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THE MANAGER ROLE IN RELATION TO THE MEDICAL PROFESSION

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ABSTRACT

Background: Managers and physicians have two important roles in healthcare organisations. However, several studies have identified problems in the manager–physician relationship and more knowledge is needed to improve the situation. Using theories on organisation, professions, and role taking to inform thinking, this thesis addresses one aspect of the manager-physician relationship, namely how managers handle their role in relation to the medical profession. This was studied in the context of sickness certification, a frequent and problematic task for many physicians in Sweden.

Aim: The aim of this thesis was to increase the knowledge about how managers in Swedish healthcare organisations handle their manager role in relation to the medical profession.

Methods: The empirical studies (I-IV) build on one another. Focus group discussions with 26 physicians (I), two questionnaires to all board-certified specialists in Stockholm county (n=2497, resp. n=2208) (II), individual interviews with 18 county council chief executive officers (CEOs) (III), and interviews with 38 healthcare managers (20 clinical department managers (CDMs) and the same18 CEOs as in study III) (IV) constitute the database for the thesis. Qualitative methods were used to analyse data in three of the studies: content analysis (I), grounded theory (III), and linguistic discourse analysis (IV). Descriptive statistics were used in study II.

Results: The problems physicians described in their work with sickness certification could be classified into four categories: the design of the social insurance system, the organisation of healthcare, the performance of other stakeholders, and the physicians' own work situation. Although all of these concern policy issues and managerial responsibility on different structural levels in healthcare, the role of managers was absent in the physicians' discussions (I). When specifically asked about management of sickness certification issues, the majority reported lack of both substantial management support and a well-established workplace policy (II).

With these findings as a point of departure, studies III and IV addressed managers' role taking. In many ways managers themselves contributed to making the manager role weak and absent in relation to the medical profession (III, IV). The CEOs had a strong focus on physicians and physicians' behaviour rather than on their own managerial behaviour or that of their subordinate managers. When strategies for managing physicians were addressed, many described physician-specific strategies that led to a paradox of control in relation to the medical profession - the pragmatic strategies helped managers to manage physicians in daily work, but seemed to weaken the manager role in the organisation (III). Few managers used a management-based discourse to construct the manager role. Instead, a profession-based discourse was predominant, where managers frequently used the attributes "physician" or "non-physician" to categorise themselves and other managers in their manager roles. Some managers also combined the two discourses in a "yes, but..." approach to management

in the organisation. Expressions of a mutually shared manager community were almost totally missing in the managers' statements (IV).

Conclusions: The results show that managers have a weak, partially absent, and rather ambiguous manager role in relation to the medical profession. How the manager role is handled and regarded within healthcare organisations constitutes part of the organisational conditions for the role taking of managers, physicians, and other healthcare professionals. The findings indicate that there is a need to support healthcare managers in their role taking in the organisation - both those managers who also are physicians, and managers with other underlying professions. Management aspects regarding sickness certification tasks also need to be strengthened. A weak and ambiguous manager role may have negative consequences not only for the work of managers, but also for that of physicians and other healthcare professionals, and for the quality of care.

Key words: healthcare management, manager-physician relationship, manager role, medical profession, managerial role taking, sick leave, sickness certification practice, Sweden.

SVENSK SAMMANFATTNING

Bakgrund: Under de senaste decennierna har sättet att organisera och leda sjukvård genomgått stora förändringar. Bland annat har förbättrade behandlingsmetoder och stora medicintekniska framsteg lett till ett behov av att effektivare administrera alltmer komplexa vårdprocesser och patientflöden, prioritera utifrån begränsade resurser, samt säkra kvalitet och vård på lika villkor för befolkningen. Genom flera politiska reformer, i Sverige liksom i andra västländer, har chefer parallellt med denna utveckling formellt getts ett ökande inflytande över sjukvården. Många studier har lyft fram hur detta har skett på bekostnad av läkares professionella inflytande och skapat problem i relationen mellan chefer och läkare. Behovet av att förbättra situationen har uppmärksammats i flera vetenskapliga artiklar och debattinlägg, både nationellt och internationellt de senaste decennierna. Emellertid finns det ännu endast begränsad kunskap om hur chefer hanterar sin chefsroll i relation till läkarrollen i organisationen.

Övergripande syfte: Med utgångspunkt i tidigare forskning samt teorier om organisation, profession och rolltagande, var avhandlingens övergripande syfte att få ökad kunskap om hur chefer i svensk sjukvård hanterar sin chefsroll i relation till läkarrollen. I avhandlingen har detta studerats i kontexten av en vanligt förekommande och problematisk uppgift i läkares kliniska praxis, nämligen hanteringen av patienters sjukskrivning.

Delstudiernas syften: Den övergripande analysen i avhandlingen baseras på resultaten från fyra empiriska studier (I-IV). Studie I och II undersökte chefers rolltagande utifrån läkares perspektiv med ett tydligt fokus på läkares sjukskrivningshantering. I studie III och IV togs ett chefsperspektiv i undersökningar av chefers rolltagande i relation till läkarrollen mer generellt. De enskilda studierna bygger på varandra och hade följande specifika syften:

Studie I: Att identifiera vilka problem läkare upplever i sitt arbete med sjukskrivningshantering

Studie II: Att undersöka i vilken utsträckning läkare i Sverige har tillgång till en policy på sin arbetsplats samt stöd från sin chef i arbetet med patienters sjukskrivning

Studie III: Med utgångspunkt från resultaten i studie I och II var syftet att undersöka hur de högsta cheferna för svensk sjukvård ser på ledning av läkare, och vilka implikationer det kan ha för chefsrollen i relation till läkarrollen i organisationen

Studie IV: Med utgångspunkt från resultaten i studie III var syftet att söka fördjupad kunskap om hur cheferna själva, i sitt sätt att tala om läkare, bidrog till att skapa (konstruera) bilden av chefsrollen i relation till läkarrollen i organisationen

Metod: Studie I bygger på data från fokusgruppintervjuer med 26 läkare från olika delar av landet och från olika medicinska specialiteter. Studie II bygger på data från två enkäter till alla läkare i Stockholms län 2004 och 2008. Av dem som svarade på

enkäten inkluderades samtliga specialistutbildade läkare yngre än 65 år som arbetade vid en klinisk verksamhet och hade sjukskrivningsärenden minst några gånger om året (2004: n=2497, 2008: n=2208). Studie III bygger på individuella intervjuer med 18 av Sveriges 20 region- och landstingsdirektörer (LD). Baserat i resultatet från Studie III genomfördes en utökad studie (IV) där också intervjuer med 20 verksamhetschefer inkluderades. Kvalitativ metod användes för att analysera data i tre av studierna; kvalitativ innehållsanalys (I), en "grounded theory"-ansats (III), och lingvistisk diskursanalys (IV). Deskriptiv statistik användes i studie II.

Resultat: De problem läkarna beskrev i sitt arbete med sjukskrivning kunde delas in i fyra områden: utformningen av sjukförsäkringssystemet i stort, hur sjukvården och olika processer inom sjukvården var organiserade, hur andra aktörer som var inblandade i sjukrivningsprocessen agerade, och läkarnas egen arbetssituation. Trots att samtliga problemområden berör övergripande policyfrågor och chefers ansvar på olika nivåer inom sjukvården, var chefsrollen helt frånvarande i läkarnas diskussioner (I). När vi i enkäten till specialistläkarna i Stockholms län specifikt frågade om ledning av sjukskrivningshantering beskrev majoriteten att de inte hade tillgång till en väl etablerad policy eller tillräckligt stöd från sina chefer (II).

Med utgångspunkt i den frånvaro av chefsrollen som framkom i studie I och II, undersöktes chefernas rolltagande i studie III och IV. På flera sätt bidrog cheferna själva till att göra chefsrollen svag och osynlig i relation till läkarrollen (III, IV). När de högsta cheferna i sjukvården ombads att beskriva ledning av läkare i sina organisationer, beskrev nära hälften av uttalandena ”hur läkare är”, snarare än strategier för att leda dem. I de fall ledningsstrategier beskrevs var ett fåtal mer allmänna och LD menade här att ledning av läkare inte skiljde sig från ledning av andra professionella grupper i vården. De flesta beskrev dock vad vi kallat läkarspecifika ledningsstrategier, där fyra typer kunde identifieras; 1) organisatorisk separation av läkare, 2) ”tjat och gnat”, 3) användning av olika typer av kompensationer, samt 4) att förlita sig på läkarrollen. Samtidigt som de läkarspecifika ledningsstrategierna hjälpte cheferna att behålla kontrollen över chefskapet i det dagliga arbetet, tycktes de, i ett längre perspektiv, bidra till att försvaga chefsrollen och minska dess legitimitet i relation till läkarrollen i sjukvårdsorganisationen (III). Vid den fördjupade analysen av *hur* cheferna talade om ledning av läkare framkom att få chefer använde vad vi identifierade som en managementbaserad diskurs för att konstruera chefsrollen i sina organisationer. Oavsett vilken grundprofession cheferna hade, var det i stället en läkarbaserad diskurs klart dominerade i hur cheferna konstruerade chefsrollen i relation till läkarrollen. Identifikation med att vara läkare eller inte var stark, och cheferna använde ofta attributet ”läkare” eller ”icke-läkare” för att beskriva och värdera sig själva och andra chefer i sina respektive chefsroller. Några chefer kombinerade också de båda diskurserna i sitt språk vilket resulterade i en sorts ”yes, but...” management, där chefsrollen å ena sidan beskrevs som stark och legitim i organisationen, men å andra sidan inte ansågs som tillräckligt stark för att leda läkares arbete. Uttryck som kunde hänföras till en gemensam upplevd chefsidentitet saknades nästan helt bland cheferna (IV).

Slutsatser: Sammantaget indikerar resultaten en svag, delvis frånvarande och oklar chefsroll i relation till läkarrollen. Trots att chefers ställning i sjukvården stärkts genom

politiska reformer de senaste decennierna, tyder tidigare forskning på att den medicinska professionen har behållit sitt starka inflytande. Den här studien, som tar ett chefsperspektiv och adresserar micro-nivån av det som har beskrivits som konflikten mellan organisations och professionsperspektivet i hälso- och sjukvården, tyder på att cheferna själva bidrar till det. Frånvaron av ledning och styrning av arbetet med patienters sjukskrivning var tydlig.

Implikationer: Hur chefsrollen i sjukvården hanteras och uppfattas utgör en del av de organisatoriska förutsättningarna för både chefers, läkares och andra professionella gruppers rolltagande i sjukvårdsorganisationen. Resultaten i den här studien tyder på att det finns ett behov att stödja chefer i att hitta och ta sin chefsroll i relation till läkarrollen – vare sig chefen själv också är läkare eller inte. Detta gäller även i relation till sjukskrivningsuppgiften. Tidigare forskning visar ett en svag och oklar chefsroll kan ha negativa konsekvenser inte bara för cheferna själva, utan också för läkare, andra personalgrupper i sjukvården, liksom för vårdens kvalitet.

LIST OF PUBLICATIONS

I. von Knorring M, Sundberg L, Löfgren A, Alexanderson K. Problems in sickness certification of patients: A qualitative study on views of 26 physicians in Sweden. *Scandinavian Journal of Primary Health Care* 2008;26(1):22 - 8.

II. Lindholm C, von Knorring M, Arrelöv B, Nilsson G, Hinas E, Alexanderson K. Health care management of sickness certification tasks: results from two surveys to physicians. 2012 (Submitted)

III. von Knorring M, de Rijk A, Alexanderson K. Managers' perceptions of the manager role in relation to physicians: a qualitative interview study of the top managers in Swedish healthcare. *BMC Health Services Research* 2010, 10:271.

IV. von Knorring M, Alexanderson K, Eliasson A E. Healthcare managers' construction of the manager role. 2012 (Submitted)

CONTENTS

1 Prologue ... 1
2 Introduction ... 2
2.1 Background ... 2
2.1.1 Rationale for the thesis ... 2
2.2 Healthcare management ... 3
2.2.1 Healthcare reform and the manager-physician relationship ... 4
2.2.2 The Swedish situation ... 4
2.2.3 Previous research ... 5
2.3 Physicians' sickness certification practice ... 8
2.3.1 The managerial task in sickness certification ... 9
2.3.2 Previous research ... 10
3 Theoretical framework ... 11
3.1 What is an organisation? ... 11
3.2 Theories on professions and power ... 12
3.2.1 The medical profession and the manager position ... 12
3.2.2 The organisational professional conflict ... 13
3.3 Theory on role taking ... 14
3.3.1 Managers' role taking ... 15
4 Aim ... 16
4.1 General aim ... 16
4.2 Specific objectives ... 16
5 Material and methods ... 17
5.1 Background regarding the data collection ... 18
5.2 Study I ... 18
5.2.1 The focus group discussions ... 18
5.2.2 Participants ... 19
5.2.3 Analysis of the data ... 19
5.3 Study II ... 19
5.3.1 The questionnaires ... 19
5.3.2 Study population ... 20
5.3.3 Analysis of the data ... 20
5.4 Study III ... 21
5.4.1 The individual interviews ... 21
5.4.2 Participants ... 22
5.4.3 Analysis of the data ... 22
5.5 Study IV ... 23
5.5.1 The individual interviews ... 23
5.5.2 Participants ... 23
5.5.3 Analysis of the data ... 23
5.6 Ethics ... 24
6 Results ... 25
7 Discussion ... 32
7.1 Managers construct a weak manager role (studies III, IV) ... 32
7.1.1 Managers use strategies that weaken the manager role ... 32
7.1.2 A profession-based discourse predominates ... 33

7.1.3 The "yes, but..." approach to management 34
7.1.4 Lack of a mutually shared manager community 35
7.2 Lack of management of sickness certification tasks (studies I, II) . 36
7.3 The organisational professional conflict – new directions? 36
7.4 Methodological considerations 39
8 Conclusions 41
8.1 Implications for practice.. 41
8.2 Implications for research.. 41
Acknowledgements 43
9 References 45

LIST OF ABBREVIATIONS

CEO	County Council Chief Executive Officer (in Swedish: *landstingsdirektör/regiondirektör*)
CDM	Clinical Department Manager (in Swedish: *verksamhetschef inom hälso- och sjukvård*)
HCM	Hybrid Clinician Manager
GP	General Practitioner
FGD	Focus Group Discussion
NPM	New Public Management

DEFINITIONS

Manager: In this thesis, the term “manager” refers to a person employed in a managerial position within an organisation, regardless of the organisational level.

The manager position: The manager position is considered here as a formal function within an employing organisation (1) that denotes official, instrumental power (2, 3) based on formal authority within the organisation (4), as well as formally defined obligations and responsibilities.

The manager role: In this thesis the manager role is defined as *a social role* (5) that is continuously created and recreated within an organisation (see managerial role taking). In this respect the manager role is understood as something conceptually different from the manager position.

Managerial role taking: The ever ongoing social psychological process in which a person handles his or her function as manager within the realm of an organisation is referred to in this thesis as managerial role taking.

Medical profession: In this thesis “medical profession” is used synonymously with “physicians”.

Healthcare professionals: All professionals, semi-professionals and vocational groups working in healthcare organisations, such as physicians, nurses, physiotherapists, psychologists, etc.

1 PROLOGUE

My work with this thesis has been a journey with two main changes of direction. It started in 2004 with a commission from the Swedish government to Karolinska Institutet to conduct a comprehensive investigation to identify problems in healthcare regarding sickness certification of patients. Our data, as well as that of others, showed that physicians experienced a number of problems in their work with sickness certification of patients.

The physicians we interviewed also described how they in different ways tried to cope with those problems, sometimes desperately. I will never forget the words of one of the physicians:

> *It happens, and not all that rarely either, that I extend sickness certifications due to pure exhaustion - you just don't have the strength. It's much easier just to write the certificate, and the patient gets it, and so you get rid of the problem, and so the patient is sick-listed, and so hopefully someone else will see them next time when they come and want an extension.*

As a psychologist who has worked with physicians and other healthcare professionals in leadership training and manager counselling for almost two decades, I expected to find management as one problem among the many described by the physicians. However, managers did not seem to be an issue for the physicians, and the role of managers was totally absent in their discussions. This finding, which is presented in study I, led to the first change of direction for my thesis. From addressing physicians' sickness certification practice it turned to address issues regarding management of sickness certification. Did the absence of managers in the physicians' discussions indicate a lack of management of sickness certification tasks? And if so, why were the managers not there?

The second change of direction for this thesis came with the pre-test of an interview guide constructed to explore management regarding sickness certification tasks. When we asked managers about this they spontaneously started talking about management of physicians in general. This discovery again raised new questions and lead to that we included a general question in the interview guide about the managers' views on management of physicians. The answers to this question eventually ended up as the database for studies III and IV.

Thus my work with this thesis has been a journey where there has been changes in direction. What started out as a thesis concerning physicians' sickness certification practice ended up as a thesis on the manager role in relation to the medical profession. The research that this journey has resulted in will provide some answers. However, I also hope that it will contribute to formulating new questions for healthcare organisations to address.

2 INTRODUCTION

2.1 BACKGROUND

The relationship between managers and physicians has been pointed out as a critical determinant of the success of healthcare organisations (6). However, in many Western countries this relationship is problematic. In a classic editorial in the British Medical Journal, Richard Smith (7) posed the question “Why are doctors so unhappy?” An intense debate followed in which a number of changes in society were identified that had resulted in changes in the unwritten contract between patients, the public, the government, and the medical profession (8, 9). For many physicians, management has become the personification of many of these changes and has even been regarded as the cause of them rather than a part wider processes in society (9). On the other hand, managing physicians, unlike managing other health professionals, seem to put specific demands on the managers in healthcare organisations (10). Colourful metaphors about the difficulties in managing physicians seem widespread among managers. For example, managing physicians’ work has been described as leading “soloists in a choir” (11), or like “trying to walk cats on a leash” (12).

Edwards (9) has argued that the poor relations between managers and physicians will affect the delivery of healthcare on many levels, and has pointed out negative consequences:

- for patients, “because well managed care generally produces better outcomes than chaotic and unsystematic care”
- for healthcare professionals, “because poor management is likely to damage their ability to work effectively”
- for society, because ”as healthcare becomes more and more expensive, there is a legitimate desire to be assured that resources are used efficiently”
- for policy development and implementation, because “as managers and policy makers have a view of the world and languages different from those of many clinicians [this means] that they tend to talk about new policies and ideas in a way that alienate[s] clinical staff” (9, page 577) .

The need to improve the relationship between managers and physicians has been addressed in a large number of studies and editorials in recent decades (see, for example, (8, 13-17). Most of the studies in this area focus on the relationship between managers on one hand and physicians on the other. However, to get a deeper understanding of the dynamics in the manager-physician relationship more scientific knowledge is also needed concerning managers’ own role taking, i.e. how the managers themselves handle the manager role in relation to the medical profession – their own medical profession or that of others.

2.1.1 Rationale for the thesis

In this thesis focus is on the manager role in relation to the medical profession. The four studies in the thesis build on one another and are based on empirical data collected in

three comprehensive research projects concerning how the process of sickness certification of patients is handled by Swedish healthcare.

Studying the manager role in relation to the medical profession in this context places the thesis in the crossroad between two research areas: health services research and sickness absence research – research areas that are, in themselves, broad and interdisciplinary. Within the field of health services research the focus in the thesis is on healthcare management, while in the field of sickness absence research the focus is on sickness certification practices.

In this chapter, the positioning of the thesis within these two areas of research will be described. An introduction to the present research as well as previous research that are relevant to the research issue will be presented. In chapter 3, the theoretical perspectives and concepts used in the thesis will be introduced.

2.2 HEALTHCARE MANAGEMENT

Many studies performed in the field of health services research investigate phenomena on rather high structural levels in society. Academy Health, the US Scientific HSR society, has defined health services research as "the multidisciplinary field of scientific investigations that studies how social factors, financing systems, organisational structures and processes, health technologies and personal behaviours affect access to healthcare, the quality and cost of healthcare and ultimately our health and well-being" (18, page 674). As healthcare is one factor that contributes to the health of the population, research on healthcare and health services partly overlap with the larger research field of public health (19).

This thesis addresses one aspect of healthcare management. With its focus on the manager role in relation to the medical profession, processes on the micro level in healthcare organisations constitute its starting point. Research on management of healthcare organisations can also be defined as medical management research, which partly overlaps with the field of health services research (18).

Placement of the thesis in the area of health services research is based on the assumption that the empirical study of organisational structures and processes on the micro level is an important piece of the puzzle for also understanding phenomena on higher structural levels in organisations as well as in society at large. It is also based on the assumption that a deepened understanding of the processes on a micro level within healthcare organisations may have implications for the quality and outcome of healthcare and thereby for the health and well-being of the population.

Research on management of healthcare organisations covers a diversity of areas. It differs with regard to focus, unit, and level of analysis, the scientific discipline in which it is performed, and the theoretical perspectives that are taken. Despite those differences, most authors agree on some basic characteristics that have implications for the management of healthcare organisations. One of these is that healthcare organisations in many Western countries can be defined in terms of being professional bureaucracies where the physicians in the organisation, by virtue of their medical

profession, have great influence over decision making in daily work and to a large degree can control their own work (20). The influence of the medical profession has been described as a second line of authority in the healthcare organisation (21).

2.2.1 Healthcare reform and the manager-physician relationship

Management in healthcare organisations was long described in terms of being a mere administrative task, with the main function being to provide the necessary facilities and resources for physicians to “get on with their work” (22, page 36) . Physicians could to a large extent control their own work without expecting interference from managers or policy makers. However, during the past three decades a number of changes in healthcare have affected the autonomy of the medical profession as well as the relationship between managers and physicians in the healthcare organisation. Different drivers for these changes have been pointed out. In most industrial societies there has been an increasing need to modernize health services (23), to improve standardisation and transparency and to increase efficiency in the delivery of healthcare (24, 25). The increasing scope, technologisation, and complexity of healthcare organisations also have led to a growing need to prioritise use of resources and, from a societal perspective, to safeguard aspects of quality and equality in the care offered to the population (6, 24, 26, 27). In addition, doubts has been raised about how clinical work is organized, as well as to what extent the medical profession can “ensure the accountability of its members” (23, page 650). Other main drivers are increasing concern about patient safety (25) and the growing cost of healthcare (23, 25).

Together, these needs to modernize and improve how healthcare is organised and delivered have led to a number of reforms during recent decades. These in turn have led to increasing influence from managerial structures in healthcare and tighter control of physicians’ work (28). Griffith’s report, which was presented in the United Kingdom in 1983, became the start of this new era of management of healthcare organisations. It concluded that general management was needed to ensure an effective leadership and clear accountability for decision-making (29). The Griffith report can be regarded as an early application of New Public Management (NPM) in healthcare organisations, which some regard as the main driver of healthcare reform last decades (30). Through NPM focus turned towards management objectives centred on cost containment, budget allocations, and quality control and thereby challenged the traditional professional values in healthcare organisations (30).

Although healthcare systems differ between countries, for example concerning the degree of state influence (31, 32), this process of increased managerial influence and tighter control of professionals’ work has taken similar routes in many countries. A cross-country comparative analysis of new directions in governing medical performance in Britain, Denmark, Germany, Italy and Norway concluded that all these countries had moved towards more hierarchy-based forms of governing medical performance (33).

2.2.2 The Swedish situation

In Sweden, with a population of 9.5 million, healthcare is, with few exceptions, publicly financed and usually also publicly organised, although more private

alternatives have been established in recent years. Similar to the UK and the other Scandinavian countries, Sweden has a tradition of a centralistic Beveridge social welfare system whereby healthcare is paid by taxes and healthcare reforms are initiated primarily by the state (31, 32). The responsibility for delivery of healthcare to the population is organised through 20 county councils, covering geographic regions (counties) with populations ranging from 100 000 to almost two million. The number of employees in healthcare in each of the counties ranges from approximately 4000 to 46 000, of which 400 to 4000 are physicians (34).

2.2.2.1 Healthcare reform and the healthcare manager position in Sweden

In line with developments in other Western countries, healthcare in Sweden has been the object of several reforms and changes in recent decades, strongly influenced by New Public Management (NPM) and market managerialism (35). In parallel with this development, ideas from Total Quality Management (TQM, in Swedish: *kvalitetsstyrning*) have had increasing influence on management of both healthcare as well as the work of physicians. Increasing customer orientation and quality control initiatives, begun and strongly reinforced through state policy, have offered an alternative to management based on trust in the medical profession (35). For example, Garpenby (36) has shown that the strong focus on quality control in Sweden has led to a mutual resource dependency between the state and the medical profession.

In parallel with the increasing interdependency between the state and the medical profession, managerial influence has been formally strengthened. The manager position also has been increasingly separated from the medical profession through reform initiatives. Traditionally, the manager role in healthcare organisations in Sweden, as well as in most countries, has been closely associated with the medical profession. In 1983, the same year as the Griffith report was presented in the UK, the Swedish government passed the first law which opened the way for those other than physicians to become managers in healthcare organisations (37). In the department manager reform of 1997 (38), separation of the healthcare manager position and the physician role was completed when the position of clinical department manager, i.e. the direct manager over physicians in clinical work, became open to professionals or vocational groups other than physicians (38). With the exception that legal medical responsibility must rest with a physician (38), the responsibility of the department manager is defined with no specific attention to the manager’s underlying profession.

2.2.3 Previous research

Previous research on the manager role in relation to the medical profession has addressed different areas. A summary of the research areas of relevance for the subject of this thesis is presented below.

2.2.3.1 New Public Management and the influence of market managerialism

Several authors have related the introduction of NPM and the expanding managerialism to a corresponding weakening of the position of the medical profession (21, 39). The situation has been described as a struggle between ideologies (40, 41) or, as Salter (27, page 263) puts it, as “a continuing struggle between state and profession for control of

the agenda setting". Freidson (39), for example, strongly opposes managerialism as a form of supervision and argues in favour of what he calls "the third logic", where the medical profession should remain in control of its work (42).

However, the debate is ongoing concerning whether the changes in healthcare during recent decades have actually increased managerial control over the medical profession. Kuhlmann and Burau contend that this is not necessarily the case (43, page 623). Salter (27) demonstrated how increased managerialism did not lead to increased control over physicians. His analysis of the UK situation (with its strong state dominance over healthcare) showed that the strong medical profession tends to criticize increased management and uses effective tactics to remain independent (42). A Dutch study demonstrated how legislation regarding disability pensions was not put into practice because the physicians were such powerful professionals and therefore had great autonomy in making decisions (44). Mark et al (45) stated that the emerging managerial culture seemed to have limited effect on influencing medical professional culture. Ackroyd (46), referring specifically to the medical profession, states that professions in the UK "have shown considerable capacity to adapt" (46, page 599).

2.2.3.2 Dilemmas in hybrid manager roles

One large area of research concerning how managers in healthcare organisations handle their manager role specifically focuses on physicians who also have manager positions. These managers are referred to in terms of doctor-managers, physician-executives, medical managers (47) or hybrid clinician managers (30) – terms that clearly highlight the *dual roles* of these managers (as managers *and* as clinicians) and do not specifically address them in terms of the manager positions they hold. In this thesis the term hybrid clinician managers (HCMs) is used for these managers.

The HCM position has been regarded as a boundary line position between profession and organisation (30, 47). The position was specifically introduced to bridge the gap that the introduction of general management has caused between what has been called the practice and the business of health (30). HCMs are now increasingly taking on formal managerial positions in many countries such as Australia, the United States and the United Kingdom (47). This has been described as a main area of change in healthcare in recent years (Ferlie and Shortell 2001; (30).

The challenge for these managers has been described as managing dual roles within an organisational context where they have to find ways to handle conflicting clinical and managerial objectives (30). There is evidence that HCMs experience internal conflict when they perceive that their manager role intrudes on what they feel is their primary job, namely their work as physicians (30). Kippist et al found that this role ambiguity have negative consequences for other members of the team (30).Research also shows that HCMs perceptions of management differ from those in business firms and that they often lack training in organisational management (47).

In Sweden, the role of manager in healthcare organisations has followed a somewhat different path and the dual manager role has not been as articulated. A HCM role has

not been formally introduced in terms of reform. However, CDMs in Sweden who also are physicians tend to add this task to their clinical work, which is less often the case for nurses who hold manager positions (48).

2.2.3.3 Managers' underlying profession

A third area of research specifically addresses managers underlying profession. Fitzgerald found that physicians who are also managers have significantly less management training than managers with other underlying professions (30). Physicians do not see management as a career path (30) whereas nurses tend to see it as a "career with no return" (48). In a study on 33 ward managers, Persson and Thylefors (48) concluded that physicians who move into management keep some of their clinical work and thereby *expand their professional role,* while ward managers abandon their nursing. Instead they integrate the perspective of nursing in the manager role and *restructure* their professional identity (48). In a study on 2637, what they call doctor managers, nurse managers, and mangers (i.e. general managers), Degeling et al showed that these managers had remarkable consistency in views on central managerial issues, and that these views clearly differed between the groups (49).

To summarize - previous research in this field shows that healthcare managers have an unclear role, and there is little research on how they perceive that role. Earlier studies have addressed issues, mainly on a macro level, regarding managerial control in relation to the medical profession, and discussion is ongoing concerning whether or not the strengthening of the manager position in healthcare organisations has actually increased managerial control over the medical profession. Most previous research on dilemmas in the manager role have focused on HCMs. Few studies address managers' role taking based on their manager position, regardless of the manager's underlying profession. Consequently, the manager role in relation to the medical profession is a worthwhile area of study.

2.3 PHYSICIANS' SICKNESS CERTIFICATION PRACTICE

Although the focus in this thesis is on the manager role in relation to the medical profession in general, the thesis is also of relevance for the field of sickness absence research. In 2003, the Swedish Council on Technology Assessment in Healthcare (SBU) concluded, based on seven systematic reviews of studies of sickness absence, that research regarding sickness absence was limited, heterogeneous and not well developed in terms of methods, theories, and concepts (50) . SBU also presented a categorisation of studies in this field, of which a modified version is presented in table 1. Within the field of sickness absence research, the position of this thesis is in the area of physicians' sickness certification practice, especially focusing the management of these tasks.

Table 1. Categorization of studies on sickness absence (50). The categories relevant to the sickness absence aspects of this thesis are indicated in bold type.

Focus of the study	Scientific discipline	Perspective taken in the study	Structural level of the data included in the empirical analyses
- Risk factors for sickness absence - Factors that hinder or promote return to work - Consequences of being sickness absent **- Sickness certification practice**	Medicine Sociology Psychology Economics Law Public health History Philosophy **Management** Anthropology	Society Local society Insurance **Healthcare** Employer Sickness absentees	**Individual** Family Workplace Community National International

Sickness certification practice in this thesis is defined as the clinical practice of physicians considering issuing a sickness certificate to a patient *as well as* all aspects and behaviours in relation to this (51, 52). Sickness certification is regarded, e.g. by the National Board of Health and Welfare, as a regular part of patient treatment in the Swedish system[1] (53, 54) and is a common task for many physicians in Sweden (51, 52, 55). There is evidence that physicians find this task problematic (50, 56-58). However, only a few studies have identified what problems physicians actually experience and how these problems can be understood (56, 59).

When having consultations in which sickness certification might be an issue, physicians in general have the following tasks (51, 52):

- To determine whether a patient has a disease or injury

[1] Some other countries, such as the Netherlands, have specific physicians who perform all sickness certifications (occupational health physicians and insurance physicians).

- To ascertain whether the disease or injury impairs the patient's functioning to the extent that work capacity is also reduced in relation to the work demands
- To consider, together with the patient, the advantages and the disadvantages of sick leave, including how it might affect the health or social situation of the patient
- To determine the degree (full or part time) and duration of sick leave and what medical investigations, treatments, or other interventions are needed during the sick-leave period, and also to make a plan of action in this regard
- To establish whether there is a need to contact other specialists, other health professionals, the social insurance office, occupational health services, the employer, or other stakeholders, and if so to establish such contacts
- To issue a certificate (standard form) that provides sufficient information for the Social Insurance Agency case manager to decide whether the patient is entitled to sickness benefits and return-to-work measures
- To document measures taken

Moreover, physicians in those cases have to handle two different roles, one as the patient's physician and one as a medical expert providing correct information to other authorities – here in the form of a sickness certificate on which the Social Insurance Agency officers can base their decision regarding the patient's right to sickness benefits (56, 58). Many physicians find that handling those two roles is problematic (58).

Sickness certification can be regarded as a clinical task where the physician makes a professional assessment of the health status, disease or injury, function, and work capacity of the patient and communicates the findings to the Social Insurance Office. Physicians' sickness certification practice is therefore a fruitful context in which to study the interrelation between management and medicine, including the role of managers in relation to the medical profession.

2.3.1 The managerial task in sickness certification

Physicians' work with sickness certification of patients involves activities that are included to only a small extent in medical education (51). Many physicians regard sickness certification as an administrative task on the outskirts of the medical profession (60). This should offer an opening for support and management concerning this task. However, a study in 2007 (61) found that managers did not know what to lead and how to provide support concerning this task.

Being a regular part of patient treatment sickness certification, as all health care in Sweden, is regulated by the Health and Medical Service Act (37). This stipulates that management of health services should be organised so that it can provide for a high level of patient safety and good quality of care, as well as promote cost efficiency (37). It also states that all healthcare should regularly and systematically develop and assure quality in the health services provided (37, 62).

Based on legislation, the specific managerial tasks in relation to physicians' sickness certification practices can be summarized as follows (adopted from responsibilities proposed by Alexanderson et al (61)):

- To have overarching responsibility for strategies for competence development of staff
- To have overarching responsibility for strategies for collaboration within healthcare and with other stakeholders regarding these issues
- To have overarching responsibility for quality assurance concerning how these tasks are handled
- To contribute to knowledge development regarding these issues

In addition to the above aspects of managerial responsibility, assuring good physical and psychosocial working conditions for all staff is a managerial responsibility regulated by law in Sweden (63).

2.3.2 Previous research

Most research in the field of sickness absence has thus far been on risk factors for sickness absence (50). A systematic review of studies published up until 2009 on physicians' sickness certification practice (59) showed that the majority of these studies focus on individual factors related to physicians or patients. Few studies include the context in which physicians work or possibilities for physicians to handle sickness certification issues in more optimal ways (59). Very few studies have addressed the management aspects of physicians' sickness certification practice (61, 64-66).

3 THEORETICAL FRAMEWORK

The theoretical framework for the overall discussion of the results from the empirical studies in this thesis stands on three legs. The first concerns how an organisation is perceived, the second concerns what constitutes a profession and how organisational and professional values are related, and the third concerns how roles are perceived and taken within an organisational context. In the following, this theoretical framework will be described.

3.1 WHAT IS AN ORGANISATION?

Research on organisations can take a number of perspectives ranging from traditional rationalist-based organisation theories to theories based on systems theory or complexity theory. One way to characterize the different perspectives is the extent to which focus is on formal structure and functions within the organisation or on informal processes and ongoing interactions and inter-relationships within the organisation and in relation to its context. Based on what perspective is taken, the concept of organisation can be defined in different ways.

In this thesis focus is on both the formal, structural aspect of the organisation and on the informal processes that are continuously ongoing within the framework of the formal structure of an organisation. This places the thesis in a neo-rationalistic organisational theoretical tradition, which is based on Weber's rationalistic theory regarding bureaucracy where organisations are described in terms of their functions (1). When taking a neo-rationalistic perspective, the manager function per se, or the organisational structures in which it is embedded, is not the only focus; focus is also on how the manager role is regarded and taken within the formal organisational structures. In this respect, neo-rationalistic theory builds on the achievements of postmodern theories that regard roles as socially constructed (1).

Abrahamsson uses two central concepts in his definition of an organisation, the concept of mandator and the concept of goal. He emphasises that organisations are "structures that originally are set up according to a plan and that are designed by some person, group, or class (the mandator) for the deliberate and expressed purpose of achieving certain goals" (1, page xv). However, Abrahamsson recognises that organisations seldom function according to what the mandator originally planned, and that other interests often oppose the goals. The formal organisation, as illustrated in organisation charts that describe functions and relationships between them, usually differs from the informal daily life of the organisation (1). Whereas the ideal (the formal organisation) is often described in terms of functions, formal positions, and decision-making procedures, the informal daily life in the organisation also is made up of "loves and hates, serious debates and pie throwing, level-headed deliberation and shows of strength" (1, page xvii). Abrahamsson states that organisation theory must deal with both these areas and add to our understanding of how they interact (1). In his theoretical approach he thereby separates the structure and functions that constitute the formal framework for an organisation (ideal) from the processes that go on within that framework (daily life), even though he stipulates their interdependence (1). "Conflicts in organisations may not, for example, be interpreted in a meaningful way until we

have an understanding of the field of battle on which these conflicts are going on" (1, page xvii).

Within the formal framework of the organisation, different roles are negotiated, created, recreated, and contested among the persons working in the organisation (1, 67). This also applies to the image of the organisation itself. Each member of an organisation will have their own picture of the organisation, i.e. they will form their "organisation in the mind" (68, 69) that will affect the way they perceive the goal set up by the mandator and thereby their own role taking.

3.2 THEORIES ON PROFESSIONS AND POWER

The second theoretical leg in the thesis concerns what constitutes a profession and how it is perceived in terms of power and impact. Based in theories from the sociology of professions, Abbott (70) has highlighted the issue of professional jurisdiction. He defines this as the link between a profession and its work tasks and argues that jurisdiction is not an issue of legal formulations or specific work descriptions, but a process created in work, anchored by formal and informal social structures. In this way jurisdiction is continuously claimed and negotiated between professions in their daily work. According to Abbott, strong (i.e. established) professions execute more power in this continuing negotiation over work tasks in the organisation than weaker professions (70).

3.2.1 The medical profession and the manager position

The medical profession is well established and one of the oldest professions in society (70). Together with the legal profession, and accountancy, the medical profession has the status of a classical profession (71). The classical professions, including the medical profession, can be defined based on the following three main characteristics, adopted from Grey (71), Thylefors (72), and Ryynänen (73):

- The members have achieved their skills through systematic academic training, and are experts within their specific fields, which gives a monopoly of knowledge
- This expertise is legitimized by the state through accreditation, which give members of the profession a professional monopoly over its work tasks
- The profession regulates itself through systematic training and ethical codes (with altruistic purposes) that the members of the profession are obliged to follow

The particular skills and knowledge held by members of the classical professions are also highly socially and economically valued (71), and members of the profession are able to exercise a high degree of closure around these skills and their specific "occupational territory" (71, page 711).

Through their specific knowledge and skills, which actually cannot be questioned by anyone but the professionals themselves, the medical profession has a high social status

in society (73). This, and the above characteristics, also differentiate the classical professions from other professional, semi-professional, or vocational groups, and are what make them powerful in relation to other professional groups in the organisations where they work (72).

In contrast to the medical profession, the position of manager in healthcare organisations is a relatively new phenomenon and cannot be regarded as a profession in the classical sense (39, 70, 71). In contrast to physicians, where the licensing procedure gives the medical profession monopoly over its work tasks – or, talking with Abbot, a very strong jurisdiction – members of *different* healthcare professions or other vocational groups can hold healthcare manager positions. The healthcare manager position is also a position that is exclusively defined within an organisational context, and it actually has no relevance outside of this context. It could possibly be regarded as a profession in the beginning of its professionalization process (71). In a Swedish study, Öfverström addressed a potential move towards what she calls a "professionalized manager role" (41, page 7).

3.2.2 The organisational professional conflict

Organisational professional conflict is defined as "an inconsistency experienced by employed professionals between the requirements of their employer and those of their vocation" (30, page 642). Organisational professional conflict thereby occurs when professionals, physicians for example, experience that there is a discrepancy between their professional values and the organisation's management objectives (30). Research on organisational professional conflict originally addressed the work of accountants (30). It was found that tension increased with the increase in professional status within the organisation (30). Accountants also reported higher levels of organisational professional conflict when they were required to be more involved in organisational objectives, which they experienced as a threat to their individual professional autonomy (30).

Several authors have in somewhat different ways addressed the problems between managers and physicians in terms of an organisational professional conflict. The conflict has been described as based in different logics, different worlds, or different values (9, 47, 48, 74, 75). Leaning on the findings from a study by Degeling et al (49), Edwards (9) has addressed how these differences affect managers' and physicians' views in some key aspects of healthcare and its delivery (Table 2).

Table 2. Differences in values between managers and physicians (based in Edwards (9) and Degeling et al (49)

Managers	Physicians
Think in terms of populations or groups and consider how resources are spent across the whole organisation	Think in terms of individual patients
Values defined by the organisation	Values defined by the profession
Accountability upwards	Autonomy/Accountability to colleagues
Promote team-based power sharing and systemisation of clinical work	Systemisation and team-based models perceived as threaths to clinical autonomy

Edwards (9) describes that managers tend to think in terms of populations or groups of patients, whereas physicians think about individual patients. Edwards states that this difference in values becomes specifically problematic with regard to financial issues. For example, he contends that “physicians do not feel comfortable with the idea that they should view a clinical decision for an individual patient as a resource allocation decision, or that they should consider the potential knock-on effect of each clinical decision they make on the resources available to all the patients in the system” (9, page 577). He also stresses that “management usually is based on a traditional hierarchical system with strong accountability upwards, whereas medicine has traditionally been based on a model of autonomy (and collegiality) “with limited accountability to any part except in the case of misconduct or extreme incompetence” (9, page 578).

3.3 THEORY ON ROLE TAKING

The third theoretical leg in the thesis concerns how roles are perceived and taken within an organisational context. One assumption in the thesis is that how we categorise and define the roles of others and ourselves is continuously created and recreated in social interaction (76). However, this continuing categorisation of self and others forms rather stable elements (5, 77), or “temporary answers” (67), or discourses (76), which can be studied.

The role taken at a specific time in a specific context can be regarded as such a stable element. Most studies taking this perspective describe this in terms of identity construction (67, 78). In a study of managerial identities, Svenningsson and Alvesson (67) emphasised how our social identities in organisations are the results of a dynamic process of ongoing struggles between our personal identity and our organisational identification in which we try to provide temporary answers to the question “Who am I?”(or who are we?) in this specific context (67). These questions have also been addressed in theory on organisational discourse, which has been described as the “principal means by which organizational members create a coherent social reality that

frames the sense of who they are" (79, page 1116). In line with this, discourse is here defined as a specific manner of talking about and understanding a context and how we place ourselves in it that "does not neutrally reflect the context or formal organisational schemes, our identity, or our social relations, but instead plays an active role in how these are created and recreated" (80, page 7). On a macro level Foucault (77) demonstrated how these discourses form interrelated sets of ideas (ideologies) that contain stable elements but also compete with each other in a continuous circulation of power in society (76, 77, 80).

3.3.1 Managers' role taking

To be able to explore managers' role taking in this theoretical context it is necessary to make a clear distinction between the manager role and the manager position. In this thesis, following the line from neo-rationalistic organisation theory, the manager role is understood as something conceptually different from the manager position. Having a manager position does not postulate how a manager is to take up or construct his or her manager role within that position. On the contrary, all managers will achieve their own understanding of the manager role and of themselves "as manager" within the social structures, cultures and discourses in which they are located (81). The manager role is in this respect a social role (5) that is continuously constructed and reconstructed within an organisational context.

The theory on managerial role taking that is applied in this thesis is influenced by Reed (3) and can be regarded as a development of the more static version of the concept, which was developed by Katz and Kahn (82). Managerial role taking is here defined as the ever ongoing social psychological process in which a person handles his or her function as manager within the realm of an organisation. Reed assumes that a person's role taking in any system is geared by how the person perceives the purpose of that system (3, 83, 84). However, according to the theory there will always be a tension between individuals' personal needs and desires, and the purpose of the system in which they are to assume their professional roles. This tension will be intensified in times of organisational change (85) and in the case of a lack of clarity in the manager's role authority and accountability (86). How a manager handles the necessary uncertainties and ambiguities surrounding his or her own role in relation to that of others, both vertical and lateral in the organisation, as well as clarity about leadership role authority and accountability, have been suggested as important requirements both for performance and well being at work (86, 87).

4 AIM

4.1 GENERAL AIM

The aim of the thesis was to increase the knowledge about how managers in Swedish healthcare organisations handle their manager role in relation to the medical profession. The research addressing the general aim was performed in the context of one specific area of physicians' clinical practice – sickness certification of patients.

4.2 SPECIFIC OBJECTIVES

The four empirical studies in the thesis build on one another and explore the research issue from the perspective of physicians (studies I and II), and from the perspective of managers (studies III and IV).

Study I: The specific objective of study I was to identify what problems physicians experience in their work with sickness certification of patients.

Study II: In order to identify if physicians were the objects of management actions when engaging in sickness certification, the objective of study II was to investigate to what extent physicians in Sweden had access to a workplace policy and managerial support in their work with sickness certification tasks.

Study III: Focusing on the management of physicians in general, and not directly related to sickness certification, the objective of study III was to understand how the top managers in Swedish healthcare regard management of physicians in their organisations and what this implies for the manager role in relation to the medical profession.

Study IV: Building on insights from the third study, the aim of study IV was to elucidate how healthcare managers construct the manager role in their organisations by analysing how they talk about the management of physicians.

5 MATERIAL AND METHODS

This thesis is based on the findings from four studies (I-IV) that used data from focus group discussions (FGDs) (study I) and questionnaires (study II) with physicians as respondents, and from semi-structured individual interviews (studies III and IV) with healthcare managers (Table 3).

Table 3 Overview of the four studies

	Study I	**Study II**	**Study III**	**Study IV**
Aim	To identify what problems physicians experience in their work with sickness certification of patients	To describe to what extent physicians in different medical specialties have access to a workplace policy and management support regarding sickness certification tasks	To understand how the top managers in Swedish healthcare regard management of physicians in their organisations	To elucidate how healthcare managers construct the manager role in relation to the physician role – their own physician role or that of others
Study population	A purposeful sample of physicians from different types of departments in four counties	All physicians living and working in Stockholm County in 2004 (n=6794, response rate 71%), and in 2008 (n=9391, response rate 57%)	All county council chief executives (CEOs) in Sweden (n=20)	Same as in Study III, and a purposeful sample of clinical department managers (CDMs) from different types of departments in five counties (n=30)
Year of data collection	2004	2004 and 2008	2006	2006
Study group	Physicians from different types of departments in four counties in Sweden (n = 26, 50% women)	Board certified specialists <65 years of age who worked in a clinical setting, had consultations involving sickness certification at least a few times per year, and answered a questionnaire (2004: n=2497, 48.1% women) (2008: n=2204, 48.9 % women)	CEOs (n = 18, 5 women, 7 physicians)	The same CEOs as in study III, and CDMs from different types of departments in four counties in Sweden (n=20, 11 women, 12 physicians) In the whole study group (n=38), 42% were women, and 50% were physicians.
Data-collection method	Focus group discussions (FGDs)	Questionnaires	Semi-structured individual interviews	Semi-structured individual interviews
Analyses	Qualitative; content analysis	Quantitative; descriptive statistics	Qualitative; a grounded theory approach	Qualitative; a discourse analysis approach
Main outcome	Categories of experienced problems	Percentage of physicians with access to a workplace policy and to managerial support	Types of strategies to manage physicians and the implications of the strategies for the manager role	Ways managers construct their managerial role in relation to the medical profession

The background regarding the data collection is described below, followed by the methods used in each of the four studies.

5.1 BACKGROUND REGARDING THE DATA COLLECTION

At the turn of the century the Swedish government identified the currently very high sick-leave rates as a major societal problem, and several interventions were introduced. These interventions were directed towards different stakeholders involved in the sickness certification process such as employers and the Social Insurance Agency. Before introducing major interventions for a third main stakeholder, healthcare, in 2004, the government commissioned the Swedish National Board of Health and Welfare to supervise how healthcare handled such tasks (53, 54, 88, 89), and Karolinska Institutet (KI) to conduct a comprehensive investigation to identify problems in healthcare regarding sickness certification of patients (64, 65). In one of the data collections in the latter investigation, focus group interviews with physicians were conducted. Study I in this thesis is based on analyses of those interviews. Moreover, KI conducted a questionnaire survey in 2004 encompassing about 7000 physicians in Sweden, which was followed up with a questionnaire sent to all 37 000 physicians in 2008. Study II in the thesis is based on analyses of data from these two questionnaires.

Independently from one another both the supervision of the Swedish National Board of Health and Welfare and the KI investigation identified, among other things, that sickness certification issues within healthcare largely lacked management (64, 65, 90).

Based on these findings, (64, 65, 90), in 2006 the Swedish government introduced a comprehensive intervention directed to the county councils with the aim of increasing the quality of how sickness certification of patients was handled. The main and first-mentioned aim of that intervention was to promote management of sickness certification issues in healthcare organisations in Sweden. To be able to evaluate the effects of this programme when it came to management, a large research project with interviews of managers on different managerial levels in Swedish healthcare was initiated to obtain baseline data (61). Studies III and IV are based on analyses of some of the data from these interviews.

5.2 STUDY I

This study was based on focus group discussions (FGDs) with physicians. FGDs can be described as a structured group interview methodology with people who possess certain characteristics, aimed at providing qualitative data on a specific issue (91).

5.2.1 The focus group discussions

A discussion guide for the FGDs was constructed based on findings in the literature, pilot interviews (64), and deliberations among the authors of Study I. The general question in focus for the FGDs was: “What problems do you experience when sick leave is considered for a patient?” The areas of competence, waiting times, role conflicts, cooperation, and responsibility of the physician, handling of referrals, and

leadership and management were covered in the guide. If these aspects did not arise spontaneously in the discussions, they were introduced as open-ended questions. In collecting data, a grounded theory approach was used, meaning that the guide was continuously developed in communication among the researchers to ensure that all important areas were covered (92-94), and that data collection was ended when no further information concerning the general question appeared in the interviews (91).

Each FGD lasted approximately 90 minutes. They were held in proximity to the participants´ worksites, and two experienced focus group discussion leaders (one the author of the thesis (MvK)) alternated between taking either the role of facilitator or the role of observer in the FGDs. All interviews were recorded on audiotape and transcribed verbatim. Validity of the transcripts was checked through listening to some of the FGDs while reading them.

5.2.2 Participants

Study I is based on data from six FGDs with physicians. In 2004, an invitation to participate in an FGD was sent to a large number of physicians (380) in five counties in Sweden. The participants were strategically selected to include physicians who came from different regions of Sweden, from urban and rural areas, and who worked in clinical departments where sickness certification was a common task, i.e. primary healthcare (GPs), orthopaedics, psychiatry, rehabilitation medicine, and obstetrics. (55, 95). In all, 26 physicians, half of them women, from four counties participated in the FGDs, with two to six participants in each FGD.

5.2.3 Analysis of the data

As the aim of this study was to identify experienced problems described by the participants themselves, a qualitative content analysis method was used in analysing the data (96). Initially, the four authors independently identified statements that concerned problems in sickness certification of patients. Only statements where consensus could be reached that they described a problem for the physician were included in the analyses. More than 600 such statements were identified and thereafter coded using NVivo software. The first level of coding was discussed and decided on in consensus between the first and second authors. Subsequent levels of coding were completed by the first author (MvK). Coding principles and emerging categories were regularly discussed and decided on through negotiated consensus among the authors.

5.3 STUDY II

This study was based on analysis of answers to some items in two questionnaires that were sent out to physicians in 2004 and 2008, respectively.

5.3.1 The questionnaires

In 2004 a comprehensive questionnaire concerning various aspects of sickness certification practice and related work tasks was developed that included 83 questions (55). This questionnaire was further developed in 2008 to include 163 questions (52). Healthcare management of the physicians' sickness certification tasks was measured by the following two questions:

1. “Do you have a joint policy in your department for handling matters related to sickness certification tasks?” The response alternatives in 2004 were: “Yes, and it is well established”, “Yes, to some extent”, and “No”. In 2008, two additional response alternatives were included: “I don’t know” and “Not applicable, I don’t work in a clinical setting”. Those who chose the last response alternative were not included in the study.

2. ‘Do you get support from your manager regarding sickness certification cases?’. In 2004 the response alternatives were: “Yes, extensive support”, “Yes, some support”, and “No”. In 2008 there were two more response alternatives: “Not applicable, I don’t have a manager” and “Not applicable, I don’t work in a clinical setting”.

5.3.2 Study population

The 2004 survey included the 7 665 physicians below 65 years of age in two Swedish counties, the counties of Stockholm and of Östergötland (55). The physicians in Stockholm County were identified through their membership in the Swedish Medical Association and by being registered as working and living in Stockholm in 2004. About 95% of the physicians in Sweden were members of that medical association. The 2008 survey included all 36 898 physicians who were living and working in Sweden in October 2008. They were identified using a register of all physicians in Sweden, held by Cegedim AB.

The questionnaires were distributed by mail in October 2004 and in October 2008, respectively, to the participants’ home addresses in order to avoid interaction with colleagues in completing the questionnaire. Two and three reminders were sent to non-responders in 2004 and 2008, respectively. Distribution, registration, scanning of questionnaires, and basic management of data were administered by Statistics Sweden.

5.3.3 Analysis of the data

Included in this study were the physicians who had answered the questionnaire, were board-certified specialists[2], mainly worked in a clinical setting in Stockholm County, were below 65 years of age, and who had consultations regarding sickness certification. The study population in 2004 comprised 6 794 physicians and that in 2008 comprised 9 391 physicians. The response rates were 71% (n=4 827) in 2004 and 57% (n=5 369) in 2008. The estimations of response rates were based on the home addresses. In all, 2 497 physicians fulfilled the inclusion criteria in the 2004 survey and 2 204 did so in the 2008 survey.

[2] A board-certified specialist is a physician who is certified as a specialist by the Board of Health and Welfare (in Swedish: *Socialstyrelsen*) after completing basic training, internship, and five years of resident training and evaluation in a specific medical speciality (in Swedish: *specialist*).

The partial non-response rates (missing data in returned questionnaires) for the two questions that assessed management of the physicians' sickness certification task were 4.2% and 0.9%, and 8.0% and 5.0% in 2004 and in 2008, respectively.

Information about board-certificated speciality was provided by the National Board of Health and Welfare. Questionnaire information about what type of clinical setting the physician mainly worked in was used for the following medical specialties: rehabilitation, oncology, occupational health services, orthopaedics, internal medicine, gynaecology, surgery, primary healthcare, psychiatry. All other specialties were combined into “other medical specialties”.

Results of frequencies regarding the two questions were stratified by type of medical specialty. Proportions, with 95% confidence intervals (CI), for giving the different response alternatives, were calculated using the SPSS 18.0 program.

To check whether the two items regarding policy and support, respectively, measured the same aspects of management or captured different aspects, we calculated Pearson’s correlation coefficient for each medical specialty between having a well established policy (well established/all other) and having substantial support from the manager in this task (substantial support/all other).

5.4 STUDY III

Both studies III and IV were based on individual interviews with managers. The bases for the interviews were results from study I and from the above-mentioned questionnaire sent out in 2004.

5.4.1 The individual interviews

The interview guide consisted of open-ended questions concerning the CEO’s views on management of the task of sickness certification and was part of a larger research project concerning how managers in healthcare organisations manage the process of sickness certification of patients who are unable to work due to illness or injury. The guide included questions on management strategies for competence development regarding sickness certification processes, strategies for cooperation within healthcare and with other stakeholders regarding these issues, and for quality assurance of related processes (97). These were also the issues mainly addressed by the participants. However, a pilot study with two managers who had previously had positions as CEOs showed that as the managers talked about their experience of management of the sickness certification task, they also spontaneously described general aspects regarding management of physicians. Based on this finding, a question that focused on the CEO’s general views on management of physicians was added to the guide. This query was phrased as follows: “Could you please tell me about your views on management of physicians?” The broad concept “management” was not defined in the interviews in order to induce the CEOs to explore as many aspects of this issue as possible and to do so from the perspective of their own pre-understanding of management.

The interviews lasted for approximately 45 minutes and were conducted by two experienced interviewers, who also had experience of leadership and management

issues within healthcare. Due to large geographical distances, most of the interviews were conducted by telephone, but in a few cases, when it was possible, they were held in face-to-face meetings with the participants. MP3 recording was used for all interviews and the recordings were then transcribed verbatim. The validity of the transcripts was checked through listening to the initial individual interviews while reading them at the same time.

5.4.2 Participants

In 2006 a letter was sent to all CEOs in Sweden inviting them to participate in individual interviews concerning leadership and management of the process of sickness certification of patients in their organisations. Two chose not to participate and referred us to subordinate managers. The interviews with those lower-level managers were not included in this study. In all, 18 of Sweden's 20 CEOs participated in this study. Seven of them were trained as physicians, whereas the remaining eleven had other professional backgrounds. Five were women.

The CEOs hold the absolute top managerial positions in the Swedish healthcare system and are responsible for the delivery of all types of healthcare - both at hospitals and in primary care - in their respective counties. In their position as senior executives, appointed by the regional governments, they have an overarching responsibility for the economy and strategy in the county councils, including the tasks of formulating visions and goals and handling policymaking, and communicating the results of this work to all employees and parts of the organisation. The CEOs do not manage physicians directly; their task is to manage managers, and they run their organisations through subordinate managers in a line management system. Depending on the size of the county council, there can be from one to several managerial levels (usually several) between the CEOs and the practicing physicians in the organization.

5.4.3 Analysis of the data

In order to understand how the top managers regarded management of physicians, and to generate an hypothesis about potential implications for the manager role, a grounded theory approach (98) was used.

The data analysis was performed in three steps: an initial open data exploration, followed by identification of the concepts and their relationships, and, finally, development of a story line. In the first step, the interview transcripts were scrutinized by the author of this thesis (MvK), and all statements mentioning physicians were extracted and gathered in one document, which was read several times to get a sense of the whole. All statements that expressed views concerning management of physicians were thereafter identified to form the unit of analysis for the study. The content of each statement was then condensed and given a code (99). In the next step of the analysis the empirically grounded findings were related to, and integrated with, prior theory, and the author's own pre-understanding (100, 101). Abbott's theory of professional jurisdiction (Abbott 1988) was used to inform thinking on managerial control and legitimacy in relation to physicians. All types of associations with both prior and emerging theories were continuously written down in memos by MvK (98), who then discussed the identified memos, codes, categories, and themes with the other authors, who searched

the text in order to give second opinions. Concepts and their interrelationships were subsequently developed in discussion with all authors, as well as alternative interpretations. During this step of the analysis a story line was also developed in which the concepts found in the analysis were represented in relation to each other (98).

5.5 STUDY IV

5.5.1 The individual interviews

The data collection in study IV was based on the same interview guide and followed the same procedure as in study III.

5.5.2 Participants

Study IV was based on interviews with 38 managers at two organisational levels in Swedish healthcare: the same CEOs as in study III and an additional 20 clinical department managers (CDMs). The CDMs are the immediate managers of physicians in the Swedish healthcare organisation. They are part of their organisation's managerial system and have a statutorily regulated administrative responsibility for work performed by staff at a clinical department in primary care or in a hospital. The number of employees in a clinical department can range from a handful up to several hundred, including physicians as well as other healthcare professionals.

A letter with an invitation to participate in an individual interview concerning leadership and management of sickness certification processes was sent to the 20 CEOs (see study III) and a purposeful sample of 30 CDMs from different types of clinical departments in five counties. In all, interviews with 18 CEOs (five women and 13 men) and 20 CDMs (eleven women and nine men) were included in the study. A total of 38 managers participated. Nineteen were physicians and 19 had other underlying professions; the absolute majority of these were registered nurses. A few had other healthcare or non-healthcare professions. The participating CDMs were managers in primary care or hospital departments in four different small or large counties. The interviews were conducted by three experienced interviewers (the same as in study III, and MvK), who also had experience of leadership and management issues within healthcare. The same interview guide as in study III was used.

5.5.3 Analysis of the data

In order to understand how the manager role was constructed and reconstructed in the way the managers talked about management of physicians, a linguistic discourse analysis approach was used (76). Specific attention was focused on the use of words and linguistic markers in the participants' statements, such as subject positions, attributes, adjectives, and clauses (76). The use of these linguistic markers provided clues as to how the managers used different discourses to construct and reconstruct the manager role in relation to the medical profession in their organisations. Analysis was made close to data and sensitive to the use of language, but at the same time aimed at "finding broader patterns and going beyond the details of the text" (102, page 1133). The process for forming the corpus of the analyses followed the same procedure as in study III. For validation, preliminary finding were continuously checked against the

data and discussed among the authors for alternative interpretations. Based on the associations that were made, on further theoretical reading, and on discussions between the authors concerning meaning in the managers' talk, changes and clarifications in how the data should be interpreted were made during the analysis process.

5.6 ETHICS

All participation was voluntary and the participants were informed about their right to withdraw from the study at any time. All four studies were approved by the Regional Ethics Committee of Stockholm.

6 RESULTS

A summary of the results for each of the four studies is given below.

Study I: *Problems in sickness certification of patients: a qualitative study on views of 26 physicians in Sweden*

The physicians described a large number of problems that could be categorised into four areas: society and the social insurance system, the organisation of healthcare, the performance of other actors in the system, and the physicians´ own working situation, (see table I, study I).

Regarding society and the social insurance system, the physicians perceived an imbalance between the policies and laws that regulate sickness benefits and the situations they met in their practice. They referred to a lack of overview and management of the social insurance system as a whole, and described unclear responsibility and instructions from the authorities concerning the purpose of the system.

Regarding how healthcare was organised concerning the task of sickness certification, the physicians described existing gearing systems and incentives as inadequate or counterproductive, making it difficult to take the time needed to motivate patients to return to work, to write correct certificates, and to assess the need for sickness absence. Other types of problems in this category were shortage of physicians in primary healthcare, problems related to referral systems, fragmentation of care, and routes of contact and access between hospital departments and between primary care and hospital care.

Concerning collaboration with others, the physicians mainly described problems in communication with the social insurance office. Other problems in this category were physicians "dumping" sick-listing cases onto GPs, GPs too hastily referring cases to orthopaedics, other healthcare professionals such as midwives and "therapists" demanding sick notes for their patients, as well as problems with patients themselves demanding to be sickness certified or, in contrast, patients who did not want to be off sick even though this was recommended by the physician.

The physicians also described several problems related to their own working situation such as handling sickness certification issues for patients with symptoms difficult to diagnose, not having access to advice and counselling from other healthcare professionals when needed, and ethical dilemmas. Many physicians, especially GPs, described their work with sickness certification issues as a work environmental problem and described feelings of fatigue, despair, and lack of pride in their work because they felt that they contributed to medicalisation and prolonged periods of sick leave for patients.

In summary, the problems the physicians described involved managerial issues such as overall leadership, how the delivery of healthcare was organised, as well as the design

of existing incentives and support systems for physicians' handling of patients' sickness certification. In many respects the problems described by the physicians seemed related to a lack of leadership and management of sickness certification issues. Although these are issues related to managerial responsibilities, the physicians were uncertain about where responsibility for such issues lay within the healthcare organisation, and when directly questioned, none of the physicians could identify anyone in charge of such issues in their department, hospital, or county. Managers did not seem of relevance for the physicians in relation to the problems they had described.

This finding raised questions, which led to the following studies. Was there a lack of management of sickness certification tasks? And if so, to what extent? And why?

Study II: *Healthcare management of sickness certification tasks: results from two surveys to physicians*

The results showed that the proportions of physicians working in clinical settings with a well-established policy regarding sickness certification were generally low both in 2004 and 2008, but varied greatly between different types of medical specialties.

In 2004, 57.7% of the physicians worked in a clinical setting with a joint policy regarding sickness certification; 17.2% stated that the policy was well established. In 2008, only 34.5% stated that they had such a policy, however 21.3% stated that they had a well established policy. The variation among medical specialties regarding access to a well-established policy was substantial in both surveys, ranging from 6.1% among physicians in internal medicine to 41.5% in rehabilitation medicine in 2004 and from 8.8% in internal medicine to 46.9% in occupational health service in 2008 (see table 2 study II). Specialists in rehabilitation medicine clinics and in occupational health services had the highest rates both years, however, with wide CIs. The proportions of physicians stating having a well established policy were about the same the two years, however, the proportion of physicians stating 'no' (policy) were higher in 2008 except for rehabilitation specialists. The proportion of GPs stating having a well-established policy was 12.8% in 2004 and 26.8% in 2008. Compared to in 2004 a higher proportion of specialists in gynecology, psychiatry, and primary care stated 2008 that they had no joint policy regarding sickness certification. However, some of the participants might be the same 2004 and 2008 while others have changed specialty and work site.

The proportion of physicians with substantial management support was 25.3% and 18.1% in 2004 and in 2008, respectively. The variation among medical specialties was about as wide as for having a well-established policy; 13.7% in internal medicine and 48.8% in rehabilitation medicine in 2004 and 10.5% in oncology and 34.2% in rehabilitation medicine in 2008. The proportions of physicians experiencing *no* managerial support were about the same in both surveys, both for all and in different specialties, with oncology and surgery having the highest rates.
For both aspects of managerial support, physicians in rehabilitation medicine had the highest proportion in both the surveys (see table 2 and 3, study II). However, the CIs were very wide.

Study III: *Managers' perceptions of the manager role in relation to physicians: a qualitative interview study of the top managers in Swedish healthcare*

Based on the findings from study I and II that many physicians lacked management of sickness certification and that managers, at least from the physicians perspective, seemed rather absent, we wanted to explore how the managers themselves regarded management of physicians in their organisations. Interviews with 18 of Sweden's 20 CEOs showed that most of the participating CEOs found it difficult to manage physicians. However, when asked about their views on management of physicians, half of their statements merely contained descriptions of "how physicians are" rather than addressing aspects of their own or their subordinate managers' managerial behaviour or strategies.

Three types of views concerning physicians were identified among the CEOs' statements:

1. *Physicians have high status and expertise*
   In this type of statements the CEOs clearly acknowledged physicians' medical expertise and academic competence, and described them as a professional group of high standing in the organisation (i.e., with high social status among healthcare professionals). The demands and challenges of managing physicians were not associated with difficulties concerning managerial strategies or behaviour, but were rather ascribed to physicians' high standing in the organisation.

2. *Physicians lack knowledge about the system in which they work*
   This type of statements concerned physicians' organisational knowledge and competence. The CEOs described physicians as lacking knowledge about the system in which they work, not only with respect to the healthcare organisation per se, but also regarding the role of healthcare in society.

3. *Physicians do what they want in the organisation*
   Statements of this type concerned what was perceived as physicians' autonomous behaviour in the organisation. CEOs described how physicians tended to avoid participating in meetings with other professional groups, were reluctant to abide by rules, and in different ways chose to follow their own agendas. This type of "do-what-you-want" behaviour was not argued as being a consequence of the CEO's or the subordinate manager's decisions or strategies. Instead, it was attributed to a strong collegial culture among physicians that was described as being "permissive" and based on loyalty and solidarity within the medical profession.

When management was described by the CEOs, only a few statements concerned the use of general management strategies in relation to physicians. The general strategies mentioned were use of *management control systems*, *motivational strategies* and *line management.* These strategies were not oriented specifically towards physicians and seemed based on the assumption that every professional group, in healthcare or

elsewhere, requires a specific approach from the manager. The majority of strategies, however, concerned strategies specifically used to manage physicians.

Four physician-specific strategies were identified:

1. Organisational separation
In this subcategory the strategy was to separate physicians from other professionals in the organisation. An example of this was to have separate department meetings for physicians even when the manager thought that the issues to be discussed actually concerned the whole staff. This strategy, the CEOs argued, was necessary to make physicians attend the meetings at all.

2. "Nagging and arguing"
This type of management strategy seemed to consist of a "nagging and arguing" behaviour on behalf of the managers, repeatedly trying to tell physicians what they should do and what their responsibilities were as employees. However, some of the CEOs argued that repeated reference to rules and regulations was not an effective strategy for managing physicians.

3. Compensations
A third management strategy was to compensate physicians for participating in activities or meetings that the manager regarded as important. These compensations were not related to ordinary salary or negotiated agreements or privileges, but were instead specifically offered by management in an effort to make participation in a particular activity attractive to physicians. Characteristic for the various forms of compensation offered to the physicians was that they were given for activities that, from the managers' perspective, were part of the physicians' ordinary work obligations and for activities that were performed during the physicians' normal working hours.

4. Relying on the physician role
A fourth management strategy was to rely on the physician role instead of the manager role when it came to managing physicians. Many of the CEOs, both those who were themselves physicians and those who were not, argued that it was easier for managers who were trained as physicians to control physicians' behaviour. Managers therefore tended to rely on this physician role, their own or that of subordinate managers, in managing physicians. This strategy seemed to be based on the assumption that the manager role was not strong enough to manage physicians.

Increased managerial control in daily work
The results indicated that the general management strategies might strengthen the manager role in relation to the medical profession. These were actually the only statements that included a clear declaration of a strong manager role in relation to the medical profession. However, most statements referred to physician-specific management strategies. These strategies seemed based on pragmatic behaviour on the part of the managers in the organisation and seemed to serve the main purpose of preserving good relations with the physicians while maintaining a certain degree of

manager control. In this respect they contributed to increased managerial control over physicians in daily work.

Weakening of the manager role
However, the physician-specific management strategies seemed to lead to a paradox of control in relation to the medical profession. At the same time as they increased managerial control in daily work, they seemed to decrease the managers' role legitimacy and contribute to a weakening of the manager role in the organisation in relation to the medical profession. However, this weak manager role was not based solely on the relationship between managers and practicing physicians, but seemed to be reinforced by how the CEOs themselves perceived their own manager role, as well as that of other CEOs or subordinate managers. These top-level managers actually seemed to feel that the manager role in itself did not have enough power to enable management of physicians.

Study IV: *Healthcare managers' construction of the manager role*

Two discourses were identified that were used by the managers to construct the manager role in their healthcare organisations, a management-based discourse, and a profession-based discourse.

The management-based discourse

In this discourse, the manager role seemed defined by the management system of the organisation and clearly rooted in the organisational structure. Although the managers who used this discourse to construct the manager role differed with regard to the type of management jargon and leadership styles they referred to in their statements, they clearly identified with their position of being mangers and expressed strong identification with the manager role. Potential authority and legitimacy in the manager role was clearly connected to the manager position. When specific tasks and responsibilities were described, these were described in relation to the goals of the organisation. In that respect, their norms and values concerning manager role authority, the purpose of management, and the need for hierarchies seemed clearly embedded in the management-based discourse, which enabled them to focus on what they perceived as the aim of the organisation, and to recognise and use their positional power to move the work processes in that direction.

In the management-based discourse the manager role was also constructed as *one* role, held by managers of different professions. This manager role was differentiated only vertically because of the prevailing line-manager system, i.e. the hierarchically organised management levels within the respective organizations. Managers with different underlying professions, both CEOs and CDMs, used the management-based discourse to construct the manager role in the organisation. However, expressions of this discourse among the managers were few.

The profession-based discourse

In parallel with the management-based discourse, delineating a unified manager role, another picture emerged in the managers' statements where the construction of the manager role was strongly associated with the managers' underlying profession. In this discourse the manager position was referred to less often, and the manager role was constructed as divided into two qualitatively different roles with different scopes of power (i.e., a vertical differentiation between the two roles within the organisation), one comprising physician managers, and the other non-physician managers. Framed within the profession-based discourse the manager role was not related to organisational purposes, but was instead embedded in everyday leadership solutions based on professional values and power relations. This discourse was created and recreated in a number of ways in the managers' statements, both by those managers who were trained as physicians and by those who had other underlying professions.

The profession-based discourse was used more frequently by the managers to construct the manager role in the organisation. It had a clear polemic character where managers defined their manager role by strongly emphasising what they were not. This polemic identification occurred from both a superior and a subordinate perspective, and by managers who were physicians and by managers with other underlying professions. By identifying themselves as non-physicians, the non-physician managers gave power to the physician role and contributed to a profession-based discourse in which the manager role was regarded as subordinate to the physician role. In the same way, the managers who emphasised that they were physicians constructed the manager role as being subordinate. By emphasising their own profession as physicians, they contributed to underscoring the distance to those managers in the organisation who were not physicians, as well as to weakening their own manager role legitimacy. Through these processes the managers, regardless of their underlying profession, mutually contributed to rendering the role of manager as almost invisible in the organisation as well as to creating a stratification of power between the manager role and the physician role.

The analyses also found few expressions of the existence of a mutually shared manager community in the managers' statements. Several of the managers who were physicians indicated a strong psychological affiliation with the physician community through their use of expressions such as "we physicians" or "colleagues" when they talked about themselves or other physician managers in their managerial roles. There was no corresponding use of "we" as a marker for belonging to a mutually shared manager community. In the very few cases in the interviews in which managers gave any indication of belonging to a manager community, their sense of commonality seemed to be based on sharing the same feelings of difficulty, or almost resignation, in "not being the only manager", but one among many, who found it difficult to manage physicians.

A "yes, but..." approach to management

In the interviews, different managers used either the management-based discourse or the profession-based discourse to construct the manager role in their organisations. However, some managers, both CDMs and CEOs, shifted between the management-based and the profession based discourses resulting in a type of "yes, but..." approach to management. On one hand, *yes*, the manager role was established as strong and important in the organisation, as illustrated by the management-based discourse; *but*, on

the other hand, as illustrated by the profession-based discourse, it was absorbed by the managers' physician or non-physician roles and not regarded as powerful enough to manage physicians. In this way managers, even at the highest executive level in the Swedish healthcare system, seemed to struggle in the clash between the two discourses – between regarding the manager role as one role, or as two qualitatively different roles in the organisation. This seemed to be a struggle between an official, formal point of view in the organisation and an unofficial, informal standpoint, in which the former (i.e. the management-based discourse) was weaker than the profession-based discourse, which was informal but more dominant in nature. Power in the manager role seemed only to a limited extent to be institutionally defined. Rather, it seemed situationally negotiated, and it was the profession-based discourse (i.e. being a physician or not) that to a large extent determined how the manager role was constructed in the organisation.

7 DISCUSSION

In this chapter, the main empirical findings from the four studies will be discussed in relation to previous research. Some theoretical implications of the findings will also be addressed. The chapter concludes with a discussion of methodological aspects of the research.

7.1 MANAGERS CONSTRUCT A WEAK MANAGER ROLE (STUDIES III, IV)

One main finding of this thesis is that the managers themselves construct of a weak and ambigous manager role in relation to the medical profession – their own medical profession or that of others. This was shown in different ways in the studies.

7.1.1 Managers use strategies that weaken the manager role

Study III showed that when asked about management of physicians in their organisations the CEOs were strongly focused on physicians and physicians' behaviour instead of on their own or their subordinate managers' managerial behaviour. When managerial strategies were described, the majority of the managers described the use of what we identified as physician-specific strategies, which differed significantly from the strategies used to manage the work of other employees in the healthcare organisation. The physician-specific strategies seemed based on pragmatic behaviour on the part of the managers, which helped them to manage physicians in daily work, but in a longer perspective seemed to weaken the manager role and undermine the legitimacy of the manager position in relation to the medical profession.

Degeling et al (23) have addressed the need for managerial pragmatism in managing physicians' work, and have related it to the close interdependence between policy implementation and clinician behaviour in healthcare organisations. They state that healthcare managers always need the "active participation of healthcare clinicians, especially doctors, to implement these policy initiatives at the level where clinical work is done" (23, page 650). Following this line of reasoning, the strategies we found may be a way for the managers to cope with the gap between policy and policy implementation. However, Degeling et al have also addressed the impact of physicians' behaviour on how policy is implemented in practice, highlighting the fact that physicians are powerful employees: "When clinicians make decisions about what constitutes best practice, they also make decisions about how care should be organised. When applying those best practice decisions in their encounters with patients, clinicians are also allocating and spending the health budget" (23, page 650). What Degeling et al describe is that policy intentions are continuously negotiated in the clinical setting, and managers have to find ways to manoeuvre in the gap between the clinical micro level, where managers need the cooperation of physicians, and the top down bureaucratic mechanisms of healthcare reform. This may explain the results in our study. Managers need physicians' active participation, so they use strategies that seem pragmatic. However, our analyses indicate that these strategies, which help the managers to control

physician behaviour in daily work, also lead to decreased manager role legitimacy in the organisation and a weakening of the manager role in relation to the medical profession.

7.1.2 A profession-based discourse predominates

Study IV, analyzing *how* managers talked about the management of physicians, showed that few managers used a management-based discourse to construct the manager role in relation to the medical profession in their organisations. Instead, a profession-based discourse, where the attributes "physician" and "non physician" were frequently used to categorize self and other managers in their manager roles, strongly dominated managerial role taking. This was not only the case for managers who also were physicians. Managers who usually do not have hybrid manager roles, such as managers from other healthcare professions or vocational groups, and top level executives, also used this discourse. The analysis also showed that some managers, mainly CEOs, constructed the manager role based on a combination of the two discourses and used what in this thesis has been defined as a "yes, but..." approach to management (see 7.1.3).

In a linguistic discourse analytical case study, Iedema et al (47) found similar results. When exploring how one HCM navigated between profession and organisation, they found that this manager positioned himself on the boundary line of at least three incommensurate discourses: the profession-specific discourse of clinical medicine; the resource-efficiency and systematization discourse of management; and an interpersonalizing discourse "devoted to hedging and mitigating contradictions" (47, page 15). This finding corresponds well with the profession-based, the management-based, and the combining of the two in the "yes, but..." approach to management found in Study IV.

There are different ways to interpret these findings. Based on the thinking of Abrahamsson (1) the findings of parallel and seemingly contradictory discourses used by the managers can be interpreted as addressing discrepancies between formal organisational structures and the informal assumptions that constitute the day-to-day organisational conditions for managers and other employees in the healthcare organisation. The thesis demonstrates one implication of this phenomenon. Within the frames of the profession-based discourse the managers divided the manager role into two qualitatively different roles, physician managers and non-physician managers, with different scopes of power. This was very obvious even among the absolute top executives, and give the healthcare organisation a character of being a split organisation, with two parallel organisational structures – one formal and one informal. In this structure, managers cannot direct their behaviour toward formal goals based on formal mandates, but instead have to navigate in a type of "as if organisation". They need to behave as if they or their subordinates have a full mandate and instrumental power based on their manager position, while in practice they do not.

These discrepancies are not surprising. Abrahamsson (1) argues that deviations from the formal organisational structures, as they were originally intended by the mandators, are often or even usually the case in all types of organisations. In his studies, Abrahamsson showed that managers (he uses the term executives) in an organisation will inevitably distort the formal structures set up by the mandators. He regards this phenomenon as part of the "logic of organisations" (1).

This informal "yes, but..." approach to management in the organisation might be what legitimize what we found in study III, that managers in a superior position by-pass managers who are not physicians, and instead turn directly to influential physicians in the organisation when trying to manage physicians. That physicians tend to continue to rely on their peers when they achieve CDM positions was also found in a study by Öfverström (41). Additionally, the results of studies III and IV show that managers also with other professional backgrounds, and CEOs, also have a tendency to rely on the physician role rather than the manager role in their organisations. That managers tend to rely on their underlying profession was also found in a study by Lindholm et al(103).

The finding that the profession-based discourse was so predominant in the managers' role taking cannot be interpreted based on organisation theory only. The results indicate that healthcare managers construct the manager role within an existing traditional, hierarchical system of professions that overarches the managerial objectives based on which they are to find and take their manager roles. In this respect the findings in this thesis support the findings in the sociology of professions, that the medical profession "has managed to retain its overall dominance in the healthcare organisation" (104, page 68). What the findings in this thesis add, is that the managers themselves seem to contribute to this. The findings in this thesis actually indicate that the way the managers themselves handle the manager role contributes to weakening the manager role and to strengthening the influence of the medical profession in the healthcare organisation.

7.1.3 The "yes, but..." approach to management

In study IV we found that the managers could position themselves across the seemingly contradictory discourses, as in the "yes, but..." approach, even within the framework of one single statement. This was also found by Iedema et al (47). They argue that this expression of what they call "boundary management" may have advantages. It enables the HCM to "dissimulate the disjunction between his reluctance to impose organizational rules on his medical colleagues and his perception that such rules, in the future (to some extent at least), will be appropriate means for managing clinical work, and through that the organization"(47, page 15). Supporting Iedemas interpretation, this , which can be regarded as a lack of clarity in the manager role, could also be described in terms of having strategic advantages on an organisational level. Miller et al (82) describe that a "strategic ambiguity" embedded in statements on executive levels in organisations can promote a more widespread commitment to organisational goals as it allows "individuals and groups to interpret these goals in varied ways" (82, page 197). By providing few or no common organisational goals to follow, organisations can force employees to design their own role behaviours and thereby be more open to differential and shifting organisational needs. However, the literature on role ambiguity also suggests that the lack of shared organisational goals has negative effects on individual

employees in terms of increased stress and decreased job satisfaction and performance (82). The potential detrimental effects of role ambiguity are also addressed by Kippist et al(30). In a study on HCMs, they found that these managers tend to prefer their clinical role and sometimes even abandon their manager role, leaving the managerial function in what they describe as a vacuum. They argue that this role ambiguity of HCMs not only causes stress in the managers themselves but also in other members of the team. They also refer to Braithwaite (2004) and contend that abandoning the manager role also has negative consequences for the performance of important managerial pursuits such as quality and process management, strategic planning and external relations - pursuits that can have long-term advantages for the healthcare organisation and may have possible benefits regarding organisational efficiency (30). The abandonment of the manager role found by Kippist et al (30) is similar to making the manager role almost invisible that we found in study IV. However, in our study managers with different underlying professions contributed to this invisible-making, which may partly explain the lack of management in a concrete clinical situation found in studies I and II.

7.1.4 Lack of a mutually shared manager community

While the managers frequently used the attributes “physician” or “non-physician” to categorise themselves and other managers in their manager roles (as described in the profession-based discourse), expressions of a mutually shared manager community were almost totally missing in the managers’ statements. Svenningsson & Alvesson (67) showed that organisational support and belonging to a manager community are important for attaining managerial identity. Öfverström (41) showed that physicians accepting clinical director positions became more comfortable in their newly attained roles when having participated in management education. The main reason for this was not, according to the managers, the content of the training, but rather that they had met other managers they could identify with who shared the same problems and difficulties as their own.

Carroll and Levy (78) described that managers tend to rely on what they call a “default identity”. Although they did not study managerial identity in relation to a “professional” identity, they suggested this as a relevant area of study. They also suggested that the existence of a default identity is not necessarily negative. Rather it represents a secure base to fall back on until new identities are allowed to be formed (78). Following Carroll and Levy’s theory on default identities, the findings in this thesis may be interpreted in this direction. Categorizing themselves and other managers in their manager roles in terms of “physicians” and “non-physicians” might be understood in terms of those identities serving as a secure base to fall back on. In an organisational structure where the manager role is weak and unclear, these categorizations used within a traditional hierarchical system of professions may serve as a familiar, safe base when a mutually shared manager community, where new emerging identities are allowed to be formed, is lacking.

7.2 LACK OF MANAGEMENT OF SICKNESS CERTIFICATION TASKS (STUDIES I, II)

The findings also contribute to research on sickness certification practice. Study 1 showed that physicians experienced a large number of problems in their work with issues concerning sickness certification of patients. That physicians experience sickness certification as problematic has been confirmed in several studies (52, 55, 56, 60, 105-116). The type of problems, and how they were discussed by the physicians, indicated lack of management support in how to handle them. This lack of management was, to some extent, confirmed in study II, which examined two specific aspects of management in relation to physicians' sickness certification practice; managerial support and policy regarding handling of sickness certification issues. The results showed that when asked specifically about management,about one third of the physicians stated that they had no support from management and nearly half stated that there was no policy for these issues at their workplace. The results were similar in the follow-up study four years later. Alexanderson et al (61) have suggested that the lack of management of physicians' sickness certification task might be due to lack of knowledge on the part of the managers - that they actually do not know what to manage. The findings in studies III and IV, that the manager role in general seems rather weak in relation to the medical profession, may be another possible interpretation for why management of this task is lacking. However, based on the studies, we do not know to what extent physicians expect or even want management regarding this task. Other studies exploring this issue may provide additional explanations.

The acknowledgement of sickness certification as a problematic area for physicians has resulted in different actions aimed at improving the situation. Within healthcare, those actions have mainly been directed towards physicians, and a main strategy has been to train physicians (117). However, the large of bulk of the problems described by the physicians in study I concerned areas where managers on different organisational levels have, at least formally, a mandate, and in some cases also a legal responsibility, to act in a way that potentially could improve the situation. This finding supports the argument in the studies by Alexanderson et al (2005 + 2007) that these issues also need to be addressed on managerial levels.

7.3 THE ORGANISATIONAL PROFESSIONAL CONFLICT – NEW DIRECTIONS?

In recent research on professional governance in healthcare there has been a shift of focus in the debate on organisational professional conflict. From mainly regarding the strong power of the medical profession as something to be controlled or curbed by managers and policy makers, focus has shifted to the question of how to balance the different roles and accountabilities of managers and physicians (49). This shift of focus also highlights the issue of how these roles are taken within healthcare organisations.

This thesis found that many managers had difficulties in finding and taking their manager role in relation to the medical profession – irrespective of whether they themselves were physicians. According to role theory (3, 83, 84) managers' role taking

is geared by how they perceive the purpose of the organisation in which they work. The overall purpose of healthcare in Sweden as formulated in the Health and Medical Service Act is to provide good health care on equal terms for the whole population (37). However, based on their profession many healthcare professionals are also faced with partly conflicting aims. For the medical profession the overall purpose of their work is often not directed towards populations but towards individual patients, and the ethical rules postulate that in their work physicians shall have the *patient's* health as the primary goal (ref). Friedson (39) has argued that this ethical rule of the medical profession obliges physicians to oppose managerial objectives. Following Friedson's argument (39), there is a basic conflict between the organisational purpose and the purpose of the medical profession, where the ethical rules of the medical profession actually override the purpose of the organisation.

This conflict has been addressed in relation to the medical profession. With the point of departure in the changing health needs in the population, Plochg (118) suggested that an explicit population health orientation should be included as one of the core values of medical professionalism, that is "to maximize health for both the individual and the population as a whole" (118, page 5) . Plochg states, argue that through including a population health perspective, medicine, "acting as a collective, would agree to consider its contribution to society in relation to its initial purpose" (118).

Including the perspective of public health as a core value underlying the practice and science of medicine may contribute to overarching part of the problems in the organisational professional conflict. It may also contribute to bringing the professional and organisational perspectives closer together.A focus on the public health purpose as a support for managers in their role taking has thus far not been as thoroughly addressed in the literature. According to the theory of role taking, it is this overall purpose of healthcare that should help managers to take their manager role and cope with the complexity involved in leading healthcare organisations. However, when discussing the managers' part in the organisational professional conflict, this has usually perceived as based on the values embedded in managerialism and business management, not in terms of population health values. A recent study on ethical competence in healthcare management found that when healthcare managers were handling conflicting interests they had great difficulties in finding a balance between professional ethics and what they perceived as the values of business management (119). Business management tasks such as cost containment, budget allocations, and quality control are important pursuits and tasks that managers carry out, but they are merely means of fulfilling the purpose of healthcare as defined in the Swedish healthcare act: to provide good care to the population on equal terms.

To more clearly address the overall public health purpose of the healthcare organisation for managers could potentially help to ease the conflict between managers and physicians in healthcare organisations, and support managers in their role taking. Previous research indicates that ambiguity in the healthcare manager role may have negative consequences not only for managers, but also for physicians and other healthcare professionals, as well as for the quality of care. Dellve and Wikström (120)have suggested that clear policies regarding decision-making processes, managerial networks, and improved communication are needed to moderate the ethical

stress experienced by managers. Kippist found that managers' role ambiguity can cause conflict in both managers and other team members (30) and risks leaving important managerial functions in a vacuum. This study found that a weak and absent manager role in the healthcare organisation may have negative consequences for the quality of care – at least regarding the task of sickness certification.

In studying processes on the micro level of healthcare organisations, this thesis has addressed one aspect of what has been called the organisational professional conflict in healthcare organisations. However, Degeling et al (49) have expressed caution regarding the assumption in the literature that there is universality in the division between a managerial perspective and that of the medical profession. The findings in this thesis also indicate that there is a need to exercise caution in drawing a clear line between the perspective of managers, as representatives of the organisation, and that of the medical profession. First, the findings in the thesis show that most managers, not only physicians, used the profession-based discourse to construct the manager role. However, there were also exceptions to this. Some managers who were also physicians clearly took a managerial perspective and used the management-based discourse to construct their manager role in relation to the medical profession. The findings also indicate that a strong medical profession does not, per definition, make the manager role weak. Although the profession-based discourse was predominant, there were examples of managers, both physicians and non-physicians, who regarded the medical profession as strong and influential while apparently still seeming to feel strong and confident in their manager roles. Although they were the exceptions, these managers may have found ways to balance the organisational professional conflict in their role taking.

7.4 METHODOLOGICAL CONSIDERATIONS

The focus of this thesis is on issues so far not much researched. Therefore, the thesis has an explorative approach where the four studies that are included build on each other. Taking departure in the empirical findings in study I and II, an abductive approach was used in studies III and IV, as well as in the overall analysis in the thesis of the empirical findings from the four studies. This approach is characterized by a continuous altering back and forth between empirical data and theory where both are allowed to gradually be reinterpreted in the light of each other (121). In this way, theory was used in the thesis as inspiration, aiming at discovering patterns that might potentially increase understanding of the empirical findings (121).

Data from both physicians and managers were used with the objective to illuminate managers' role taking from different aspects. This can be regarded as a form of triangulation (122, 123). Triangulation was also used with regard to data-gathering methods where different types of data were used (questionnaires, individual interviews, focus group discussions). The thesis also used different types of methods for data analysis. The use of triangulation contributes to increased validity (122) and strengthens the transferability of the findings to other settings (123).

To assure credibility in the qualitative studies, the analyses were made close to data, the context of sickness certification was thoroughly described, as well as the theoretical framework for the overall analysis in the thesis of the empirical findings from the four studies.

The use of questionnaires in study II made it possible to include a large number of participants. All physicians in Stockholm County, not just a sample, were included which is a strength of this study. Another strength is the relatively high response rates, considering the often low rates among physicians (124). However, there were substantial rates of non-responders, and a major limitation is that we have no way of knowing how those would have responded. The response rate was also lower in 2008 (57% 2008 and 71% 2004), which is possibly partly due to the expanded questionnaire, from 83 to 163 questions. It is also a limitation of this study that the response alternatives differ somewhat between the two surveys. This might be one explanation for the results showing a lower rate of management support in 2008.

In the studies using qualitative analyses, the participants were selected to provide as many different experiences of the research issue as possible. In study I, physicians from different types of clinics in different parts of the country, and both women and men participated. Sampling in this study also followed a stepwise procedure when new FGDs were formed. Inclusion was ended when saturation was reached and no more aspects of the research issue (i.e. types of problems) were presented in the FGDs (91). In study III all CEOs in Swedish healthcare were invited, with low drop out. In study IV, the additional participating CDMs had different underlying professions, came from different types of clinics in different parts of the country, and included both women and men.

How sampling is done is closely related to validity and to what extent the findings are transferable to other settings (122). In all types of research and in qualitative research in particular, the influence of the researcher on the research issue also has to be taken into consideration (121). The researchers' experience and specific insights of the researcher in the studied area will contribute to increase the possibility of interpreting complex social phenomena (123). However, the experiences of the researcher will also affect what the researcher chooses to investigate, from what perspective, in what way, as well as how conclusions are framed and communicated (122). This is also the case in this thesis. To avoid subjectivity bias (122) based in my experiences and training, researchers with different professional and scientific backgrounds participated in the collection of the data as well as in the analyses of data in the four studies. Ideas and potential hypothesis were discussed and contested among all researchers for alternative interpretations. In the analyses of interview data, (studies I, III, IV) this was of extra importance; all analyses and categorisations were repeatedly discussed among the researchers. The theories used to inform the overall analysis was also presented.

To, as here, study managers role taking in the context of physicians' sickness certification practice has advantages. Sickness certification is a task for which it is evidence that physicians find it problematic to handle (56, 58), which should leave considerable room for management concerning this task. However, since this task has low status (56), and in some cases is, by physicians themselves, not even considered to be a major responsibility of physicians (60), application of this approach may have highlighted particular problems in managing physicians that might not be as evident in other areas of medical practice. With this limitation in mind, there is no reason to believe that the aspects regarding managers' role taking in relation to the medical profession that has been identified in this thesis are manifested only in relation to the task of sickness certification. Even though the association with sickness certification was the topic of the interviews in studies III and IV, most statements were of a general nature and did not refer to that particular task. In this respect, the findings do not only have relevance and contribute to the area of sickness absence research, but should contribute also to the general area of healthcare management. The overall analysis of the empirical data in the four studies was also performed within a theoretical framework, which increases the communicative transferability of the results (122).

Finally, the studies in this thesis were performed in Sweden. Although healthcare reforms have taken similar routes in many industrialized countries, comparison between countries should be done with caution, due to context sensitivity (125). That means that it is unclear to what extent the results can be generalised to other (welfare) nations. However, as pointed out in the introduction, similar problems have been observed in other countries and there is reason to believe that the results here can provide a fruitful base for further studies also in other systems and countries.

8 CONCLUSIONS

The aim of this thesis was to increase the knowledge about how managers in Swedish healthcare organisations handle their manager role in relation to the medical profession.

The findings show that managers have a weak, partly absent, and rather ambiguous manager role in relation to the medical profession.

Few managers used a management-based discourse to construct the manager role in their organisations. Instead, a profession-based discourse was predominant, where managers frequently used the attributes “physician” or “non-physician” to categorise themselves and other managers in their manager roles. Some managers also combined the two discourses in a “yes, but...” approach to management in the organisation. (IV). When strategies for managing physicians were addressed, many described physician-specific strategies that helped managers to manage physicians in daily work, but seemed to weaken the manager role in the organisation (III). Regarding physicians’ sickness certification, which is the clinical practice that has been the context for this study, many physicians experienced a lack of management concerning these tasks (I, II).

8.1 IMPLICATIONS FOR PRACTICE

This thesis has explored and analyzed one aspect of daily life in healthcare organisations: how managers handle their role in relation to the medical profession – whether it is their own medical profession or that of others.

How the manager role is handled and regarded within healthcare organisations constitutes part of the organisational conditions for the role taking of all employees in the organisation - managers, physicians, as well as other healthcare professionals. The findings in this thesis indicate that there is a need to support healthcare managers in their role taking in the organisation - both those managers who also are physicians and managers with other underlying professions. A weak and ambiguous manager role may have negative consequences not only for the work of managers, but also for that of physicians and other healthcare professionals, and for the quality of care.
There seems also to be a need to strengthen management regarding sickness certification tasks. The findings in this thesis show that many physicians lack management regarding this task, despite the fact that they experience a number of problems in their sickness certification practice. This may have negative consequences both for physicians and patients.

8.2 IMPLICATIONS FOR RESEARCH

Despite the strengthening of the formal manager position through government initiatives during the last three decades, previous research show that the medical profession has managed to retain its overall dominance in the healthcare organisation. The findings in this thesis indicate that healthcare managers themselves may contribute to this situation. Rather than potentially contributing to an emerging professionalization

process in the role of manager, managers seem to contribute to preserving the dominance of the medical profession and in different ways eroding the legitimacy and authority of the manager position. This hypothesis needs to be further studied.

This thesis found that managers with different underlying professions and on different managerial levels contribute to construct a weak, partly absent and ambiguous manager role in relation to the medical profession. To explore whether there are differences between or within groups was not within the scope of this thesis and still needs to be studied.

The "yes, but..." approach to management which was identified in the thesis raises questions about the organisational conditions for managers' role taking in healthcare and about a potential prevalence of "strategic ambiguity" in healthcare organisations. To further explore the organisational conditions for managers' role taking in healthcare organisations would be of great interest for future research.

Another issue for future research concerns management of sickness certification tasks. The results in study II showed that despite the many interventions to increase management of how sickness certification of patients is handled in healthcare many physicians did not experience such management. This finding raises questions about possible reasons for this. Further studies using different theories and perspectives are needed in order to explore this.

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9 REFERENCES

1. Abrahamsson B. The logic of organizations. Newbury Park: Sage; 1993.
2. Yukl G. Leadership in organizations (5th ed.). Upper Saddle River, New Jersey: Prentice Hall2002.
3. Reed B. An exploration of role. London: Grubb Institute2001.
4. Rayburn JM, Rayburn LG. The changing power equation in hospitals. Journal of Hospital Marketing. 1997;11(2):115-32.
5. Danermark B. Explaining Society. An Introduction to Critical Realism in the Social Sciences. London: Taylor & Francis; 2001.
6. Kaissi A. Manager-physician relationships. An organizational theory perspective. Health Care Managment. 2005;24(2):165-76.
7. Smith R. Why are doctors so unhappy? British Medical Journal. 2001;322:1073-4.
8. Edwards N. Doctors and managers: poor relationships may be damaging patients - what can be done? Quality and Safety in Health Care. 2003;Dec;12 Suppl 1:i21-4.
9. Edwards N. Doctors and managers: building a new relationship. Clinical Medicine. 2005;5(6):577-9.
10. Treasure T. Redefining leadership in health care. BMJ. 2001;323:1263-4.
11. Brommels M. Solister i kör? Om ledarskapsuppgiften i sjukvården (In Swedish). Sjörs G, Lindquist L, Carlsson I-M, editors. Uppsala: Fyris-tryck, 1998; 1995.
12. Rocco H, Westin H. Chefers syn på ledning av läkare i hälso- och sjukvården. Stockholm: Institutionen för Lärande, Informatik, Management och Etik(LIME), Karolinska Institutet2007.
13. Shortell SM, Waters T, Clark KW, Budetti PP. Physicians as double agents: Maintaining trust in an area of multiple accountabilities. Jounal of the American Medical Association. 1998;280(12):1102-08.
14. Nash DB. Doctors and managers: mind the gap. British Medical Journal. 2003;326:652-3.
15. Davies H, Hodges C, Rundall T. Views of doctors and managers on the doctor-manager relationship in the NHS. British Medical Journal. 2003;326(7390):626-8.
16. Rivers PA, Woodard B, Munchus G. Organizational power and conflict regarding the hospital-physician relationship: symbolic or substantive? Health Services Management Research. 1997;10:91-106.
17. Rundall T, Davies H, Hodges C. Doctor-manager relationships in the United States and the United Kingdom. Journal of Healthcare Management. 2004;49(4):251-68.
18. Brommels M. Management and medicine: Odd couple no more. Bonding through medical management research. Scandinavian Journal of Public Health. 2010;38:673-7.
19. Delnoij DMJ, Groenewegen PP. Health services and systems research in Europe: overview of the literature 1995-2005. European Journal of Public Health. 2007;17, Supplement 1:10-3.
20. Mintzberg H. Toward healthier hospitals. Health Care Manage Rev. 1997 Fall;22(4):9-18.
21. Pool J. Hospital Management: Integrating the dual hierarchy? International Journal of Health Planning and Management. 1991;6:193-207.
22. Harrison S, Pollitt C. Controlling health professionals. Buckingham: Open University Press; 1994.
23. Degeling P, Maxwell S, Kennedy J, Coyle B. Medicine, management, and modernisation: a "danse macabre"? British Medical Journal. 2003;326:649-52.
24. Kuhlmann E, Saks M, editors. Rethinking professional governance. International directions in healthcare. Bristol: Policy Press; 2008.

25. Kuhlmann E, Allsop J, Saks M. Professional governance and public control. A comparison of healthcare in the United Kingdom and Germany. Current Sociology. 2009;57(4):511-28.
26. Kuhlmann E. Modernising health care. Reinventing professions, the state and the public. Bristol: Policy Press; 2006.
27. Salter B. Governing UK medical performance: A struggle for policy dominance. Health Policy. 2007;82:263-75.
28. Kuhlmann E, Burau V, Larsen C, Lewandowski R, Lionis C, Repullo J. Medine and management in European healthcare systems: how do they matter in the control of clinical practice? The International Journal of Clinical Practice. 2011.
29. Griffiths R. NHS Management Inquiry. London: HMSO; 1983.
30. Kippist L, Fitzgerald A. Organisational professional conflict and hybrid clinician managers. The effects of dual roles in Australöian health vare organisations. Journal of Health, Organization and Management. 2009;23(6):642-55.
31. Kumpers S, van Raak A, Hardy B, Mur I. The influence of institutions and culture on health policies; different approaches to integrated care in England and The Netherlands. Public Administration. 2002;80(2):339-58.
32. Giaimo S, Manow P. Adapting the welfare state. The case of health care reform in Britain, Germany, and the United States. Comparative Political Studies. 1999;32(8):967-1000.
33. Burau V, Vrangbaek K. Global markets and national pathways of medical re-regulation. Kuhlmann E, Saks M, editors. Bristol: The Policy Press; 2008.
34. Landstingsanställd personal 2006 Available from: Available from: http://www.skl.se/web/Landstingsanstalld_personal_2006_1_1.aspx.
35. Bejerot E, Hasselbladh H. Nya kontroll- och maktrelationer inom sjukvården. Arbetsmarknad & arbetsliv. 2003;9(2).
36. Garpenby P. Resource dependency, doctors and the state: quality control in sweden. Social science & medicine. 1999:405-24.
37. Hälso- och sjukvårdslagen1982:763.
38. Socialstyrelsens allmänna råd. Verksamhetschef inom hälso- och sjukvården (Recomendations from The Board of Health and Welfare. Department manager in healthcare) (In Swedish). Socialstyrelsen, editor: SOSFS.
39. Freidson E. Professionalism. The Third Logic. Chicago: University of Chicago Press; 2001.
40. Thorne ML. Colonizing the new world of NHS management: the shifting power of professionals. Health Services Management Research. 2002;15:14-26.
41. Öfverström H. Steget till chefskap. Om läkare som verksamhetschefer (The step to management. Doctors as clinical managers) (In Swedish). Gothenburg: Gothenburg University; 2008.
42. Von Knorring M, De Rijk A, Alexanderson K. Managers' perceptions of the manager role in relation to physicians: a qualitative interview study of the top managers in Swedish healthcare. BMC Health Services Research. 2010;10(271):1-12.
43. Kuhlmann E, Burau V. The 'healthcare state' in transition. National and international contexts of changing professional governance. European Societies. 2008;10(4):619-33.
44. Bannink D, Kuipers S, Lantink T, editors. Reform in Europe: braking the barriers in government.2006.
45. Mark A, Scott H. Changing cultures - determining domains in the NHS. Health Services Management Research. 1991;4(3):193-205.
46. Ackroyd S. Organization Contra Organizations: Professions and Organizational Change in the United Kingdom Organization Studies. 1996;17(4):599-621.
47. Iedema R, Degeling P, Braithwaite J, White L. 'It's an Interesting Conversation I'm Hearing': The Doctor as Manager. Organization Studies. 2004;25(1):15-33.
48. Persson O, Thylefors I. Career with No Return: Roles, Demands, and Challenges as Perceived by Swedish Ward Managers. Nursing Administration Quarterly. 1999;23(3):63-80.

49. Degeling P, Zhang K, Coyle B, Xu L, Meng Q, Qu J, et al. Clinicians and the governance of hospitals: A cross-cultural perspective on relations between profession and management. Social Science & Medicine. 2006;63:757-75.
50. SBU. Sjukskrivning - orsaker, konsekvenser och praxis. En systematisk litteraturöversikt (In Swedish). Stockholm: Statens beredning för medicinsk utvärdering2003.
51. Löfgren A. Physicians' Sickness Cerification Practices. Frequency, Problems, and Learning. Stockholm: Karolinska Institutet; 2010.
52. Lindholm C, Arrelöv B, Nilsson G, Löfgren A, Hinas E, Skåner Y, et al. Sickness-certification practice in different clinical settings; a survey of all physicians in a country. BMC Public Health. 2010;10(752).
53. Socialstyrelsen. Sjukskrivningsprocessen i primärvården. Återföring av tillsynsbesök 2004 (In Swedish). Stockholm: Socialstyrelsen 2004.
54. Socialstyrelsen. Socialstyrelsens tillsyn av sjukskrivningsprocessen år 2003-2005 - sammanfattande slutsatser (In Swedish). Stockholm: Socialstyrelsen2006.
55. Löfgren A, Arrelöv B, Hagberg J, Ponzer S, Alexanderson K. Frequency and nature of problems associated with sickness certification tasks: A cross sectional questionnaire study of 5455 physicians. Scandinavian Journal of Primary Health Care. 2007;25(3):178-85.
56. Wahlström R, Alexanderson K. Swedish Council on Technology Assessment in Health Care (SBU). Chapter 11. Physicians' sick-listing practices (review). Scandinavian Journal of Public Health. 2004;63:222-55.
57. Alexanderson K, Norlund A. Sickness absence - causes, consequences, and physicians´ certification practice. A systematic literature review by the Swedish Council on Technology Assessment in Health Care. Stockholm2004. Report No.: 167:2003.
58. Söderberg E, Lindholm C, Kärrholm J, Alexanderson K. Läkares sjukskrivningspraxis; en systematisk litteraturöversikt (Physicians' sickness certification practice: a systematic literature review)(In Swedish): Socialdepartementet; SOU 2010:1072010.
59. SOU. Läkares sjukskrivningspraxis. En systematisk litteraturöversikt (In Swedish). Stockholm2010. Report No.: 2010:107.
60. Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. British Medical Journal. 2004 Jan 10;328(7431):88.
61. Alexanderson K, von Knorring M, Parmander M, Tyrkkö A. Hälso- och sjukvårdens ledning och styrning av arbetet med patienters sjukskrivning. Stockholm: Institutionen för klinisk neurovetenskap, Sektionen för personskadeprevention2007.
62. Socialstyrelsens författningssamling. Ledningssystem för systematiskt kvalitetsarbete. Socialstyrelsen, editor: SOSFS.
63. Arbetsmiljöverkets författningssamling. Systematiskt miljöarbete. Arbetsmiljöverket, editor: AFS.
64. Alexanderson K, Brommels M, Ekenvall L, Karlsryd E, Löfgren A, Sundberg L, et al. Problem inom hälso- och sjukvården kring handläggning av patienters sjukskrivning (Problems in healthcare regarding management of patients' sickness certification)(In Swedish). Stockholm: Karolinska Institutet2005.
65. Alexanderson K, editor. Bilaga till rapporten 'Problem inom hälso- och sjukvården kring handläggning av patienters sjukskrivning' (Appendix to the report 'Problems in healthcare regarding management of patients' sickness certification')(In Swedish). Stockholm: Karolinska Institutet; 2005.
66. Ljungquist T, Arrelöv B, Lindholm C, Löfgren Wilteus A, Nilsson GH, Alexanderson K. Physicians who experience sickness certification as a work environmental problem: where do they work and what specific problems do they have? A nationwide survey in Sweden. BMJ Open. 2012;2012;2:e000704.
67. Svenningsson S, Alvesson M. Managing managerial identities: Organisational fragmentation, discourse and identity struggle. Human Relations. 2003;56:1163-93.
68. Hirschorn l. The workplace within. Cambridge, MA: MIT Press; 1998.
69. Armstrong D. Organization in the Mind: Psychoanalysis, group relations and organizational consultancy. London: Karnac; 2005.

70. Abbott A. The system of professions. Chicago: The University of Chicago Press; 1988.
71. Grey C. Management as a technical practice: Professionalization or responsibilization? Systems Practice. 1997;10:703-25.
72. Thylefors I. Ledarskap i human service-organisationer. Stockholm: Natur och kultur; 2007.
73. Ryynänen K. Constructing physicians's professional identity - explorations of students' critical experiences in medical education. Oulo: University of Oulu; 2001.
74. Wikström E, Dellve L. Contemporary leadership in healthcare organizations. Fragmented or concurrent leadership. Journal of Health, Organization and Management. 2009;23(4):411-28.
75. Choi S. Competing logics in hospital mergers. The case of the Karolinska University Hospital. Stockholm: Karolinska Institutet; 2011.
76. Johnstone B. Discourse Analysis. 2nd ed. Oxford: Blackwell; 2008.
77. Foucault M. Power/Knowledge: Selected interviews and other writings, 1972-1977. C.Gordon, editor. New York: Pantheon; 1980.
78. Carroll B, Levy L. Defaulting to Management: Leadership Defined By What It Is Not. Organization. 2008;15(1):75-96.
79. Oswick C, Keenoy TW, Grant D. Discourse, organizations and organizing: Concepts, objects and subjects. Human Relations. 2000;53(9):1115-23.
80. Winther Jörgensen M, Phillips L. Diskursanalys som teori och metod (Discourse analysis as theory and method) (in Swedish) Lund: Studentlitteratur; 2000.
81. Watson TJ. Managing identity: Identity work, personal predicaments and structural circumstances. Organization. 2008;15(1):121-43.
82. Miller K, Joseph L, Apker J. Strategic ambiguity in the role development process. Journal of Applied Communication Research. 2000;28(3):193-214.
83. Reed B, Bazalgette J. Organisational Role Analysis at the Grubb Institute of Behavioural Studies: Origins and development. In: Long I, Newton J, Seivers B, editors. Coaching in depth: the Organisational Role Analysis Approach. New York: Other Press. Under publication; 2004.
84. Sandahl C, Falkenström E, Von Knorring M. Chef med känsla och förnuft. Om professionalism och etik i ledarskapet (Managing with sense and sensitivity. Professionalism and Ethics in Leadership) (in Swedish). Stockholm: Natur & Kultur; 2010.
85. Simpson P, French R. Managing oneself in role. Public Money and Management. 1998;18(2):45-50.
86. Jaques E. Requisite organisation. A total system for effective managerial organisation and managerial leadership for the 21st century. Arlington VA: Cason Hall1996.
87. Huffington C, James K, Armstrong D. What is the emotional cost of distributed leadership? Conference paper, unpublished. 2003.
88. Socialstyrelsen. Sjukskrivningsprocessen i företagshälsovården. Återföring av tillsynsbesök 2005 (In Swedish). Stockholm: Socialstyrelsen2005.
89. Socialstyrelsen. Sjukskrivningsprocessen hos privatläkare inom specialiteterna allmänmedicin, ortopedi och psykiatri. Återföring av tillsynsbesök 2005 (In Swedish). Stockholm: Socialstyrelsen2006.
90. von Knorring M, Sundberg L, Löfgren A, Alexanderson K. Problems in sickness certification of patients: A qualitative study on views of 26 physicians in Sweden. Scandinavian Journal of Primary Health Care. 2008;26(1):22 - 8.
91. Kreuger RA, Casey MA. Focus groups. A practical guide for applied research. 3rd ed. Thousand Oaks: Sage Publications; 2000.
92. Starrin B, Dahlgren L, Larsson G, Styrborn S. Along the Path of Discovery, qualitative methods and grounded theory: Studentlitteratur; 1997.
93. Glaser B, editor. More grounded theory, methodology: a reader. Mill Valley, California: Sociology Press; 1994.
94. Glaser BG. Remodeling Grounded Theory. Forum: Qualitative Social Research. [Art. 4]. 2004;5(2).

95. Löfgren A. Läkares arbete med sjukskrivning - problem och önskemål inom olika kliniska verksamheter. Stockholm: Sektionen för personskadeprevention, Institutionen för klinisk neurovetenskap2006.
96. Krippendorff K. Content analysis: an introduction to its methodology. Thousend Oaks: Sage; 2004.
97. Alexanderson K, Norlund A. Sickness absence - causes, consequences, and physicians' sickness certification practice. A systematic literature review by the Swedish Council on Technology Assessment in Health Care. Scandinavian Journal of Public Health. 2004;32(Supplement 63):1-263.
98. Corbin J, Strauss A. Basics of Qualitative Research. Tecniques and Procedures for Developing Grounded Theory. . 3rd ed. Tousand Oaks: Sage; 2008.
99. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004 Feb;24(2):105-12.
100. Layder D. New strategies in social research. Cambridge: Blackwell; 1993.
101. Layder D. Sociological practice. Linking theory and social research. London: Sage; 1998.
102. Alvesson M, Karreman D. Varieties of discourse: On the study of organization through discourse analysis. Human Relations. 2000;53(9):1125-49.
103. Lindholm M, Udén G, Råstam L. Management from four different perspectives. Journal of Nursing Management. 1998;7:101-11.
104. Calnan M, Rowe R, editors. Trust relations and changing professional governance: theoretical challenges. Bristol: The Policy Press; 2008.
105. Gulbrandsen P, Hofoss D, Nylenna M, Saltyte-Benth J, Aasland OG. General practitioners' relationship to sickness certification. Scandinavian Journal of Primary Health Care. 2007;25(1):20-6.
106. Swartling MS, Peterson SA, Wahlström RA. Views on sick-listing practice among swedish general practitioners - a phenomenographic study. BMC Family Practice. 2007;8(44).
107. Arrelöv B, Alexanderson K, Hagberg J, Löfgren A, Nilsson G, Ponzer S. Dealing with sickness certification - a survey of problems and strategies among general practitioners and orthopaedic surgeons. BMC Public Health. 2007;7(273).
108. Lous J, Nord-Larsen M, Olesen F. [Prolonged sick-leave: the role of general practitioner]. [Danish]. Ugeskrift for Laeger. 1997;159(27):4266-9.
109. Chew-Graham C, May C. Chronic low back pain in general practice: the challenge of the consultation. Family Practice. 1999;16(1):46-9.
110. Edlund C. Långtidssjukskrivna och deras medaktörer - en studie om sjukskrivning och rehabilitering (Long-term sick listed and their co-actors - a study of sickness absence and rehabilitation)(In Swedish) [Monografi]. Umeå: Umeå University; 2001.
111. Getz L, Westin S, Paulsen B. [Physician and expert--a conflict situation? General practitioners work with disability pension's errands in a time of restraint policy]. [Norwegian]. Tidsskrift for Den Norske Laegeforening. 1994;114(12):1435-40.
112. Timpka T, Hensing G, Alexanderson K. Dilemmas in Sickness Certification among Swedish Physicians. E J Public Health. 1995;5:215-9.
113. Woivalin T, Krantz G, Mantyranta T, Ringsberg KC. Medically unexplained symptoms: perceptions of physicians in primary health care. Fam Pract. 2004 Apr;21(2):199-203.
114. Mayhew HE, Nordlund DJ. Absenteeism certification: the physician's role. Journal of Family Practice. 1988;26(6):651-5.
115. Hiscock J, Ritchie J. The role of GPs in sickness certification: Department for Work and Pensions2001. Report No.: 148.
116. Melsom H, Noreik K, Carlsen TG. [Use of psychiatrists in security matters]. Tidsskr Nor Laegeforen. 1993 Dec 10;113(30):3760-1.
117. Engblom M. Sickness certification when experienced as problematic by physicians. Stockholm: Karolinska Institutet; 2011.
118. Plochg T, Klazinga NS, Starfield B. Transforming medical professionalism to fit changing changing health needs. BMC Medicine. 2009;7(64).

119. Falkenström E. Verksamhetschefens etiska kompetens. Om identifiering och hantering av intressekonflikter i hälso- och sjukvården (in Swedish). Stockholm: Stockholms universitet; 2012.
120. Dellve L, Wikström E. Managing complex workplace stress in health care organizations: leaders' perceived legitimacy conflicts. Journal of Nursing Management. 2009;17:931-41.
121. Alvesson M, Sköldberg K. Tolkning och reflektion. Vetenskapsfilosofi och kvalitativ metod. Lund: Studentlitteratur; 2008.
122. Malterud K. Qualitative research: standards, challanges, and guidelines. The Lancet. 2001;358:483-88.
123. Marshall C, Rossman GB. Designing Qualitative Research. Tousand Oaks: Sage Publications; 2006.
124. Pransky G, Katz JN, Benjamin K, Himmelstein J. Improving the physician role in evaluating work ability and managing disability: a survey of primary care practitioners. Disabil Rehabil. 2002 Nov 10;24(16):867-74.
125. Yardley L. Dilemmas in qualitative health research. Psychology and health. 2000;15:215-28.