, førsteamanuensis

Vedlegg: Doktorgradsskisse

APPENDIX C – Interview guide

Sociodemographic questions

- Age

- Civil status

- Job title

- Professional specialization

- Education

- Commisions/management committees

- Career path and management experience

Job position

- What are your responsibilities and tasks in this position?

- What does a typical work day look like for you?

- What does middle management mean to you?

- What are the characteristics of a good manager?

- How do you perceive your job?

Challenges and demands

- What are the challenges related to being a manager for a clinical department/section?

- What kind of support do you receive from your organization (e.g. management assistant, management courses)?

- How is your work/life balance?

- How do you experience the relationship between the top management and the clinical level in the organization?

- How do you disclose messages from the top management level to your staff and from your staff to the top?

- How do you communicate your departments´/sections´ needs to your supervisor?

Role and identity

- What are your thoughts about your work environment?

- Where does your loyalty lie?

- Do you have any management role models?

- What are your thoughts about your own identity?

Organizational change

- How do you experience the change processes in your own health trust?

- What do you think about change in general?

- How do you manage change? (For example reorganizations or new demands for effectivity)

Sickness absence

- What are your thoughts on sickness absence in this organization?

- What are your thoughts on sickness absence in general?

- Can a manager do something to influence sickness absence?

APPENDIX D – Approval to conduct the study [in Norwegian]

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Harald Hårfagres gate 29
N-5007 Bergen
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Lars Erik Kjekshus
Institutt for helseledelse og helseøkonomi
Universitetet i Oslo
Postboks 1089 Blindern
0317 OSLO

Vår dato: 05.01.2010   Vår ref: 23228 / 2 / LT   Deres dato: Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 11.12.2009. Meldingen gjelder prosjektet:

23228	*Clinical Leadership: A Study of clinical Leadership and related Leadership Models in Norwegian Hospitals*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Lars Erik Kjekshus*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.
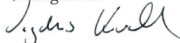
Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, vedlagte prosjektvurdering - kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 08.09.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

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1. List of papers: Publication year has been added for paper III.

2. Material and methods: Indentation has been added to the first paragraph.

3. Discussion: Indentation has been added to all paragraphs.

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Clinicians' experiences of becoming a clinical manager: a qualitative study

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Abstract

Background: There has been an increased interest in recruiting health professionals with a clinical background to management positions in health care. We know little about the factors that influence individuals' decisions to engage in management. The aim of this study is to explore clinicians' journeys towards management positions in hospitals, in order to identify potential drivers and barriers to management recruitment and development.

Methods: We did a qualitative study which included in-depth interviews with 30 clinicians in middle and first-line management positions in Norwegian hospitals. In addition, participant observation was conducted with 20 of the participants. The informants were recruited from medical and surgical departments, and most had professional backgrounds as medical doctors or nurses. Interviews were analyzed by systemic text condensation.

Results: We found that there were three phases in clinicians' journey into management; the development of leadership awareness, taking on the manager role and the experience of entering management. Participants' experiences suggest that there are different journeys into management, in which both external and internal pressure emerged as a recurrent theme. They had not anticipated a career in clinical management, and experienced that they had been persuaded to take the position. Being thrown into the position, without being sufficiently prepared for the task, was a common experience among participants. Being left to themselves, they had to learn management "on the fly". Some were frustrated in their role due to increasing administrative workloads, without being able to delegate work effectively.

Conclusions: Path dependency and social pressure seems to influence clinicians' decisions to enter into management positions. Hospital organizations should formalize pathways into management, in order to identify, attract, and retain the most qualified talents. Top managers should make sure that necessary support functions are available locally, especially for early stage clinician managers.

Keywords: Leadership, Administration and organization, Health services administration, Nurse manager, Doctor, Qualitative research

Background

Challenges with managing patients with complex chronic diseases, advanced and expensive treatments, and growing societal expectations to the health care system, have raised the awareness of effectiveness and quality of care [1,2]. In addition, a focus on clinical governance [3] requires "a model which recognizes clinicians' central role in the design, provision, and improvement of care" [4]. There has consequently been an increased interest in recruiting, developing and encouraging clinicians to take on management positions in health care [1,4-8]. International research initiatives have recently been formed, including the European Cooperation in Science and Technology Action: "Enhancing the role of medicine in the management of European Health Systems" [9]. In addition, a range of leadership development programs have been launched in the NHS, including The Clinical Leadership Competency Framework project [10] and The Medical Leadership Competency Framework [11]. In Irish hospitals, the integration of clinicians into managerial roles has been recognized "as a key determinant of operational effectiveness" [12]. The focus on clinicians in management is not

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limited to Europe, but is seen internationally, including in countries such as Australia [5] and New Zealand [13].

The involvement of clinicians in management has received interest also in Norway, following the introduction of unitary management through the Specialist Health Services Act in 2001. Recommendations from the Office of the Auditor General of Norway state that clinicians should become more involved in budgetary and strategic decisions, in order to improve the economic efficiency of healthcare organizations [14].

Understanding factors that influence management development in healthcare organizations is crucial for creating environments in which clinicians can develop the skills and expertise needed to become successful managers [15]. However, little is known about the factors that influence individual clinicians´ decisions to become managers, and how they experience the transition from clinician to manager. The aim of our study is to explore clinicians' experiences of becoming managers, in order to identify drivers and barriers to recruitment and development of clinical managers in hospitals.

Leadership can be enacted with and without formal authority [16]. While leadership is often understood as motivating or influencing others to produce change, management is usually described as achieving specific results by planning, organizing and problem solving [17]. Many authors have used these terms interchangeably, as both activities are usually integrated in formal management positions [18]. In order to avoid conceptual confusion, we refer to clinical managers as clinicians in formal management positions who may or may not retain a role in clinical work. This differs from the term "clinical leadership", which is an often used term in the NHS [10]. Reaching a consensual definition of clinical leadership has proven to be difficult [19]. Edmonstone [20] refers to clinical leaders as someone who retains a clinical role while also engaging in management related activities, such as strategic and collaborative work with health care managers and professionals. This definition excludes clinicians who have become full-time general managers in hospitals and other health care organizations. Such managers, however, are included in our own definition.

Theoretical framework

The literature on management and recruitment can broadly be differentiated between sociological theories of professions and the more "generic" management literature, often applied to the private sector. The former perspective has emphasized professional dominance and autonomy as underlying motives for engaging in management [21-23]. According to the sociological perspective, clinicians are motivated to seek and maintain influential positions, as their profession is engaged in a struggle for dominance and self-governance against competitive forces. These forces include the competing logics of market forces and government regulations [21], as well as other professions competing to expand and maintain their jurisdictions [22]. Studies of doctors in management positions tend to lend support to this perspective. For instance, Doolin [13] found that many doctors in New Zealand hospitals chose to enter management in order to protect medical practice from interventions by general managers. Forbes, Hallier, & Kelly [24] interviewed Scottish doctors that had recently engaged in management positions, and found that many had assumed management roles in order to protect their specialties from outside influence or from individuals they considered to be inappropriate clinician-managers. Similar accounts have been gathered from interviews with Norwegian doctors in management [25,26]. Edmonstone [19] points to the traditions in medicine of a representative, rather than hierarchical function in management. Doctors are accountable to management, but also to their peers, who continue to regard them as representatives of their own views and interests.

While most scholars in the sociological tradition have focused on doctors, similar ideas can be extended to other clinical professions, including nurses. Norway is one of the few countries where reforms have seen nurses competing directly with doctors for management positions. According to Johansen & Gjerberg [26], Norwegian nurses have assumed management positions in order to increase their professional recognition and status. This explanation is in accordance with sociological theories about professionalism, in which management positions become instrumental in strengthening one´s own profession. Professionalism is in sharp contrast to how managers have been depicted in the more "generic" management literature, where managers are described as individuals who seek towards management out of intrinsic motivation:

"The management models in the private sector highlight characteristics like innovativeness, creativeness and competency in management. In addition, managers are expected to show a spirit of entrepreneurship, high motivation and responsibility. Ideal manager type is one who has visions, leads via ideas and example, and strives towards a goal" [27].

Similar attributes have been emphasized in the New Public Management doctrine [28], which portrays the ideal manager as a person who is responsible [29] and passionate about management, and who is committed to the interests of the organization. These characteristics have been endorsed by policy makers within the NHS [10], who are eager to involve motivated clinicians, serving as "model managers who are committed to meet the requirements of the new public management" [27].

Although the two perspectives differ in terms of the underlying motives for engaging in management, there appears to be an underlying assumption of voluntariness.

While the former describes engagement from a strategic standpoint, the latter suggests that individuals seek management positions out of interest and motivation for the task. According to Gouldner [30], there are two ideal types of latent identities in an organization: "cosmopolitans" and "locals". Cosmopolitans are characterized by a strong commitment to professional values and skills, a strong outer reference group, and weak loyalty towards the organization. Locals tend to be less committed to professional skills, have a local reference group (such as managers in similar positions within the same hospital), and show stronger loyalty towards the organization. While sociological theories tend to emphasize professionals as "cosmopolitans", general management theories tend to view managers as "locals" [10,27]. The two perspectives might therefore be ordered along a continuum, from a more cosmopolitan identification in the former, to a more local identification in the latter, as illustrated in Figure 1. The figure suggests that different aspects must be taken into account when recruiting and developing managers in the different sectors. We seek to further expand the knowledge in this area of research.

Methods

Participants

We found a qualitative approach suitable, and recruited 30 clinical managers for interviews. The managers were chosen from clinical departments and sections within two Norwegian health trusts. We used a maximum variation sampling strategy in order to include a wide range of informants and collect a broad range of experiences [31]. We recruited the participants through their superiors in the organization. One clinician declined to participate. The sample includes 16 nurses, 13 doctors, and one participant with another healthcare background. Mean age was 51 years (ranging from 36–65 years). While some of the participants had held their position for several years, others had only held their position for a few months. Characteristics of participants are presented in Table 1. Twenty of the managers were recruited from medical departments, and ten were recruited from surgical departments. In total, they spanned across four geographical locations (hospitals) in two health trusts. One health trust had a five-level hierarchical management structure (executive director, division management, department

management, section management and unit management), while the other had four management levels.

Data collection procedure

An interview guide was developed on the basis of existing literature and two focus group interviews with a total of 20 clinicians who participated in a management course. The first author conducted tape-recorded, face to face in-depth interviews with 30 participants. The interviews were done at their workplace. The participants were, among other aspects of being a clinical manager, asked about their career paths towards their current management positions. The interviews lasted from 45 to 90 minutes. The first author also observed 20 of the participants in management and staff meetings and during informal talks with colleagues. In interview studies, realities are constructed from respondents´ languages, based on how they conceptualize practices and experiences. Observations enable the researcher to generate a (partially) independent view of the same experiences which respondents draw on to construct their realities [32]. Combining observations and interviews may therefore provide different data on a given phenomenon. We wanted to investigate whether observations would validate, expand on, or contradict accounts given in interviews. A special interest was on the barriers and facilitators in the manager role. Observations were carried out on the same day as the interviews. The author usually met up with participants at the start of their working day, and followed the participant throughout the day. One participant was followed over the course of two consecutive days. The author did not participate in clinical consultations with patients. Field notes from the observations were written down and kept for later analysis.

Table 1 Characteristics of participants (N = 30)

Characteristics	No	%
Gender		
Female	17	(57)
Male	13	(43)
Age		
36-45	9	(30)
46-55	12	(40)
56-65	9	(30)
Management level		
Department	17	(57)
Section (includes nine first-line managers)	13	(43)
Mean age		
Doctors	55	
Nurses	49	
Other clinical background	40	

Cosmopolitans	Locals
Sociological theories of professions	Generic management literature

Figure 1 The two predominant perspectives on management, placed on a continuum of organizational identity and commitment.

Data analysis

Several steps were performed to ensure the quality of the analysis [33]. Firstly, NVivo8 computer software was used to facilitate the analysis of interview transcripts. The interviews were analyzed by systemic text condensation, according to the principles of Giorgi's [34] phenomenological analysis. The analysis followed four steps: (1) Reading all the material to form an overall impression; (2) identifying units of meaning representing different aspects of the participant´s career paths and subsequently coding for these units; (3) condensing and summarizing the contents of each of the coded groups; and (4) generalizing the description and contents reflecting participants´ management paths and motivations. In addition, transcripts of several of the interviews were analyzed for content and structure by all three authors of this paper, resulting in general agreement on a coding frame. Lastly, citations were translated to English by an experienced translator and then back-translated to Norwegian by the authors. This was done to detect possible semantic differences between the translated and original versions. Field notes from observations were analyzed for emerging themes, independently from interviews. Relevant themes were then assessed against findings from interviews, with special interest on observations that could illuminate accounts which participants gave in interviews.

Ethical considerations

Ethical approval to conduct the study was granted by the Norwegian Social Science Data Services (ref: 23228/2/LT). Written consent to participate in the study was obtained from all study participants.

Results

Developing leadership awareness

Many participants recounted personal characteristics that they believed had predisposed them towards entering management. A female surgeon suggested that she had inherited a natural authority from her father:

> "[My father] has always been a leader. And his father was a foreman [. . .] I believe that personalities are inherited".

When reflecting on their careers, participants described that they had always been taking responsibility, such as taking on commissions from a young age and becoming elective representatives. They speculated that this might have prompted them to seek or accept managerial proposals, although they had not initially envisioned any career plans involving management. Other explanations were centered around being outspoken or informal leaders. This is reflected in a statement from a male surgeon, who stated: *"I have become a manager because I cannot shut up".* Some participants, mostly notably at the department level, described themselves as energetic and inclined towards seeking new challenges. One doctor cited boredom in his job as a clinician, as his work had become characterized by routine after years of experience in clinical practice:

> "It becomes unsatisfying, that is a reason that I am sitting here now. [. . .] I could perform it so well and felt so confident [. . .] then the work day also becomes sad, kind of boring".

He described how he had become easily bored in other situations too:

> "I attempted several years ago to teach at the medical school [...] And I remember the first group of students, they were very interesting students. I used evening after evening to make nice [lecture] slides. . . The next group, it was ok [. . .] and the third time I had had it up to my throat. I couldn´t be bothered to say the same things for the third time. . . and that probably characterizes me somewhat. I. . . need to have changes".

Some participants recounted that they had a need for controlling their surroundings, while others admitted that they liked the feeling of power and being able to influence decisions. A male nurse said that he had wanted to influence decisions, but that he was not able to do this as a nurse. He said that this had sparked a desire to become a manager instead:

> "I have enjoyed working in teams, but never [when] someone else has decided many things for me. . . and that corresponds very badly with the nursing profession [. . .] And the need I had, contrasted with always being overridden by a professional group [doctors] with knowledge, power and authority, that suits me badly".

Taking on the manager role

With the exception of some clinicians who actively sought the position because they wanted to seek a new and interesting challenge, or promote professional interests, many of the initial entries into management were characterized by informal ways of recruitment, often by persuasion from the current manager. Participants stated that they had not had ambitions of becoming a manager initially, but that their superior, who was either retiring from work or stepping down, persuaded them to take their place. This was a consistent account given by the participants when describing their first, and sometimes consecutive manager roles. Participants expressed a feeling

of pressure following these encouragements, which drove them to apply for the position. They recounted that they knew they would effectively become the new manager, as there were rarely other applicants for the position. Some participants had to take some time to think over the offer before accepting it, because it came suddenly and unexpectedly. One nurse was unsure whether to take on the job as a department manager, because she had no experience or preparation for the role. For her, the confidence in the skills of the staff was a contributing factor for finally accepting the management proposal:

"The reason why I dared was that there were so many competent people in that department, so I thought it could not possibly be hard to be the leader of the flock here, because there is so much competence".

A doctor who also had to take some time to think through the offer, finally accepted the proposal because of a matter of principle, as he did not want the job out of personal interest or motivation:

"But I have the view that I think it is important that also doctors are managers. Not that all managers should be doctors, but that at least some managers are doctors. [...] And then I was going around thinking that if I mean that, then perhaps I have to take the consequence of that view, and then at least be a manager for a while".

Some participants experienced a pressure to accept the management proposal due to choices they had made in the past. A nurse had taken a course in management and team building at a business school, in order to increase her managerial competence after being asked to take over as a manager assistant at her section. Shortly after, she received a phone call from her supervisor who strongly urged her to take a section management position that had opened up. Although she wanted to take some time off after finishing the course, she was eventually persuaded to take the position:

Interviewer: "What were you thinking when you received the phone call?"

Participant: "I thought that I really didn´t want to [...] but I have to admit that my current boss has quite strong persuasiveness and challenged me strongly about the fact that I had gone to the business school. [My boss] said `you <u>do</u> [emphasized by the participant] mean something by that?´"

Another nurse who worked as a manager assistant was formally and automatically appointed as the section

manager, after the previous manager had stepped down. Some of the participants with a medical background mentioned that the motivation to protect their own profession from external influence had pressured or driven them into taking a management position:

"Advancing the professional field was the reason for why I applied. One could say that it was kind of a negative motivation, that I saw that it wasn´t so many others that were appropriate or... more suitable to do it, myself I am perhaps more of a professional man and engaged with the profession and research, so that I believed I could contribute to preserve and develop the profession in the hospital".

A surgeon used the words "painted myself into a corner", when describing an attempt to prevent someone else from being chosen for a vacant management position:

"The person they were about to hire was someone I could not live with as a boss, and the others in the department could not live with as a boss either [...] so I went into dialogue with the management and painted myself in a corner, where finally the only solution was that I applied for the position as department manager, something I really hadn´t planned".

Only one participant was actively recruited to her current position as part of a formalized system, in which nurses took turns holding a section management position for a year.

The experience of entering management

Participants experienced that they had been "thrown into" the management position, and that they were unprepared for several aspects of their new position. The most significant challenges were related to the workload and understanding the language and procedures associated with budgets and HSE (health, safety and environment). Some experienced the job as lonely and wished for a mentor or colleagues with whom they could share experiences. They had a sense of being left to themselves, having to *"reinvent the gunpowder"* or learn management *"on the fly"*. One department manager with a medical background told that he longed for a book with "the right answers", which he could go to when dealing with medical issues:

"We don´t have, where is the book, you know. And I can go to my book if I receive a professional question, so that I can find out what is recommended and the reference list for those recommendations and so forth. And if I bother, I can even go in and read it myself,

and see if I agree, you know? And that reference list does not exist here".

A consequence of the unpreparedness was that participants saw their days being filled with increasing workloads. Participants told that they did not have time to perform their managerial tasks in a satisfactory way, and many had a long list of unread emails. One manager had a list of several hundred unread emails. A nurse said that the unattended workload had become so large after she returned from a vacation that she *"contemplated a new vacation in order to escape the workload".* A doctor who was appointed as acting manager when the previous manager went into a year-long management course, had difficulties completing tasks in time, because he continuously had to learn new terminology associated with each new task. The number of new tasks increased faster than he was able to finish the old ones. The lack of local support personnel, such as IT support and financial controllers, was also mentioned in the interviews, and several participants wished for an assistant that could relieve them of administrative work. One of the managers had to assemble new office furniture by herself. Some participants told that the lack of organizational support prevented them for practicing newly learned skills that they had acquired from external management programs; they were to busy with administrative tasks. One participant said that he experienced increased interest in management after having participated in a national top management program. The interest waned quickly after returning to work, because administrative work had piled up in the meantime. Some of the managers at the larger departments had a formal assistant, and while one of the managers described this person as *"indispensable",* because the assistant categorized her emails in a prioritized order, another said that his assistant had made the job *" more livable".*

Participants mentioned that their motivation for taking the manager role was not related to financial incentives, but doctors told that they now worked more than they had done as full-time clinicians, for less money. A recurrent theme was that the payment inherent in the manager role did not compensate for the ensuing overwork. Doctors had reduced the amount of time they spent on patients, but they usually retained some degree of clinical work.

Another theme that emerged in the interviews was the challenges related to task delegation. Some participants were unsure of what tasks they could or should delegate. A clinician who had been three months in a new department manager position felt that this affected his job satisfaction negatively:

"I think that this is <u>too</u> [emphasized by the participant] much, too much that I haven´t managed to delegate yet, because everything is new and

unknown and there are too many barriers for this to be a gratifying job now. Unfortunately, I don't really enjoy being in this role".

Others wanted to maintain an overview of every aspect of the organization, including personally overseeing as many emails and assignments as possible. One manager had taken on so many tasks that she was unsure if she wanted to continue in management:

"Because I do feel somehow that I have become stuck, that there are many assignments, and I think many things are exciting, maybe saying yes to too many things, assignments have become pretty extensive [. . .] it has become pretty all-encompassing".

A third group felt guilty for burdening their assistants or managers below in the hierarchy, because they were already overwhelmed with work. One participant felt that other managers were delegating too much:

"And then we have manager assistants that can take something of course, but, it´s about how much you want to delegate to them. And some people. . . I feel that some people are maybe delegating too much to them".

While the stories above were characteristic of participants who were new in the role, participants with more experience were under the impression that a good manager was someone who delegated work tasks, rather than attempting to do everything themselves. However, participants also emphasized that, unlike in private companies, they were not allowed to hire their own support personnel.

Finally, some of the nurses who had become department managers experienced resistance from medical staff. Encouragement and support from colleagues was recounted as important in the process of overcoming this resistance and learning to take unpopular decisions, as illustrated below:

"So in the beginning when I first took over as department manager, I felt that everybody at times were against me, I won´t forget that once [. . .] everyone was angry, and then one of the doctors I know came in [to my office]. . . and then I cried. And then she says: `now they are tough on you´. `Yes´, I said, `now they are so tough on me that I don´t know if I can bear to be in this situation any longer´. And then she said: `remember that you were not chosen in this position so that you would be liked, you are here to do a job, and that´s why you are here´. And that´s true, it´s okay to think about that now and then".

Observations validated the accounts that participants gave about their experiences of the manager role. Observations confirmed that clinicians struggled with terminology related to finance and health, safety and environment. There were also examples of participants receiving urgent emails and work tasks during the day which meant that other planned tasks needed to be postponed, simultaneously increasing their total workload. In one specific case, a department manager struggled to delegate work tasks to his section managers during a management meeting, because of reluctance on the latters´ part to take on the task. In the end, the issue was left unresolved, because no one volunteered or accepted to do the task. Accounts that participants gave in interviews were also repeated in discussions with other healthcare workers and colleagues, indicating consistency in attitudes.

Discussion

We found that there were three phases in clinicians' journey into management; the development of leadership awareness, taking on the manager role and the experience of entering management. Participants had not anticipated a career in clinical management, and experienced that they had been persuaded to take the position. Being thrown into the position, without being sufficiently prepared for the task, was a common experience among participants. Being left to themselves, they had to learn management "on the fly". Some were frustrated in their role due to increasing administrative workloads, without being able to delegate work effectively.

Path dependency

A recurrent theme from the interviews was the experience of pressure towards taking a management position, in which some clinicians became "trapped" or restricted to a specific path. This was mentioned both by clinicians who sought management training to function better in their new management role, and by doctors who wanted to protect their professional interests. Following the descriptions above, we find the concept of path dependency relevant for illustrating our findings. The path dependency literature emphasizes that "history matters" [35], as actors are often tied to previous decisions which are hard to reverse [36]. The literature has mostly been applied to a macro level of analysis, such as describing the variations in national health service reforms [36,37]. Our findings suggest that the idea of path dependency could be applied also at the micro level, in which an initial decision to enter management can tie the clinician to an existing path, and close off other paths due to internal or external pressures. Although other authors have found instances of doctors becoming managers by "accident" [24,38], we find that the same can apply for nurses. Furthermore, the concept of path dependency suggests the process by which some clinicians

"accidentally" enter and stay in management, or in extreme cases might become "stuck managers" [38]. Drummond and Chell [39] have applied the term "entrapment" in describing the career decisions of some lawyers. They described a process where individuals make decisions to take promotion for economic reasons. When later regretting their choice, they could not find a way to get back to doing the work they liked. Clinicians do have the option to opt out of a management role and return to clinical practice. But there also appears to be a belief among clinical managers of a "point of no return" [40] in abandoning clinical work, which leaves the clinician with few options but to pursue a full-time management career.

Our study further suggests that the full range of motivations for entering and sustaining formal management positions are not easily captured by either sociological theories of professions or general management theories. Firstly, the notion of professional actors pursuing management positions in order to secure autonomy [21,22] was shown to have limitations in accounting for the management motives given by our participants. Although some doctors stated that they were motivated to protect their work from outside influence, other participants came into management reluctantly and for other reasons. And although some were drawn to new challenges, few of the participants in our study recounted strong initial ambitions towards engaging in management. Indeed, participants in our study were generally less enthusiastic towards engaging in management than what could be expected from the generic management literature. The emergence of doctors and nurses in management positions could evidently be more path dependent than what is implied by existing theories. Figure 2 expands on the illustration we presented earlier in the paper. Our results suggest that an added dimension is needed to fully grasp the processes by which

Figure 2 Contrasting perspectives on clinicians´ engagement in management.
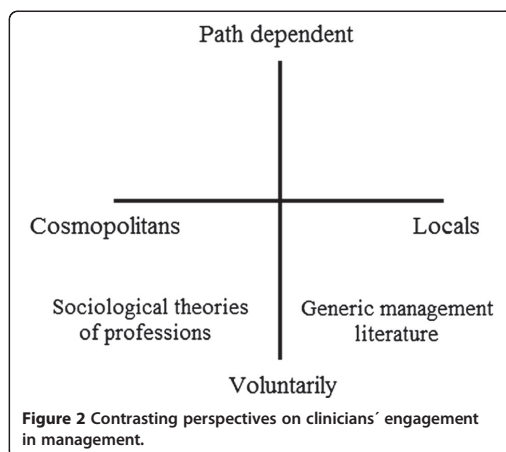
clinicians become formal managers. While the concept of path dependency runs counter to the implicit notions of the generic management literature, it does not necessarily dismiss the professional perspective. Rather, it could serve to expand the understanding of how clinicians who are professionally invested become and remain managers.

We do not dismiss the idea of clinicians situated in the lower right quadrant of our figure. Indeed, some of our participants recounted more positive journeys into management, as have clinicians in other studies. Mo [25] has given an account of Norwegian doctors in department management positions and their motivations for entering management. Although some felt persuaded to apply, others had entered management because of a feeling of curiosity. Forbes and colleagues [24] have noted that some doctors could be described as "investors", actively pursuing management as an alternative to medicine. Although we find reason to question the precision of current theories in explaining the motives of clinicians in management, these theories could be more precise when applied to upper management positions, where status, pay and competition for positions is higher. Chief executives in a study by Ham et al. [41] displayed mostly positive attitudes towards their job. Hoff [42] also found that doctors in upper-level management reported greater job involvement than doctors at lower levels of management.

Being unprepared for the management role

There were similarities in how clinicians experienced the first meeting with their new position. Many were unprepared for the challenges in their new role and struggled with increasing workloads and the lack of organizational support. In this regard, the accounts from our participants somewhat mirror that of doctors who become chief executives in the NHS, in that both groups received little structured advice and guidance as they transitioned into management roles [41]. Some of our participants noted that they had to learn management "on the fly", and one doctor longed for a form of reference guide. Entering into management is a significant transition from clinical work, where tasks and routines are usually standardized, and in some way offer "a relative oasis of calm and predictability" [41] compared to the dynamic tasks inherent in a management role. Although some of our participants mentioned management training as part of their route into management, it is possible to assume that clinicians who enter management through path dependent routes might be less prepared for the inherent challenges in the new position. A consequence could therefore be that they are more likely to experience the new position as overwhelming. In addition, increasing workloads may follow from an inability to delegate sufficiently. Lord and Hall [43] studied the development of leadership skills ranging from a novice to expert level. The authors concluded that "early attempts

at leadership are guided by leaders' desires to match their surface features (e.g., behaviors) to implicit theories of effective leadership". It appeared that participants in our study initially sought to retain an overview of the whole organization. Clinicians with longer experience in managing were more likely to mention that they had learned to organize effectively, and that they had to derive support from individuals with different expertise from themselves. Chief executives in Ham´s study [41] also recounted that they had learned to involve colleagues in supporting roles:

"A key theme here was the importance of recognizing gaps in competence and experience that needed to be filled by others. This had often resulted in the appointment of experienced colleagues as chief operating officers, medical directors and other roles to ensure that appropriate support was available" [42].

Kane-Urrabazo [44] notes that delegating tasks is among a healthcare manager´s central responsibilities. Healthcare professionals in the NHS who received a three-day course designed to examine their own behavior as managers, reported that they took on less responsibilities and delegated more to their staff [45]. This suggests that experience alone is not the only prerequisite for improving management skills, and that effective delegation might be learned at an earlier stage than what is currently the case.

Methodological considerations

We were able to combine insights from both interviews and observations to strengthen our findings and insights. Observations of participants in dialogue with other staff members confirmed accounts that they had previously given in interviews. The study was done in a Norwegian hospital setting, but we believe that our findings are transferable to other countries without explicit policies and systems for recruiting and developing clinical managers. The accounts given by the participants in our study should be understood in light of a Scandinavian context where cultural norms against showcasing or boasting may be present, a prevailing social code in Nordic countries [46], which Gullestad [47] calls equality based on conformity. These cultural norms may perhaps account for why we did not find more obvious "investors" [24] among the participants, describing themselves as natural or "born" leaders and innovators. Another limitation is that we did not seek to include clinicians that had either left management or turned down such offers. By including such participants, we could have been better able to identify barriers towards taking management positions, which could evidently be addressed in management training and development. We could also have asked managers about how they select their successors. Future studies could incorporate these considerations in their research design. Subsequent studies could also compare management trajectories in different countries in order to identify

practices that foster and nurture the development of clinical managers across contexts.

Implications

Firstly, we found that clinicians experienced pressure to enter into management positions. While other studies have suggested that doctors might reluctantly take a management position [24,38], our results suggest that the process by which these individuals engage or "get stuck" [38] in management, could in part be understood as a form of path dependency. To address this issue, it is important to identify and attract motivated clinicians at an early stage. Mountford and Webb [48] have suggested a systematic approach towards gathering and telling stories of successful clinical managers. This might help to increase the pool of interested candidates, so that fewer clinicians become managers by "drawing the short straw" [13].

Secondly, engaging clinicians in management is "about more than simply appointing people to particular positions" [49]. There needs to be a more formalized and structured career path towards management, in which clinicians are offered necessary training and preparation in advance, rather than having to learn "on the fly". This necessitates a strong organizational interest in management development [50], in which management development "is not a program; it is an organizational commitment" [51]. Lessons can be drawn from organizations that have already fostered successful values and routines for recruiting and developing potential managers. One example is the Mayo Clinic [52], which is recognized for building a culture of organizational support around its managers. Our study suggests that clinical managers would benefit from early advice on how to delegate effectively. Another suggestion would be to offer managers more administrative support in form of designated personnel in assistant or support roles [53-55]. Several authors have suggested the use of mentoring [15,41,56,57]. Nurse managers in Allen´s [15] study noted that social support, often through a mentor, was instrumental in encouraging them to engage in early management experiences. Involving mentors early, and potentially before clinicians enter management, might help to better prepare them for a management role. Creating social arenas and networks for collective sharing of experiences between clinical managers might also prove beneficial.

It is relevant to note that Edmonstone [58] and other authors [59] have criticized the set of assumptions that underlie competency based frameworks, such as in management and leadership development programs in the NHS. Their argument is that competency based approaches may oversimplify management by fragmenting, rather than integrating, different leadership and management activities. Edmonstone and Western [60] state that competency based

approaches could prove of limited practical applicability within increasingly complex healthcare organizations, "in which tasks are increasingly complex and messy". The development of capability, a form of reflective insight derived from practical experience, is argued to be better suited for handling unexpected, ambiguous and dynamic problems.

The distinction between work-based approaches, such as mentoring or coaching, and course-based programs, such as MBAs, could also be relevant when discussing management development. Edmonstone and Western [60] make the point that both types of approaches have their advantages and disadvantages, which need to be recognized in order to move beyond "either/or fashion swings". For example, while traditional course-based approaches might help to instill important management skills related to HSE and finance, an excessive reliance on externally based programs might be problematic, because of limited time schedules. Edmonstone and Western [60] evaluated two leadership development programs for executive directors of NHS organizations. Participants reported that geographically distant locations were a barrier for attending the programs. On the other hand, skilled mentors might be few in numbers or unavailable locally, which could limit the impact of work-based approaches [61].

Finally, while there is an understanding of the need for appropriate remuneration in private sector organizations, financial incentives for doctors are more often perceived as lacking in public healthcare systems [19]. Chief executives in Ham et als.´ [41] study argued that pay differences could be a major deterrent for experienced hospital specialists who already had significant sources of income from private practice. A lack of appropriate remuneration could also provide frustrated or overworked clinicians with an incentive to opt out of early management roles.

Conclusion

Path dependency and social pressure seems to influence clinicians' decisions to enter into management positions. The notion of path dependency is relevant both for theory development and for practical implications. Firstly, the idea of motivated clinician managers needs to be nuanced. While theoretical perspectives from sociological and general management literature emphasize external or internal motivations for engaging in management roles, the path dependency literature provides a framework for understanding other paths into management. In this regard, path dependency might contribute to theory development in the broader area of healthcare organization and management. Secondly, the negative implications of path dependency implies that hospital organizations should formalize pathways into management, in order to identify, attract, and retain the most

qualified talents. Newly learned management skills and behaviors also need to be encouraged and supported by the local organization in order to be practiced effectively. If provisional skills learned in external course based programs go unsupported, such courses may be of limited value to clinicians in manager roles. Top managers should consequently make sure that necessary support functions are available locally, especially for early stage clinician managers.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

All authors were involved in the design of the project. IS carried out the observations and interviews. JCF and LEK provided assistance with coding and analyzing data from the interviews. The drafts of this article were revised critically by all authors. All authors have approved the final version of the manuscript.

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II

Professional identity and role transitions in clinical managers

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Abstract

Purpose - The aim of this study is to investigate how clinicians' professional background influences their transition into the managerial role and identity as clinical managers.

Design/methodology - We interviewed and observed 30 clinicians in managerial positions in Norwegian hospitals.

Findings - A central finding was that doctors experienced difficulties in reconciling the role as health professional with the role as manager. They maintained a health professional identity and reported to find meaning and satisfaction from clinical work. Doctors also emphasized clinical work as a way of gaining legitimacy and respect from medical colleagues. Nurses recounted a faster and more positive transition into the manager role, and were more fully engaged in the managerial aspects of the role.

Practical implications - We advance that health care organizations need to focus on role, identity and need satisfaction when recruiting and developing clinicians to become clinical managers.

Originality/value - Our study suggests that the inclusion of aspects from identity and need satisfaction literature expands on and enriches the study of clinical managers.

Keywords: Role transition, Identity, Hybrid management, Clinical manager, Doctor, Nurse

Introduction

Clinicians who take a role as clinical manager have to balance and mediate between different worlds - the managerial and the professional - with different and often conflicting demands and logics (Gray and Harrison, 2004; Llewellyn, 2001; Witman et al., 2011). While some authors suggest that clinicians can occupy such roles easily (Llewellyn, 2001, p. 593), others argue that clinicians may fail to meet their own and other's expectations (Fulop 2012, p. 579; see also Kippist and Fitzgerald, 2009). There is a need for more research on how clinicians conceptualize and 'do' management in order to better understand why expectations might not be met (Witman et al., 2011). Clinicians' professional background influences their identity and might have an impact on how they perceive and transition into the managerial role (Fitzgerald et al., 2006).

In Norwegian hospitals, unitary management became a legal requirement in the Specialist Health Services Act in 2001. The act came as a response to the long existing practice with dual management in Norwegian hospitals. The hospitals were run by nurses and doctors in two parallel hierarchies. The final responsibility was difficult to pinpoint and a need to force hospitals to have 'profession neutral' management was required (Spehar and Kjekshus, 2012). The main purpose of the act was to clarify the total responsibility of the management position and to introduce unified management. This legal framework inspired us to study clinicians as they take on and transit into the role as manager, and to explore how this transition influences their identity and role understanding.

We did a study to investigate clinicians' experiences in the role as clinical manager, with a view to exploring how professional background influences their transition into the managerial role and identity as clinical managers. While there have been previous studies on clinicians´ motivations for engaging in management (e.g. Mo, 2008; Spehar et al., 2012), less is known about the factors influencing role transition and identity development. Understanding these factors could help explain why some clinicians succeed and others fail to occupy the role of clinical manager. We use the term clinical manager to denote clinicians in formal management positions who may or may not retain a role in clinical work.

Role transitions and identity

The term 'hybrid management' has been coined to denote managerial roles where individuals combine a professional background with managerial tasks and responsibilities (Llewellyn, 2001; Montgomery, 2001). Clinicians who take on a managerial position bring with them a

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professional identity, which can be defined as the relatively stable set of attitudes, beliefs, motives, values and experiences in which individuals define themselves in a professional role (Schein, 1978). While identity refers to one´s perceived self, a role is defined by a position in social space (e.g., clinician, manager) with a concomitant set of expectations towards the role holder (Hall, 1971). The literature suggests that role transitions are facilitated by changes in identity and likewise hampered by a lack of change in identity. For example, Lord and Hall (2005) argue that a change in 'deep structure' factors, such as identity and values, is necessary for a successful transition into a manager role. Identity might also play a part in role attachment, or the degree of emotional intensity of involvement in a given role, which affects how individuals enact the role (Sarbin, 1954; Sarbin and Allen, 1968). At the low-intensity end of the continuum, role behavior occurs with a minimal degree of effort and involvement. At the opposite end of the spectrum, the role is performed with a high degree of effort and with a high degree of identification.

Linking this to a hospital setting, studies suggest that clinicians´ need to draw on different identities in order to function effectively as managers. Iedema and colleagues (2004) undertook a discourse analytical study based on situated talk and interview data from a clinical manager with a medical background. They found that the manager navigated between different identities, such as manager, medical colleague and first among equals, in his attempts to construe shared meaning among colleagues and staff. Sometimes they could 'glimpse rapid transitions across these personas, even within the same turn or even utterance' (Iedema et al., 2004, p. 29). This aligns with management literature describing successful managers as having developed a 'complex identity' (Day and Harrison, 2007, p. 367), enabling them to integrate different identities and choose between them when appropriate (Quinn et al., 2011). In contrast, Patti and Austin (1977) assert that when a clinician 'clings indiscriminately to the clinical mindset, his/her ability to internalize the knowledge, values, and skills needed for management is likely to be seriously impaired' (p. 269). For example, retaining a primarily clinical mindset could limit the ability to learn and integrate essential management skills, such as financial and strategical skills, into the role as manager.

Research suggests that doctors and nurses differ in how they experience the transition from being a clinician to becoming a clinical manager. While nurses appear to be more positive towards engaging in management, doctors have traditionally been reluctant towards adopting managerial roles and responsibilities (Spehar and Kjekshus, 2012). Studies also suggest that doctors appear to retain a clinical mindset after taking on managerial

responsibilities (e.g. Johansen and Gjerberg, 2009; Mo, 2008). According to Fitzgerald (1994), the time doctors spend on managerial activities 'is constantly assessed against the criteria of what could be achieved by using that time for clinical practice' (p. 43). In contrast, moving into management is considered as a positive career move by nurses (e.g. Allen, 1998; Johansen and Gjerberg, 2009), and nurses engage more fully in the managerial role.

The findings above present researchers with the question of what facilitates the development of a managerial identity in a professionalized context. While clinicians´ professional background appears to play a role, there is limited knowledge about how it influences role transition and identity development. The difference between doctors and nurses outlined above provides us with contrasting lenses for studying identity and role transitions among clinicians entering the managerial realm. This contrast might help us to better understand the interplay between professional background, role transition and identity. In the following, we set out our research context and design, before we present and discuss the results from our study.

Methods

Participants

30 clinical managers were recruited for interviews. 20 of these were observed in management and staff meetings during the day. We used a maximum variation sampling strategy so that we could include a wide range of informants and collect a broad range of experiences (Kuper et al., 2008). Our sample included 16 nurses, 13 doctors, and one participant with another health care background. Twenty managers were recruited from medical departments, and ten were recruited from surgical departments. Mean age was 51 years (ranging from 36-65 years). Some of the participants had held their position for several years, while others had only held their current position for a few months. Characteristics of participants are presented in Table 1.

Table 1. Characteristics of participants

Characteristics	No	%
Gender		
Female	17	(57)
Male	13	(43)
Age		
36-45	9	(30)
46-55	12	(40)
56-65	9	(30)
Management level		
Department	17	(57)
Section (includes nine first-line managers)	13	(43)
Mean age		
Doctors	55	
Nurses	49	
Other clinical background	40	

Setting

The Norwegian public health system is under the jurisdiction of the Ministry of Health and Care Services, which has the overall responsibility for the national health policy. The responsibility for provision of services is decentralized to the regional and municipal level. Hospitals are organized in local health trusts, which are governed by four regional health authorities. In addition to the public hospitals, there are some private hospitals and health clinics delivering specialized health care services. Our participants spanned across four public

hospitals in two health trusts. One health trust had a five-level hierarchical management structure (executive director, division managers, department managers, section managers and unit managers), while the other had four management levels (excluding unit managers).

Data collection

An interview guide was developed on the basis of two focus group interviews with a total of 20 clinicians who participated in an executive master program in health administration. None of these were recruited in the subsequent interview and observation study. The first author conducted tape-recorded, face to face in-depth interviews with 30 participants at their workplace. The interviews lasted from 45 to 90 minutes. The author also observed 20 of the participants in management and staff meetings and during informal talks with colleagues. In interview studies, participants´ realities are constructed from how they conceptualize their own practices and experiences. By employing observations, a researcher can generate a partially independent view of some of the experiences that respondents draw on to construct their realities (Erlandson et al., 1993). Combining observations and interviews may therefore provide more extensive data on a given phenomenon. We wanted to investigate whether observations would validate, expand on, or contradict accounts given in interviews with a special interest on whether participants enacted and experienced their clinical manager role in ways that were different than what they indicated in interviews. Observations were carried out on the same day as the interviews. The author usually met the participants at the start of their working day and followed the participant throughout the day. One participant was followed over the course of two days. The author did not participate in clinical consultations with patients. Observations were documented in field journals, where they were kept for later analysis.

Data analysis

Several steps were performed to ensure the quality of the analysis. NVivo8 computer software was used to facilitate the analysis of interview transcripts. The interviews were analyzed by systemic text condensation (Malterud, 2012). This approach follows four steps: (1) Reading all the material to form an overall impression; (2) identifying units of meaning and subsequently coding for these units; (3) condensing and summarizing the contents of each of the coded groups; and (4) generalizing the description and contents reflecting participants´ enactment of their manager role. Transcripts of several of the interviews were analyzed for content and structure by all authors of this paper, resulting in general agreement on a coding

frame. Field notes from observations were analyzed for emerging themes, independently from interviews. Relevant themes were subsequently assessed against findings from interviews, with special interest on observations that could illuminate accounts which participants gave in interviews.

Our data analysis was guided by the research questions, i.e. investigating how professional background influences clinicians´ transition into the managerial role and identity, but also sought to identify emergent themes and issues.

Findings

We found that doctors experienced difficulties in reconciling the role as health professional with the role as manager. They maintained a health professional identity and reported to find meaning and satisfaction from clinical work. Doctors also emphasized clinical work as a way of gaining legitimacy and respect from medical colleagues. Nurses recounted a faster and more positive transition into the manager role, and were more fully engaged in the managerial aspects of the role. We elaborate further on these findings below. We have organized the findings in three sections: transitioning into the managerial role, doing clinical management, and views on being a clinical manager.

Transitioning into the managerial role

Doctors and nurses differed in how they experienced the transition into the managerial role. Participants with a medical background gave descriptions of conflicting feelings and a stronger identification with their professional background. The passage below, taken from an interview with a department manager, illustrates both of these themes:

> Participant: I would say that I am first and foremost an academic, then a doctor. And then a manager. But you do of course grow, having been a manager for seven years, it does something to you. I have grown, changed a little, and maybe not for the positive.
>
> Interviewer: In what way, for example?
>
> Participant: Well, it´s about gaining a bigger acceptance for the motive for doing things, for example that we can ´t afford it and we can´t do it, than I would have had before.

A surgeon mentioned a sense of disillusionment when taking the position as department manager. He told that he had been naive when accepting the job as a manager, as he had expected to use more time on clinical activities than on administrative tasks. Regardless, he held the position for almost eight years, in order 'not to let the others down', as other clinicians were not eager to take the position, and he did not want to impose the role on one of his colleagues.

Some doctors spoke of a sense of increased responsibility and an ability to see the larger picture after taking the manager role. A doctor who was three months into a department manager position told that he started to experience increased responsibility for length of stay: 'I feel much more responsibility for long lengths of stay, so I take much more care to send the patients out faster'.

Some doctors were about to terminate their clinical commitments, as they had concluded that it was not possible to combine clinical responsibilities with being a full-time manager. These participants had several years of experience in management and were managing large departments. One participant had received a request from his supervisor to terminate his clinical commitments, while the others had reached the decision themselves. The doctors described this transition as a 'sense of loss'. One participant said: 'No doctor does it with an easy heart. That´s just how it is'.

> In contrast, nurses recounted a faster transition into the manager role and described it as a positive transition from being a clinical nurse, as illustrated in this quote:

> So, it kind of became like that, with time, after ten years of working shifts and having small, crying children, I thought that I have to become something when I grow up, so maybe I should become a manager.

Doing clinical management

Participants emphasized that being available for, and being able to listen to their staff, were important characteristics of being a good clinical manager. Administrative work was usually described as 'boring', and something that interfered with their attempts at being good leaders. Some told that they would have liked to be more visible and engage in more small talk with their staff, but that they instead ended up doing administrative work because they were being measured on administrative activities by top management.

Participants spoke of their professional background as personal assets in their role as managers and expressed a sense of pride related to their background. While nurses told that their clinical background gave them an understanding of their organization and the work that staff carried out, doctors spoke of their clinical background as important for maintaining authority. In particular, managers in surgical departments emphasized that they had to be competent in their profession to maintain legitimacy and trust among medical staff. Therefore, they attempted to retain a considerable clinical workload, and to do research on the side, as illustrated below:

> Participant: I have to be unassailable with regard to the profession, I believe, to be a good manager at this level. People can´t say that you don't know how to do this, I have seen you standing there with shaking hands, you can´t do anything, I can´t have it like that. [...] And I also have to be active academically, some research and publications and lectures and those kind of things, I have to continue with that.

> Interviewer: How long could you in theory stay away from your profession, just working as a manager? Before you lost respect?

> Participant: I wouldn´t feel comfortable, I need to do these things. Preferably on a regular basis.

While doctors argued that retaining clinical work was necessary for maintaining respect and legitimacy, they also told that it gave a sense of meaning and satisfaction. This was also indicated through observations of the participants. During one of the field observations, a department manager who had cut back on her clinical commitments due to increased administrative work, came smiling back from a patient consultation and said: 'Now I remember why I like surgery so much'. Observations of the participants also showed that managers with a medical background stepped in for other doctors in case of sickness absence or leave. When one of the department managers went into the ward, he was greeted by nurses who praised him for being a manager who consulted patients. In contrast, nurse participants did not usually retain clinical commitments, although some would help out with simple patient related tasks if the situation called for it, for example if there was sickness absence among staff.

While doctors were reluctant to show signs of weakness in front of colleagues, nurses were less concerned about not being perceived as experts by other nurses. When some of the

nurses helped out with patient-related tasks, they would communicate clearly to the staff which tasks they were not qualified to perform, as illustrated in this quote:

> I have also been out and worked on weekends if there´s been a crisis [with the staffing] and they need someone with nursing experience. But I have gone out and said that I can´t be an expert at everything, I can´t, so I have to trust that you have the competence. […] So if I go out and work, then I ask, then I have to ask those out there.

Another nurse believed that helping out in the clinic, while also admitting her shortcomings, served to increase her legitimacy as a manager:

> It´s got something to do with legitimacy. I always say that I can sit here and take the phone and write notes. I can´t make any (clinical) decisions, but I can help you. And you can come to me and discuss a problem, but I can´t solve it, because I don´t know the professional field well enough […] That I can do those practical things for them, and then they see that I´m a person that can support them in situations where they are busy, and I think that has something to say for their attitudes towards me as a manager, that I can help out when it´s needed.

The quotes above serve as contrasts to how doctors described the need to demonstrate clinical competence. A surgeon who had become a full-time manager spoke of how he still attempted to demonstrate clinical competence in meetings with staff:

> I show up on morning meetings. I show myself in the intensive care unit and in radiography, as long as I don´t have meetings that prevent me from going. I try to be a part of, or at least to <u>simulate</u> (emphasized by the participant) that I am part of the clinical activity. And I participate in discussions, I break through, show that I know the profession.

Views on being a clinical manager

We found that participants could be categorized into three groups - positive, ambivalent and negative - based on their attitudes and motivations towards being in a management role. Some participants held on to their managerial position because they perceived it as enjoyable and meaningful. The positive group of doctors spoke of themselves as managers first and doctors second. Participants cited the enjoyment of being able to plan their own workdays and influencing decisions as a key factor in sustaining their management position. These participants used the word 'fun' to describe their work and stated that management had become more fun as they had gained more experience and become more competent in management. Participants in this group had several years of experience as managers and held

few clinical commitments. A department manager with a medical background told that he was 'too old to do anything else', and did not consider other viable options to the manager role.

> Interviewer: Have you thought about how long you want to continue (in management)?

> Participant: It´s a frightening thought to stop working, I will at least work until I become sixty-seven, that´s for sure. But I would perhaps want to step down a bit and work four-day weeks. With one day off. But that´s not compatible with being a manager. So then I would have to go over to a supporting or advisory role, but it´s management that I´m good at. That´s what I know best. So […] I know that I would most rather want to be a manager.

Other participants were ambivalent towards their managerial role. Although they found enjoyment in influencing decisions, they also spoke of a desire to be closer to the staff and to reduce the amount of administrative work. Some experienced the job as lonely and told that they would have liked to have a mentor or colleagues with whom they could share their experiences. They described a sense of being left to themselves in the managerial role, with few social arenas for meeting other clinical managers. Some wanted to prioritize activities that they were the most competent in, namely clinical and academic activities, as these were perceived as more interesting. Activities in which they had less experience and competence, such as finance, were considered as a less rewarding part of their role, as illustrated by this statement:

> The economical bit is perhaps the one that I think is the hardest, also because my competence is low, you know, with my background that´s of course where I have the least competence. While profession, and developing the profession, that´s interesting to do I think.

The third group of participants were frustrated with the managerial role. They experienced little freedom in how they could enact the role, because of a high amount of administrative work and a lack of support staff. A nurse was recruited into management as part of a formalized system in which nurses at the department took turns holding a section management position for a year. She experienced a reduced sense of freedom in the managerial role and illustrated this by comparing the managerial position to her previous position as a clinician with responsibility for the professional development of the nursing staff:

> Some days it´s administration and administration and administration and administration. And then you <u>have to</u> (emphasized by the participant) sit here (in the office). So there´s no choice. But as a nurse in charge of the professional development of the nursing staff you have a whole other type of freedom. You lead in a more informal way. You´re available, you have a hands-

on approach, you´re out with your colleagues. You´re a good role model, how do we greet the patients, how do we talk to the patient, how do we document what we do. You know, you can be out there. And you can´t do that as a manager.

A common feature of participants in this group was that they spoke of themselves as 'doctor/nurse first and manager second'. A sense of pressure was involved in why they held on to the manager role. A surgeon who had held a manager position for several years had requested to participate in a formalized management training program to develop his management skills and find interest in the administrative side of the role, which until then had left him with disdain. The management program did not change his view of administrative work, but he recounted a sense of pressure to continue in management because of his earlier request.

> When I was [later] presented with a kind of fait accompli - taking the position as department manager – […] I kind of had to, with the management program in my hand, then I couldn´t really say no to apply for the position as manager.

Other participants in this group spoke of the managerial role as a form of extension of their professional identity, serving as a means to protect or promote their professional sub-discipline. The following account was given by a surgeon who was initially prepared to leave a department manager position after several years in the role:

> I had already been a manager for over six years, so I thought that it was perhaps time for someone else to have the job, and for me to return back to the clinic. But […] I believed that the other applicants would not be very enjoyable to work under.
>
> Interviewer: Because of their professional background?
>
> Because they are nurses.

Observations validated the accounts that participants gave about their experiences of being in the manager role. Accounts that participants had given in interviews were also made in discussions with professional colleagues and staff, indicating consistency in attitudes.

Discussion

Professional identity

We found that doctors and nurses approached their managerial role differently. Doctors maintained their professional identity in the enactment of the role as clinical manager, a finding that follows Montgomery´s (2001) argument that doctors in management roles enhance, rather than replace, their clinical identity, by incorporating the management role into their professional identities. According to Berg (1996), doctors have traditionally wanted to manage and lead, but they prefer to view leadership as the continuation of their own medical role, instead of a separate, managerial discipline. Our results expand on these notions, by suggesting reasons for why doctors retain their professional identity. We found that the motivation for maintaining a professional identity was twofold. Firstly, participants derived a sense of meaning and satisfaction from clinical work, emphasizing autonomy, competence and acknowledgement from colleagues and staff. The notion of clinical practice as a rewarding and reinforcing activity could help explain why clinicians continue to emphasize their professional identity when becoming managers.

Secondly, our results suggest that doctors´ understanding and conceptualization of the manager role is closely related to their professional identity, as there was a belief that competent managers needed to have authority and legitimacy among staff. This authority was derived from a professional, as opposed to a managerial, background. The perceived importance of professional identity in the enactment of the manager role could explain why some clinicians are ambivalent towards adopting a managerial identity. In contrast, nurses sought to derive legitimacy by de-emphasizing their professional competence and actively communicating their professional shortcomings to the staff. According to nurses who were interviewed by Currie and colleagues (2010), they are 'socialized into roles where they are dependent upon others´ clinical decisions, rather than exercising clinical judgment themselves' (p. 949). This might explain why nurses place less importance on demonstrating clinical competence. In addition, they might seek to distance themselves from the clinical role, instead emphasizing the managerial role, which is linked to more autonomy, status and authority (Johansen and Gjerberg, 2009). Bondas (2006) studied nurse managers in Finnish health care organizations and found that the thought of quitting the current job and returning to nursing was related to "feelings of shame of their careers sliding downwards" (p. 336).

The de-emphasis on clinical competence contrasts with how doctors seek to demonstrate clinical competence in order to earn, and continuously renew, their authority as a clinical manager. Ebaugh´s (1988) theory about role exit holds that individuals 'tend to maintain role residual or some kind of "hangover identity" from a previous role as they move

into new social roles' (p. 5). The author found that the more personal involvement and commitment individuals had in their former role, the more of this residual tended to manifest itself into the new role. Doctors develop a strong professional identity through the socialization that takes place during medical education (Pratt et al., 2006). Freidson (2001) emphasizes the deep sense of solidarity and community among all those who have passed through it. The time and effort involved in developing a medical identity, and the continued focus on maintaining clinical competence, suggests that doctors bring a stronger hangover identity into the managerial role than what nurses do. Furthermore, doctors are socialized into viewing management and leadership in form of individual traits and attributes, in which medical knowledge and experience constitutes an integral part. Thorne (1997) writes that doctors expect clinicians in management positions to be the best among equals. This mindset encourages doctors to maintain their medical identity in the role as clinical manager. In contrast, there is an idea among nurses that 'being a nurse with good clinical skills and expertise does not necessarily equip you to become a good manager' (Sambrook, 2006, p.57). Viitanen and colleagues (2007, p. 120) studied first-line nurse managers in Finland and found that the management frameworks they took on reflected their professional background and culture as nurses, emphasizing 'nurturing, looking after and concern, only the target being a subordinate instead of a patient'.

Psychological needs and role transition

Psychological needs were a recurrent theme in the interviews and observations. Participants who were positive towards the managerial role spoke of having freedom to plan their own workdays and the ability to influence decisions. They also spoke of themselves as being competent in the managerial role. Participants who were ambivalent or negative towards the managerial role spoke of having little freedom in the role and a lack of social support.

According to self-determination theory, humans are inherently directed towards activities that satisfy psychological needs and will tend to orient away from activities that thwart those needs (Ryan and Deci, 2000). Deci and Ryan (2000) have argued that human beings have three basic psychological needs: autonomy, relatedness and competence. Satisfaction of these needs facilitates intrinsic motivation for a task (i.e. doing the task because of enjoyment and interest in the task itself), while inadequate satisfaction undermines intrinsic motivation. Studies on need satisfaction have found positive relations between

satisfaction of psychological needs and factors such as job satisfaction (Ilardi et al., 1993; Vansteenkiste et al., 2007), job engagement (Deci et al., 2001) and identity formation and commitment (Luyckx et al., 2009). Need satisfaction, as depicted by Deci and Ryan (2000), might have a part in sustaining clinicians´ motivation to engage in and identify with the managerial role. Based on the arguments above, doctors and other clinicians who experience a lack of need satisfaction in the managerial role might choose to emphasize tasks that provide a stronger sense of accomplishment, relatedness and autonomy, and thus orient away from what Gouldner (1957) has termed a 'local', managerial identity, towards a 'cosmopolitan' identity. While 'locals' tend to be less committed to professional skills and hold stronger loyalty towards the organization, 'cosmopolitans' are characterized by a strong identification and commitment to professional values and skills. A somewhat similar notion has been proposed by Fulop (2012), drawing on work from Carroll and Levy (2008), who claims that clinicians come with a 'hard-wired' or 'default' identity of leadership - rooted in a professional mindset - to which they may turn when confronted with change and uncertainty. Relating this to a hospital setting, clinicians might continue to hold on to the formal position as clinical manager while turning to their professional identity where they feel more competent and autonomous. Indeed, some of the participants in our study described themselves as doctors first and spoke more positively about activities that they had a stronger interest and competence in, such as clinical and research activities. Clinicians who experience need satisfaction in their managerial role, however, are more likely to perceive the managerial aspects as enjoyable and fulfilling, and are thus more likely to develop and incorporate a managerial identity, as did participants in our study.

Combined with the results from our study, the need satisfaction perspective could help explain why some clinicians continue to engage in and identify with the professional role after becoming clinical managers, especially when the professional role offers a strong sense of autonomy, relatedness and competence. Doctors in our study appeared to achieve a strong sense of competence and acknowledgement from engaging in their professional role. Doctors have also traditionally enjoyed a high degree of autonomy or 'clinical freedom' (Doolin, 2002). In this regard, there might be more at stake for doctors than for nurses and other clinicians working in positions that generally provide less need satisfaction.

Methodological considerations

Witman and colleagues (2011) argue that there is a systematic bias in the literature on clinical managers, as most of the research is based on interviews, with little emphasis on observations. The fact that we were able to observe participants in meetings with staff and other professionals gave us an opportunity to observe possible discrepancies in verbalizations and behaviors. It also enabled us to analyze views in a more nuanced manner. Observations validated the accounts that participants gave in interviews about their experiences and enactment of the manager role. Another strength of our study is that we explored both doctors and nurses´ views and experiences in the same organizations, which allowed us to pinpoint differences between managers with different professional backgrounds. Although there will be individual exceptions, we believe that our findings are transferable to other countries, as clinicians, and especially doctors, often have similar socializations into their professional role. The difference in education and status between doctors and nurses is also similar. Although we have suggested that need satisfaction could play an important part in successful role transition, we were not able within the design of the present study to test this hypothesis. Future studies could quantitatively compare the degree of need satisfaction experienced by clinicians in manager roles versus their respective professional roles. Researchers could also apply a longitudinal approach by following the same individuals over several years and exploring factors that influence transitions in identity. Lastly, we also found that doctors recounted a sense of loss involved in terminating clinical commitments. Coupled with results from other studies (e.g. Ham et al., 2011), this appears to constitute a general pattern among medical managers and can be understood from the strong sense of meaning and purpose derived from doing patient related work (Pratt et al., 2006). Although the sense of loss did not constitute a general theme among the nurses in our study, similar experiences might be involved when other health professionals take on managerial roles. This could be studied further.

Implications

Management programs aimed at clinicians who take on managerial responsibilities have traditionally emphasized the development of specific competencies, skills and techniques. Our findings suggest that health care organizations should acknowledge the importance of need fulfillment in the managerial role. Need fulfillment may be associated with effective identity building and role transition. The role as manager needs to become part of one´s self-identity in order to sustain interest for the years required to develop and practice complex management skills. If clinicians are to develop an interest in management, and subsequently

develop a complex identity, taking on management responsibility should be seen as contributing to need satisfaction, rather than thwarting it. Management programs should also acknowledge the sense of meaning and purpose imbedded in the professional role, and that this could create a feeling of loss when clinicians move into management positions.

Conclusion

Our study suggests that the inclusion of aspects from identity and need satisfaction literature could enrich studies of clinicians´ transition into managerial roles. Our study suggests that need satisfaction might have a part in sustaining clinicians´ motivation to engage and identify with a managerial role, and thus developing a complex identity. Organizational efforts to engage clinicians in management need to acknowledge the professional identity they bring into the managerial role, and the specific barriers that need to be addressed in order to support the transition into a new identity. Our results indicate that aspects related to re-socializing and identity should be included in management development programs.

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RESEARCH ARTICLE   **Open Access**

Clinicians in management: a qualitative study of managers' use of influence strategies in hospitals

Ivan Spehar*, Jan C Frich and Lars Erik Kjekshus

Abstract

Background: Combining a professional and managerial role can be challenging for doctors and nurses. We aimed to explore influence strategies used by doctors and nurses who are managers in hospitals with a model of unitary and profession neutral management at all levels.

Methods: We did a study based on data from interviews and observations of 30 managers with a clinical background in Norwegian hospitals.

Results: Managers with a nursing background argued that medical doctors could more easily gain support for their views. Nurses reported deliberately not disclosing their professional background, and could use a doctor as their agent to achieve a strategic advantage. Doctors believed that they had to use their power as experts to influence peers. Doctors attempted to be medical role models, while nurses spoke of being a role model in more general terms. Managers who were not able to influence the system directly found informal workarounds. We did not identify horizontal strategies in the observations and accounts given by the managers in our study.

Conclusions: Managers' professional background may be both a resource and constraint, and also determine the influence strategies they use. Professional roles and influence strategies should be a theme in leadership development programs for health professionals.

Keywords: Norway, Professions, Power, Roles, Managers, Health care, Doctor, Nurse

Background

There has been an increased emphasis on engaging clinicians into management [1]. While the focus on efficiency, effectiveness and quality of care has played a role in public discourse, others point to the engagement of clinicians being critical to successful healthcare reforms [2]. There have also been attempts to co-opt clinicians into management roles in response to the shortcomings of New Public Management and professional resistance towards top-down initiatives and directives [3-5]. Researchers have argued that policy makers fail to understand professional social structures that could threaten the effectiveness of policy drives and management reforms designed to engage clinicians in management [6,7]. Resistance to change and conflicts in health care organizations may be rooted in power struggles and the organizational structure. There has been little research on the ways in which managers with a clinical background exercise influence. Understanding more about the factors that determine their influence strategies may be important for training and support.

In Norway, a new law required unitary management at all levels in hospitals from 2001 [8]. Previously, hospitals had been run by doctors and nurses in two parallel hierarchies. Unitary and "profession neutral" management was enforced to strengthen accountability and professionalize management. Managers became responsible for all employees in a department, and a manager with a nursing background would be managing the doctors in a department and vice versa. The model departs from governance models commonly used in other countries, where the main responsibility for running clinical departments usually lies with a doctor, either alone or together with a general manager and a nurse [9]. The Norwegian case represents a unique opportunity to study the variations in influence strategies used by managers with a clinical background.

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Aim of the study

We did a study to explore influence strategies used by doctors and nurses who are managers in hospitals with a model of unitary and profession neutral management at all levels.

Theoretical perspectives

Hybrid management

The terms "hybrid leadership" and "hybrid management" have been used to describe managers who combine a professional background with managerial skills and responsibilities [5,10]. Within healthcare, the term "hybrid" reflects an underlying assumption that medicine and management represent two different logics, and that a hybrid manager is able to embody, translate and mediate between the logics of management and medicine [5,11-14]. The term is used to refer to doctors [10], but has also been used to describe nurses and other professionals [15,16]. Savage and Scott [17] have defined hybrid management as "a new type of management in which non-medical health care professionals engage in aspects of general (or 'generic') management, combining this with their clinical management responsibilities". While there are national differences in how clinicians have reacted to top-down initiatives, new hybrid roles have appeared in several countries, including Denmark, Finland, England and Australia [4,14,18].

In this study, we focus on clinicians in formal management positions who may or may not retain a role in clinical work. These managers could also be described as "hybrids", as they combine a professional background with a formal position in management.

Influence and power

Power may be defined as "the ability to affect others' beliefs, attitudes, and courses of action" [19]. Hospitals are sites for continuous exercise of influence and power, including competition over resources, jurisdiction, tasks and mindsets [20-22]. The language of "battles" and "fights" has been especially apparent in the sociological literature, such as in the work of Abbott [20] on the system of professions and Freidson's [23] work on professionalism and professionals' claims of expertise. The literature on hybridity reflects these struggles, and Waring and Currie [24] have shown how managerial expertise can be detached from managers and drawn into professional practice, enabling professionals to extend their influence over management and avoid unwanted interference in their work.

Mintzberg [25] has described hospitals as "professional bureaucracies" in which power resides in expertise through knowledge and skills. These organizations are characterized by an inverted power structure, where front-line staff usually has more influence over daily decision making than those in formal positions of authority. Managers need to acknowledge this culture when negotiating with staff [26]. Braithwaite and colleagues [27] assert that their jobs "are more about negotiation and persuasion than command and control". French and Raven have published a typology of various power bases [28]: legitimate (having a formal position or title), reward (ability to compensate another for compliance), expert (superior skills, experience and knowledge), referent (perceived attractiveness) and coercive (ability to punish others for non-compliance). Informational power (potential to utilize information) was later added as a sixth power base [29]. Building on French and Raven's [28] framework, Northouse [19] distinguishes between position power, the power an individual derives from a position or status that embodies notions of legitimate, reward and coercive power, and personal power that embodies the notions of referent and expert power [19]. We hypothesized that a hybrid managers' professional background could have an impact on what power bases they had access to.

Role as resource

Roles are often defined as the behavioral expectations associated with and emerging from positions in a social structure [30]. Usually, structures will be a constraining feature of social roles, while interactionist perspectives highlight independence and agency in role-playing [31]. The theory of role as resource is an example of an agent-centered perspective. Baker and Faulkner [32] found that filmmakers used different roles, such as producer and screenwriter, strategically to gain legitimacy, underscoring that roles can be used as platforms for exercising power and influence. Callero [33] followed up on this idea, arguing that roles, being cultural constructs, could both facilitate and constrain. Roles enable access to cultural, material and social resources, and an individual in a given role can exploit these to pursue personal or group interests. Firstly, a minimum level of cultural endorsement or acceptance needs to exist for a role to be used as a resource. Stronger acceptance of the role increases its accessibility as a resource. Secondly, Callero [33] makes an analytical distinction between cultural endorsement and cultural evaluation. Although a role might be recognized and perceived as legitimate, it can simultaneously be evaluated in a negative light. Thirdly, roles with high prestige become more effective tools for gaining power. Callero argues that these types of roles tend to require long-term education (specifically mentioning doctors as an example), be severely limited in number, or require a highly valued commitment to the role.

Hybrid managers combine a professional background with a formal position or status as manager [1], and they often move in and out of roles [34]. The focal point of interest in our study is the manager's role as doctor or nurse. Doctors generally hold a high social and cultural

position within society [35]. Compared to nurses, doctors have higher income, longer education and more professional autonomy. Both professions have high degree of cultural endorsement, but evaluation and prestige is usually lower for nurses, a pattern seen in society in general, as well as in hospitals [36]. We believe that the differences in status may have an impact on how they use their professional role as a resource. We anticipated that there may be differences in their access to power, and, consequently, what strategies they use to exert influence. Viitanen and Konu [37] studied the leadership roles that were used by middle managers in Finnish health organizations, and nurses more often took on a mentor and facilitator role compared to doctors, who were more task-oriented. Furthermore, hybrid managers are located in-between a managerial and clinical mindset. While the former emphasizes a hierarchical approach towards power and influence, the latter emphasizes decentralized decision making [38]. We therefore expected that managers' influence strategies vary according to whether they seek to exert influence upwards (towards a managerial mindset) or downwards in the hierarchy (towards a clinical mindset).

Methods

Ethical approval

Ethical approval to conduct the study was granted by the Norwegian Social Science Data Services (ref: 23228/2/LT). Written consent to participate in the study was obtained from all of the study participants.

Setting and participants

Considering the explorative approach of this paper, we found a qualitative approach appropriate, and we did a study collecting data through individual interviews and observations of 30 managers with a clinical background. Norwegian public hospitals are organized in local health trusts, which could consist of several hospitals, and four regional health authorities. Our participants spanned across four public hospitals in two health trusts. One health trust had a five-level hierarchical management structure, consisting of the executive director of the organization, division managers, department managers, section managers and unit managers. The other had a four-level structure, excluding the unit management level but otherwise similar. The first author contacted division and department managers and asked for permission to contact potential participants directly through email and phone. In a few cases the superior forwarded our request directly to the participants, who then contacted the first author. We used a maximum variation sampling strategy in order to include a wide range of informants with a broad array of experiences. We sought variation in terms of hospital size (university hospital or local hospital), clinical specialty (internal medicine or

surgery), management level (department or section) professional background and gender. The sample includes 16 nurses, 13 doctors and a participant with another health care background. Characteristics of the participants are presented in Table 1. We recruited 20 managers from medical departments and 10 from surgical departments.

Data collection procedure

The interview guide was developed on the basis of theoretical studies and was revised based on data from two pilot focus group interviews with 20 clinicians in an executive program in health administration, and who did not participate in any of the subsequent interviews or observations. The first author, a doctoral student with a background in psychology, conducted tape-recorded, face to face in-depth interviews with all 30 participants at their workplace. None of these 30 had participated in the focus group interviews. The interviews lasted from 45 to 90 minutes. The first author also observed 20 of the participants (11 department managers, 9 section managers) in staff and management meetings and during informal talks with colleagues. The data was collected from March to December 2010. By combining interviews with observations, we were able to look for consistency and discrepancies in the stories that participants told, and gain more insight into how they were "doing" management. Observations were also important for understanding the actors' perceptions and interpretation of their own social world and generating independent insight into the organizational structures and work life. Observations were carried out on the same day as the interviews, and IS usually met up with the participants at the start of their work day and followed the participant throughout the day. The authors did not

Table 1 Characteristics of participants (N = 30)

Characteristics	No	%
Gender		
Female	17	(57)
Male	13	(43)
Age		
36-45	9	(30)
46-55	12	(40)
56-65	9	(30)
Management level		
Department	17	(57)
Section (includes nine first-line managers)	13	(43)
Mean age		
Doctors	55	
Nurses	49	
Other clinical background	40	

participate in clinical consultations with patients. Observations were documented in field journals and kept for later analysis.

Data analysis

Several steps were taken to ensure the quality of the analysis. We used NVivo8 computer software to facilitate the analysis of interview transcripts and field notes. The interviews were analyzed by systemic text condensation [39]. This approach followed four steps: (1) Reading all of the material to form an overall impression; (2) identifying units of meaning and subsequently coding for these units; (3) condensing and summarizing the contents of each coded group; and (4) generalizing the description and contents reflecting participants' attempts at exerting influence. Transcripts of several of the interviews were analyzed for content and structure by all three authors, resulting in general agreement on a coding frame. Field notes were analyzed independently for emerging themes and then assessed against findings from interviews, with special interest on observations that could validate, contradict or add additional insights to the interview data.

For the purpose of methodological and analytical clarity, we chose to focus the analysis mainly on accounts given by managers at the department level because they have similar assignments and responsibilities regardless of clinical background. While nurses usually have responsibility for a larger number of staff and allocate most of their time to staffing and scheduling shifts, doctors are able to allocate more of their time to medical and academic work. Experiences from interviews and observations of section managers have in some cases been included when relevant to our study aims. This includes section managers who had previous experience as department managers, or who recounted encounters with other department managers.

Results

Managers with a nursing background argued that medical doctors could more easily gain support for their views. Nurses reported deliberately not disclosing their professional background, and could use a doctor as their agent to achieve a strategic advantage. Doctors believed that they had to use their power as experts to influence peers. Doctors attempted to be medical role models, while nurses spoke of being a role model in more general terms. Managers who were not able to influence the system directly found informal workarounds. We did not identify horizontal strategies in the observations and accounts given by the managers in our study.

We have organized the results in two sections: the strategies that managers used to influence upwards in the management hierarchy (towards their supervisor and top management), and the strategies they used to influence downwards in the organization (towards section managers and the professional staff). Table 2 summarizes the variety of strategies used by the managers in our study, and how they relate to different bases of power. We describe these in detail below.

Influencing upwards

Participants told that they attempted to emphasize their employees' competence when arguing upwards in the organization. They believed that they had to present professional arguments in order to be heard, but also expressed distrust towards the higher level managers, feeling ignored or being misunderstood. A department manager with a medical background told how he had rearranged his working day to make a point:

> The management thinks that [our department] hospitalizes too many patients, based on some numbers from a few years ago. We hospitalize more patients than another hospital in our health trust. The other hospital sends them to another hospital and never sees them. It's a very complicated and expensive patient group, the other hospital doesn't have that at all, while it's a large part of our activities. […] And those numbers don't take into account the travel distance. Some patients travel three hours to get here. Elderly, complicated illnesses. Are we going to send them home again with a taxi? That's expensive.

Table 2 Examples of the variation in influence strategies used by managers in our study, and how they relate to different bases of power [28]

Influence strategy	Type of power
Upwards in the hierarchy	
Advance professional considerations/concerns	Expert
Use a doctor as one's agent to increase argumentative strength	Expert
Use different titles strategically	Expert
"Whine"/argue that "everybody else gets more resources"	Informational
Avoid shouting "wolf" too often	Informational
Sabotage	Coercive
Downwards in the hierarchy	
- Be a professional role model (e.g. performing surgery)	Expert
- Challenge arguments (e.g. "I have done this procedure before")	Expert
- Be a general role model (e.g. arriving early to work)	Referent
- Be a facilitator (e.g. doing the "crappy" work)	Referent
- Rephrase and redefine language	Informational

[They said] "we have to do something about it".
And then I said: "Ok, everything will go
through me. No one can hospitalize a patient to
this department without going through me".
I did this for several weeks. It didn't really influence
the number of admissions.

Interviewer: Did you communicate this to the top
management?

Yes, but it isn't so easy to, you know, what we are
talking about now are excuses. The figures
[emphasized by the participant] are there. They deal
with the figures. And then we have to show that we
are doing something about it. And what we do is
that I deal with these admissions myself.

The participant spoke of this as a form of "sabotage",
as a way of making his concerns visible and being heard
upwards, even though it prevented him from performing
his other managerial tasks: "It has influenced my work
day to the point where it has become almost impos-
sible". It was important for participants that their supe-
riors understood their work and the challenges they had
to manage. The manager took on these tasks because he
experienced that the management was only interested in
figures, without asking what was behind them. This was
a frequent concern, and utterances such as "the manage-
ment level above doesn't know our day-to-day reality"
were frequent. In cases where department managers
experienced that they were not able to persuade higher
level managers through professional or logical argu-
ments, they found ways of sabotaging or circumventing
the system, as illustrated above. There were also other
examples of workarounds and sabotage. A department
manager spoke of circumventing the system by calling
IT-support directly on their mobile phone. This was fas-
ter and more efficient than going through the formal
system for contacting technical support:

We have people we can use when we understand how
to circumvent the system. We have their private
mobile phone numbers and can call them unofficially
and say "you have to help me". "Well, I'm not allowed,
but I'll come". We make it work that way. But it's
absolutely unofficial and illegal. Because it's not
supposed to be like that. And they get reprimanded if
they help us, unless it's through the service phone or
the helpdesk phone.

During one of the observations, a department manager
with a medical background suggested to one of his sec-
tion managers that they could buy modern, experimental
equipment, and when other necessary equipment would

be broken, the health trust would have to replace that
equipment. This would be a way of ensuring additional
medical equipment, without having to use the existing
money on upgrading old equipment.

Budgets were described as something one had to "fight"
for. A manager with a nursing background told that she
had managed to "whine" herself into acquiring a new
member of staff, by saying "why should the other [depart-
ments] have more staff than us, when we have just as
much to do". Another participant spoke of the importance
of not complaining or shouting "wolf" too often, in order
to be taken seriously by one's supervisor.

Nurses in section management positions spoke of bene-
fits of having department managers with a medical back-
ground, because their department would stand stronger in
negotiations for budgets and resource allocations:

…and then you can say that in some battles it would
be an advantage or disadvantage if my supervisor was
a nurse or doctor, you know, will the nurse be as
strong in all situations and discussions as if the
person had been a doctor instead. Because the
doctors have strong credibility in the system.

Some managers with a nursing background used their
medical advisors strategically to carry their own agendas
across. An example is provided below:

And it happens sometimes, when I'm arguing for
certain issues, when I'm going into discussions with
groups of doctors […] I may consciously use the
senior consultant to strategically front my views.
There are some that think, or at least I think that a
part of the system regards your arguments as weak
when you don't have that medical background,
unfortunately. So I sometimes push the head senior
consultant [doctor] strategically in front of me
to win through (department manager with a
nursing background).

A section manager with a nursing background told that
she had sometimes used her job title strategically. Follow-
ing changes in organizational titles, her title had changed
from "department nurse" to "section manager". Although
she still used her old title, because she liked the connection
to her profession, she made sure to change from the less
powerful "department nurse" title to the more ambiguous
"section manager" to gain leverage in strategic situations:

What I have sometimes used it for, the section
manager title, is related to authority, it gives a little
more authority to say that you are a section manager,
I've experienced. For example, if we have to contact
the chief district doctor. I've noticed that another title

can be useful in those circumstances. Then you get more impact. I'm also a deputy for the department manager, so I've used that as well. I've had a sign where it said "deputy for the department manager".

Influencing downwards

A recurrent theme in the accounts given by the doctors, was the importance of being perceived as a competent clinician in order to be taken seriously by the medical staff. A surgeon described it with the following example:

> If a non-doctor attempts to take medical decisions it usually goes wrong. Not because the decisions are bad, but because they don't get support from below… and that's why it has been important for me to demonstrate that, yes, I am doctor, yes, I understand what we do and yes, I can contribute. And that's why I also made a point of going in and doing a complicated procedure, because nobody else were able to do it, because the guy who was supposed to do it was ill, and a patient coming from a city [1,600 kilometers away in distance] would have to be sent home. And then I did it, even if it messed up my day. Because it gives, you know, afterwards people talk about it and say "yeah, at least he is able to contribute and work", and that gives respect among surgeons.

Another influence strategy mentioned by participants with a medical background was to become good at a particular niche in their professional field. This served as a form of compensation for clinicians who had to cut back on the time spent in the clinic, because of increasing management responsibilities. "One strategy is to become very good at one specific thing, for example pacemakers. The doctors will say: 'well, he can't really do that much surgery, but he is really good with pacemakers'" (a department manager working within a surgical department).

Nurses were more concerned with profession neutral ways of appearing as role models. In the example below, a department manager with a nursing background told of the importance of arriving on time for meetings:

> The attitude one radiates, it influences, like expectations, you know. For example, when we meet in the morning at eight for joint meetings and when someone holds a lecture like today, then I think it's rude to arrive five or seven minutes late. It interrupts and it's impolite towards the person who has spent hours to prepare the presentation. It's obvious that if I come dragging myself in five six seven minutes late every day or every other day, it will give signals. That these things are ok to do.

Although nurses told that they were proud of their nursing background, they appeared to downplay their professional background, emphasizing instead their role as facilitators or someone who took care of the "crappy things" for the doctors. One of the department managers with a nursing background told that she was challenged by doctors on how they would be able to do clinical research in the department:

> When I began as a manager and was a nurse, then you hear that thing about "how are we going to do research in our department?" I say that I will facilitate so that you can conduct research. I will take all those crappy things outside, the practical things, you won't have to sit and talk with all these people about whether you need to fill out this or that form. […] They won't need to have to do all that. I think that's really important for the doctors, that they feel that someone can take all of those things and that they can do their own things. Facilitating, enabling them to do it.

Participants also spoke of the importance of having worked among front-line staff. A participant with a medical background commented:

> It's worth its weight in gold that I have worked on the floor, then I know as a manager how things work, and what's realistic and can say "it's not like you say". How can you prioritize between all the demands from the different section managers, if you don't know what goes on in the department and how useful the different devices are?

Observations of participants in meetings and in discussions with staff provided examples of how their professional knowledge and experience became relevant when confronted by staff. In one situation, a department manager with a nursing background "won" a dispute with a section manager (also with a nursing background), because the former had previous experience with a specific intervention that they were discussing. The section manager tried to argue against the current organizing of syringes in relation to the intervention, to which the department manager disagreed. The department manager effectively ended the dispute by stating: "I have done those interventions myself". While nurses generally appeared to downplay their professional background in negotiations with medical staff, this example illustrates that they could still use their nursing background strategically to "win" arguments against other nurses.

Participants did not only rely exclusively on their professional skills and experience in negotiations with staff. Observations of the participants also showed that both

doctors and nurses engaged in rephrasing. A department manager was observed in a meeting with his section managers. He explained that the hospital would only get one new anesthetic machine, but the section managers replied: "We need more". The department manager attempted to calm the situation by saying: "If we are going to have a 'who has it the worst', then [another hospital in the health trust] has it the worst". "We need more" was in this way redefined to "others have it worse".

Discussion

Role as both a resource and restraint
In this study, we were interested in exploring hybrid managers' use of influence strategies and power, trying to differentiate between influence strategies used upwards and downwards in the organization. Our data illustrate how a professional background may both be a door opener and a restraint for action in both directions in the hierarchy. Callero [33] has argued that when roles serve as resources, behavior may be limited and constrained because one is being denied access to other roles. Our findings are in line with this observation. Not having a medical background, nurses believed that their impact upwards in the organization was not as strong as that of doctors, and they found other ways of accessing expert power. Nurses could draw indirectly on expert power by "disguising" themselves as doctors, or by using doctors as their agents to gain strategic leverage. A different pattern emerged in the influence strategies employed downwards in the organizations. As pointed out by Currie [6], because of the medical hegemony in decision-making, nurses' influence over doctors is significantly reduced. We found that managers with a nursing background were able to draw on other types of power to achieve influence downwards in the organization. Nurses tried to be perceived as facilitators, by taking on administrative chores, thus shifting towards a referent power base.

While nurses were mostly restrained from acting on an expert base, a recurrent theme from interviews and observations of doctors was that they could not act *without* drawing on expert power. This was especially evident in the way that they sought to influence professional colleagues, which coincides with the expectations doctors have of professionals in management positions as the best among equals [40]. There appears to be a belief that simply having a medical background is insufficient for influencing medical colleagues. While a doctor might use expert power upwards in the hierarchy by virtue of being a doctor, in the same way as nurses might use a doctor as their agent, doctors believe that they have to maintain their clinical skills in order to retain credibility among peers e.g. [41,42]. Expert power is thus not earned once and for all, but had to be continuously reestablished and negotiated, which may represent a dilemma for

doctors. For example, if a doctor relied on position or referent power in managing clinical staff, the doctors' access to the expert base could be weakened over time as her or his status as an expert dwindled. Our findings suggest that roles do not serve to restrict behavior only because they constrain access to other roles (e.g. nurses being denied the role of doctor), but also because of the inherent expectations towards the role holder (e.g. doctors in leadership positions being perceived as the best among equals).

Roles, power and influence in a hospital setting
Our results reflect the authoritative coordination mechanisms found in hospital settings, and how managers within this setting are influenced by those mechanisms. Although our participants had some freedom in choosing influence strategies, the strategies seemed to be determined by the power bases they could access. More specifically, the emphasis that the participants placed on expert knowledge limited the influence strategies that were available. While some power bases, such as expert knowledge, are not exclusive to healthcare organizations (they area also relevant in other professional bureaucracies, such as in universities and law and accounting firms), they reflect some of the institutionalized rules and norms that exist in a healthcare context, i.e. that power lies in expertise [43]. Legitimate power, understood as formal authority, appeared to be less visible in the strategies used by managers in our study. Clinicians, and especially doctors, might perceive an experienced or merited doctor to have the legitimate right to influence them. This could explain why hybrid managers tend to draw on personal power, rather than position power in dealing with clinical staff [19]. Position power is not very effective upwards in the hierarchy either, as a manager at the department level is placed below in the formal hierarchy. Thus, not using position power reflects the separate worlds in hospitals [44], where managers simultaneously inhibit the world of the formal management hierarchy and an informal, meritocracy based world. Position power seems not to be very effective in either.

Numerato and colleagues [3] did a comprehensive review and argued that the dynamics and interplay between management and professionalism could be classified in five ideal outcome categories: (1) managerial hegemony; (2) co-optation; (3) negotiation; (4) strategic adaptation; and (5) professional resistance. Hybridization occurs in between hegemony and resistance, through the merging of managerial and professional skills, values, tools and knowledge. In our study, managerial hegemony and professional resistance was demonstrated through doctors sabotaging or circumventing the system in response to "unyielding" managers. Our results do not demonstrate examples of professionals taking on managerial or bureaucratic

tools and logics. Adaptation was instead demonstrated by the nurse who used a doctor as an agent and the nurse who used different job titles strategically. This reflects Noordegraaf's [45] description of healthcare organizations becoming "ambiguous domains" in which expertise can no longer be isolated from other experts [45].

Where are the horizontal strategies?

Our study suggests that clinicians might resort to using sabotage or finding informal and "illegal" workarounds. Although these influence strategies do not necessarily constitute a conscious attempt to punish top management, they have a coercive element, threatening to punish the whole organization. Further, these reactions appear more individualistic than collectivistic in nature. Indeed, a somewhat surprising finding was that we found no examples of horizontal strategies in the interviews and observations of the managers in our study. Participants appeared to be concerned mainly with their own department or professional sub-discipline, and more often spoke of other departments or hospitals in terms of "competitors" rather than "collaborators".

Johnson [46] argued that coalition building, in the sense of gathering influential people together, plays a vital part in building power and influence. Ganz [47] tells the story of grape workers' ability to mobilize support from other communities through building horizontal coalitions. A similar influence strategy in a hospital setting would be to mobilize support from peer department managers, but this strategy was not present in our data. One explanation may be that that coalition building fails when managers are too focused on their own functional silos [46]. It should be noted that a number of Norwegian hospitals have organized doctors and nurses in separate units following the implementation of unitary management, so that managers at the lower levels of the organization only manage their own professional group. For example, a study of Norwegian health trusts in 2009 revealed that 60% of all hospitals had separated the bed units as independent units with their own management [48]. Edmonstone [11] underscores that clinicians are trained to think on a micro-level, with clinical leaders having a micro-view focus on patients and patient service. In a sense, professionals become competitors and representatives for their own professional unit.

Practical implications

Various authors have pointed out that policy makers fail to understand the social structures that exist in professionalized contexts [6,7,49,50]. The results of our study could inform policy making in this area. Our study highlights some of the institutionalized rules and norms that exist in hospitals, namely the perception that power lies in expertise and that managers with a clinical background

are more likely to draw on expert power than on formal position power. While nurses are restricted from directly accessing expert power, doctors are in a sense also restricted - not from accessing expert power, but from avoiding to do so - because of the importance they place on being perceived as professional role models. Decision makers and top managers need to acknowledge the social structure in hospitals and the challenges facing managers with different backgrounds, before implementing new management models and responsibilities. Our study suggests that professional roles and influence strategies should be a theme in leadership development programs for health professionals.

Methodological considerations and further research

Witman and colleagues [42] point to a systematic bias in the literature on managers in healthcare, in that most of the research is based on interviews, with little emphasis on the use of observations. By using observations, a researcher can generate a partially independent view of the experiences that respondents draw on to construct their realities [51]. The fact that we were able to observe participants throughout their work day gave us an opportunity to produce a greater pool of data and to observe possible discrepancies between what our informants said and did. Observational data confirmed and provided additional examples of themes that emerged from interviews. Another strength of our study is that we explored both doctors and nurses' views and experiences in the same organizations. A limitation of our study is the high proportion of male doctors and female nurses. It would be ideal to have more variation in terms of gender and professional background. We asked participants about their perception of the role of gender in relation to management and power, and they did not perceive it to be important. We believe that our results are transferable outside of the Norwegian context, as professional hegemonies are common in hospitals and other health care organizations [6] and access to power is therefore likely to follow from one's professional background, regardless of national context. We have also answered Baker and Faulkner's [32] request for the utility of the theory to be explored by applying it to more complex organizations. We applied the theory to a professionalized context and developed it further by combining it with literature on hybrid managers and power.

Future studies could investigate our findings further, for example by addressing the access to and use of power bases by general managers in health care organizations. It would also be interesting to investigate the conditions under which horizontal strategies are more and less likely to be used. Lastly, we found examples of managers circumventing and sabotaging the system. Although we deemed it beyond the scope of our paper to discuss these findings in more detail, we encourage other authors to

take on a more comprehensive study of these phenomena in hospitals. Possible research questions include in what ways the formal organization of hospitals promote the use of these strategies, and whether hospitals (and other health care organizations) could be organized so that strategies which are useful for the individual are also useful for the organization.

Conclusions

Managers' professional background may be both a resource and constraint and determine the influence strategies they use. Professional roles and influence strategies should be a theme in leadership development programs for health professionals.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
All authors were involved in the design of the project. IS carried out the observations and interviews. JCF and LEK provided assistance with coding and analyzing data from the interviews. The drafts of this article were revised critically by all authors. All authors have approved the final version of the manuscript.

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