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MEDICAL PROFESSIONALS DESIGNING HOSPITAL MANAGEMENT MODELS

BY
VIBEKE BYG

DISSERTATION SUBMITTED 2016

AALBORG UNIVERSITY
DENMARK

MEDICAL PROFESSIONALS DESIGNING HOSPITAL MANAGEMENT MODELS

by

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AALBORG UNIVERSITY
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ENGLISH SUMMARY

Health care administration in many OECD countries has undergone substantial changes in recent years as a consequence of NPM reforms, rising costs, the pace of technological innovation, heightened competition for patients and resources, quality of managed care and demographic shifts (Pollitt and Bouckaert, 2000, Greve, 2007, Brock, Powell, and Hinings, 1999, Neogy and Kirkpatrick, 2009, Jacobs, 2005, Sehested, 2002). Hospitals especially have been reformed due to the high proportion of resources they absorb and the apparent difficulty of prioritizing and coordinating health care within hospitals (Kirkpatrick et al., 2013). As part of these changes an alternative hospital management model has been developed and adopted globally (Kirkpatrick et al., 2013, Harrison and Pollitt, 1994). There is abundant research literature on the topic of reforming hospital management models. Enhancing the role of medicine in hospital management, with a special emphasis on the strategy or pressure of co-opting medical professionals into management, is researched and discussed (Jacobs, 2005, Neogy and Kirkpatrick, 2009).

The existing research provides insight into how medical professionals across Europe have reacted and responded to the implementation of new hospital management models (e.g. Jacobs, 2005, Neogy and Kirkpatrick, 2009). Lacking from the literature, however, is insight into how we can understand and explain how medical professionals adapt hospital management over time in relation to changing hospital management models that are global in their influence in hospital organizations. What is interesting in this regard is that empirical knowledge about the outcome of medical professionals' responses to hospital management models is primarily derived from an Anglo-Saxon health system context. Based on results from comparative studies, which highlight that not only institutional and regulative contexts but also more distinctive national or regional contextual factors may have implications for the translation of the changing hospital management models (Kirkpatrick et al., 2013), it may be valuable and useful to enhance our knowledge about how medical professionals adapt and interpret changing hospital management models in other contextual settings, such as the Nordic context, which differ from the Anglo-Saxon context according to a number of funding and institutional conditions (Magnussen, Vrangbæk, and Saltman, 2009). This also applies to management changes in the contexts of Anglo-Saxon and Nordic health systems.

Taking this into account, the Nordic health system context represents an interesting case. We might expect that this context, with a tradition for a consensual nature of policy making, strong position of professional associations, "institutional autonomy" of medical professionals, and their strong influence in practice, might have an impact on the opportunities for medical professionals to capture, colonize, alter and interpret their management roles and models locally in hospital

organizations. In comparison, this has been less the case in the Anglo-Saxon health system context where, for example, change brought about by NPM reforms has been more strongly driven from the top and has led to restricted opportunities for medical professionals to dominate management work locally. Given this, it is interesting to explore in depth how medical professionals adapt, negotiate and interpret management changes in hospital management models in hospital organizations over time, and especially within an underexposed context such as that of the Nordic health system. Here we might expect medical professionals to have both the opportunity to play a more innovative role in the local management change process and also more autonomy to interpret, negotiate and design their own management models, which may increase their level of engagement in hospital management. In this dissertation I take as empirical point of departure the Danish health system as an illustrative case for the Nordic countries, as Denmark is arguably the Nordic country in which management reforms and health care change have been introduced most softly.

The aim of this dissertation is to understand and explain how medical professionals adapt, interpret and negotiate hospital management over time in relation to changing hospital management models in hospital organizations in the Nordic health system context, illustrated by the Danish health system.

In relation to theories of organizational change and transformation, this dissertation applies the concepts of archetypes (Greenwood and Hinings, 1988, 1993), and of intra-organizational dynamics (Greenwood and Hinings, 1996), as a theoretical framing. The concept of archetypes is useful when studying how hospital management models change and transform. The concept of intra-organizational dynamics is useful when explaining how and why hospital management models have been adapted over time by professionals.

To investigate empirically how medical professionals adapt, interpret and negotiate changing hospital management models within hospital organizations in a Nordic health system context, a longitudinal embedded single case study was conducted from 2010 to 2013 in the Department of Cardiology within Aarhus University Hospital which is in the Danish health system. The Department of Cardiology had experienced a strong growth in both sub-specialization and the amount of employed professionals from 1992 to 2013, which required the consultants to re-organize their department management model, including the authority structure, decision system and interpretive scheme. The data used in the study is based on interviews with 43 informants, direct observations and documentary material.

Regarding its contribution to research, the dissertation advances the literature on professional responses to NPM reforms, showing alternative pathways of change in the more consensus orientated Nordic health system context by providing detailed and rich descriptions of the process by which medical professionals adapt changing

hospital management models within hospital organizations in a Nordic (Danish) health system context. Regarding the theory of organizational change and transformation, this dissertation contributes to the concept of archetype theory (Greenwood and Hinings, 1988, 1993), as it reveals insights into the process of movements between archetypes at a micro institutional level. It does this by examining how a management archetype template within a hospital organization becomes adapted or institutionalized by medical professionals through an organizational management change process. Furthermore, this dissertation contributes to the concept of intra-organizational dynamics (Greenwood and Hinings, 1996) by revealing insight into the micro institutional level of analyses of internal dynamics within organizations. In this respect, I have focused on the process by which individuals as medical professionals have adapted, interpreted and negotiated changing management archetype templates within a hospital organization. Furthermore, the dissertation contributes to the limited research literature that has applied the concepts of archetype theory and intra-organizational dynamics to professional health care service organizations empirically (Kitchener, 1999, Mueller et al., 2003, McNulty and Ferlie, 2002, 2004). Regarding contribution to practice, this dissertation reveals how it is crucial for medical professionals (especially consultants) to take an interest in and feel commitment to creating management changes in their organization. Such interest and commitment is necessary before any management change process in a hospital organization can be propelled or driven towards a defined end point, which the medical professionals should also agree upon. In this regard the dissertation also reveals that it is particularly important that medical professionals are or become aware of managerial and organizational issues that challenge their overall professional work and performance. Finally, the dissertation reveals how medical professionals, by virtue of their position of authority in hospital organization in a Nordic health system, have the ability and capacity to steer a managerial change process in the direction they deem advantageous to their authoritative status and professional work. In this regard, the dissertation also reveals how medical professionals as individuals and as a group possess the power and capacity for action to shape and design a hospital management model they find advantageous within a hospital organization in a Nordic health system.

DANSK RESUME

Mange OECD-lande har forandret deres administration af sundhedsvæsenet væsentlig som en konsekvens af NPM reformer, stigende omkostninger, teknologisk innovation, øget konkurrence om patienter og ressourcer, kvaliteten af behandling og pleje samt demografiske forskydninger (Pollitt and Bouckaert, 2000, Greve, 2007, Brock, Powell, and Hinings, 1999, Neogy and Kirkpatrick, 2009, Jacobs, 2005, Sehested, 2002). Især administration af hospitaler er blevet forandret og reformeret på grund af den høje andel af ressourcer, de absorberer samt vanskelighederne ved at prioritere og koordinerer sundhedsydelser (Kirkpatrick et al., 2013). Som en del at dette, har en alternativ hospitalsledelsesmodel fra The Johns Hopkins Hospital i Baltimore, USA, udviklet sig, og er blevet spredt og adapteret globalt (Kirkpatrick et al. 2013, Harrison og Pollitt, 1994).

I forskningslitteraturen får reformeringen af hospitalsledelsesmodeller betydelig opmærksomhed og særligt lægers styrkede rolle og position i ledelse af hospitaler er blevet undersøgt og diskuteret (Jacobs, 2005, Neogy og Kirkpatrick, 2009). Eksisterende forskning giver således indsigt i hvordan læger i en række forskellige europæiske lande har reageret på implementering af nye hospitalsledelsesmodeller (fx Jacobs, 2005, Neogy og Kirkpatrick, 2009). Indsigt i hvordan vi kan forstå og forklare, hvordan læger involverer og engagerer sig i ledelsesmæssige forandringsprocesser vedrørende hospitalsledelsesmodeller over tid i hospitals-organisationer, er dog begrænset. I den forbindelse er det interessant, at vi først og fremmest har empirisk viden om lægers reaktioner på ledelsesforandringer i hospitalsledelsesmodeller fra det angelsaksiske sundhedssystem. Resultater fra komparative undersøgelser fremhæver netop, at institutionelle og lovgivnings-mæssige kontekster, men også mere karakteristiske nationale eller regionale kontekstuelle faktorer kan have implikationer for hvorledes hospitalsledelses-modeller forandres og institutionaliseres lokalt (Kirkpatrick et al. 2013). Det antages derfor at være særlig interessant, at øge vores viden om, hvordan læger tilpasser og fortolker ledelsesforandringer i hospitalsledelsesmodeller i andre kontekstuelle områder som for eksempel i den nordiske kontekst, der netop varierer fra den anglesaksiske kontekst (Magnussen, Vrangbæk, Saltman, 2009). Dette gælder særligt i forhold til ledelsesforandringsprocesser inden for sundhedssystemerne i de nævnte kontekster. Det nordiske sundhedssystem repræsenterer i denne sammenhæng en interessant case, i det det antages, at den nordiske tradition for konsensus orienterede politiske beslutningsprocesser, de stærke lægeforeninger på samfundsniveau, samt at lægerne besidder en høj grad af "institutionelle autonomi" og stærk indflydelse i praksis på hospitalsorganisations niveau, kan have en positiv indvirkning på muligheden for, at læger kan tilpasse og fortolke ledelsesroller og modeller lokalt i hospitalsorganisationer. Dette har i mindre grad været tilfældet i det angelsaksiske sundhedssystem, hvor f.eks. NPM

reform forandringer i højere grad er blevet drevet fra toppen og har ført til forandringer, der har begrænset mulighederne for, at læger kan dominere hospitalsledelsesarbejdet lokalt. På denne baggrund er det interessant at udforske i dybden, hvordan læger tilpasser, forhandler og fortolker ledelsesforandringer i hospitalsledelsesmodeller i hospitalsorganisationer over tid, og især i en underbelyst sundhedskontekst som f.eks. det nordiske sundhedssystem, da det antages, at læger både kan have mulighed for at få en mere innovativ rolle i den lokale forandringsledelsesproces, men også besidder mere autonomi til at fortolke, forhandle og designe deres egne ledelsesmodeller, hvilket kunne tænkes at ville øge deres niveau af engagement i hospitalets ledelse. I denne afhandling tages der empirisk udgangspunkt i det danske sundhedssystem, som en illustrativ case for de nordiske sundhedssystemer. Danmark er antageligvis det land blandt de nordiske lande, hvor ledelsesreformer og forandringer i sundhedsvæsenet er blevet indført gennem den mest konsensus orienterede form og proces. Formålet med denne afhandling er således, at forstå og forklare hvordan læger tilpasser, fortolker og forhandler hospitalsledelse over tid i forhold til forandringer i hospitalsledelses-modeller i hospitalsorganisationer i det nordiske sundhedssystem, illustreret ved det danske sundhedssystem.

I forhold til teori vedrørende organisatorisk forandring og transformation, anvender denne afhandling begreber fra arketype-teorien udarbejdet af Greenwood og Hinings (1988, 1993), men også begreber omkring intra-organisatoriske dynamikker udarbejdet af Greenwood og Hinings (1996), som en teoretisk ramme. Arketypebegreberne er brugbare, når det studeres, hvordan hospitalers ledelsesmodeller forandres og transformeres. Begreberne vedrørende intra-organisatoriske dynamikker er brugbare, når det skal forklares, hvordan og hvorfor hospitalers ledelsesmodeller er blevet tilpasset over tid af læger.

Det empiriske fundament for afhandlingen er et longitudinelt single casestudie foretaget fra 2010 til 2013 i afdelingen for Hjertesygdomme på Aarhus Universitetshospital i Danmark. Afdelingen for Hjertesygdomme havde oplevet en stærk vækst i både sub-specialisering, og i antallet af ansatte i perioden 1992-2013, hvilket krævede, at lægerne reorganiserede deres afdelingsledelsesmodel, herunder strukturen, beslutningstagningssystemet og værdierne knyttet hertil. De anvendte metoder i undersøgelsen er baseret på interviews med 43 informanter, direkte observationer og dokument studie.

Afhandlingen bidrager til litteraturen om professionelles reaktioner på NPM reformer, idet den illustrerer alternative veje for forandring i den mere konsensus orienterede nordisk sundhedssystem kontekst, ved at give detaljerede og rige beskrivelser af lægers tilpasningsprocesser af en hospitalsledelsesmodel i en hospitalsorganisation i en nordisk sundhedssystem kontekst. I forhold til teori om organisatorisk forandring og transformation, bidrager afhandlingen til arketypeteorien (Greenwood og Hinings, 1988, 1993), da afhandlingen giver indsigt

i en proces omkring bevægelser mellem arketyper på et mikro-institutionelt plan, da det er blevet undersøgt, hvordan en ledelsesarketype i en hospitalsorganisation er blevet tilpasset af læger gennem en organisatorisk ledelsesforandringsproces. Ydermere bidrager afhandling til begreberne vedrørende de intra-organisatoriske dynamikker (Greenwood og Hinings, 1996), ved at give indsigt i de interne dynamikker i en organisation på et mikro-institutionelle niveau, idet fokus har været på den proces, hvor læger har tilpasset, fortolket og forhandlet skiftende management arketyper i en hospitalsorganisation. Endelig bidrager afhandlingen til den begrænsede mængde forskningslitteratur, der har anvendt begreberne fra arketype teorien og begreberne vedrørende intra-organisatoriske dynamikker empirisk i professionel sundhedsorganisationer (Kitchener, 1999, Mueller et al., 2003, McNulty og Ferlie, 2002 2004). I forhold til praksis giver afhandlingen indsigt i, hvordan det er afgørende, at læger (især overlæger) interesserer sig for og føler engagement for, at skabe ledelsesforandringer i deres hospitalsorganisation, før ledelsesforandringsprocesser i en hospitalsorganisation kan drives mod et defineret mål. Et mål som lægerne også bør være enige om. I den forbindelse giver afhandlingen indsigt i, at det er særlig vigtigt, at læger er eller bliver opmærksomme på, at være bevidste om ledelsesmæssige og organisatoriske problemstillinger, der udfordrer deres generelle faglige arbejde og resultater heraf. Endelig giver afhandlingen indsigt i, hvordan en lægegruppe i kraft af deres topledelsesposition i vid udstrækning i en hospitalsorganisation i et nordisk sundhedssystem har evnen og kapaciteten til at drive en ledelsesmæssig forandringsproces i den retning, de skønner fordelagtig i forhold til deres autoritative status mellem professioner og deres professionelle arbejde. I den forbindelse giver afhandlingen også indsigt i, at læger, både individuelle og som gruppe, besidder en magt og evne til at forme og designe den hospitalsledelsesmodel de finder fordelagtig i en hospitalsorganisation i et nordisk sundhedssystem.

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This dissertation is about changing hospital management models and how medical professionals adapt hospital management models in hospital organizations in a Nordic health system context. As such, it is a result of a fruitful cooperation with the Department of Cardiology at Aarhus University Hospital, Denmark and my work as a doctoral student in the research group for Public Administration and Organization at the Department of Political Science and the Centre for Organization, Management and Administration at the Department of Sociology and Social Work, Aalborg University, Denmark.

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The responsibility for this dissertation's content is mine.

Aalborg, May 2016

Vibeke Byg

To Peter Kragh Jespersen

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CHAPTER 1. INTRODUCTION

Health care administration in many OECD countries has undergone substantial changes in recent years as a consequence of New Public Management (NPM) reforms, rising costs, the pace of technological innovation, heightened competition for patients and resources, quality of managed care and demographic shifts (Pollitt and Bouckaert, 2000, Greve, 2007, Brock, Powell, and Hinings, 1999, Neogy and Kirkpatrick, 2009, Jacobs, 2005, Sehested, 2002). Hospitals especially have been reformed due to the high proportion of resources they absorb and the apparent difficulty of prioritizing and coordinating health care within hospitals (Kirkpatrick et al., 2013). As part of these changes an alternative hospital management model has been developed and adopted globally (Kirkpatrick et al., 2013, Harrison and Pollitt, 1994). There is abundant research literature on the topic of reforming hospital management models. Enhancing the role of medicine in hospital management, with a special emphasis on the strategy or pressure of co-opting medical professionals into management, is researched and discussed (Jacobs, 2005, Neogy and Kirkpatrick, 2009).

The existing research provides insight into how medical professionals across Europe have reacted and responded to the implementation of new hospital management models (e.g. Jacobs, 2005, Neogy and Kirkpatrick, 2009). Lacking from the literature, however, is insight into how we can understand and explain how medical professionals adapt the process of hospital management over time in relation to changing hospital management models that are global in their influence on hospital organizations. What is interesting in this regard is that empirical knowledge about the outcome of medical professionals' responses to hospital management models is primarily derived from an Anglo-Saxon health system context. Based on results from comparative studies, which highlight that not only institutional and regulative contexts, but also more distinctive national or regional contextual factors may have implications for the translation of the changing hospital management models (Kirkpatrick et al., 2013), it may be valuable and useful to enhance our knowledge about how medical professionals adapt and interpret changing hospital management models in other contextual settings, such as the Nordic context, which vary from the Anglo-Saxon context according to a number of funding and institutional conditions (Magnussen, Vrangbæk, and Saltman, 2009). This also applies to management changes in the contexts of Anglo-Saxon and Nordic health systems, as illustrated by the UK and Danish health systems.

For example, the health system contexts in UK and Denmark vary as to how the NPM management reform process has been imposed. In Denmark the willingness of medicine to cooperate has been relatively high, partly because reforms have not posed a direct threat to the profession (Sehested, 2002). In this regard Denmark has

been characterized as “a ‘consensual regime’ where focus is on corporatist style bargaining and consultation, and only limited use of market like mechanisms” (Kirkpatrick et al., 2009:653). For example, change has been introduced in soft ways, as illustrated in a Danish government report: “*Our task is to inspire the hospital sector to develop alternative solutions, aimed at the double theme of service level and use of resources*” (Indenrigsministeriet, 1984:124). In the Danish health system, a tradition of democratic consensual decision making has been reinforced by a multi-level governance structure characterized by “strong political decentralized and local authority ownership and administration of hospitals” (Kirkpatrick, Dent, and Jespersen, 2011:495). This has materialized a tradition for devolved and consensual policy making instead of imposed, top-down reforms as seen implemented in the UK. In Denmark professional associations traditionally have had a strong position and especially the medical professionals within the hospital organizations have enjoyed considerable “institutional autonomy” to extend and shape their involvement in management and how it is implemented locally. In other words, there has been a reliance on medical professionals themselves to drive through required changes in practice, which has made their influence especially strong (Kuhlmann et al., 2013, Kirkpatrick et al., 2009, Kirkpatrick, Dent, and Jespersen, 2011).

In contrast, in the UK has medical profession experienced a downgrading of its tradition of consensual decision making and corporatist relations. New management regimes have been imposed with minimal consultation and the medical profession has been “targeted as scapegoat whenever politically convenient” (Kirkpatrick et al., 2009). This has arguably fostered an environment where medical professionals have been less supportive of reforms and also participate less in the management of health organizations. The UK has specifically elected to break with the traditions of consensus administration by recruiting general managers from outside. It is argued that this action has institutionalized a separation between medical and management roles (Kirkpatrick et al., 2009). The development of an internal market has also exaggerated the tendency to challenge the dominance of medicine, by strengthening the role of managers (Kirkpatrick et al., 2009).

Another difference is the state-professional formation; Denmark has a “continental” model of professionalism which involves pursuing status and power through the institutions of the state. Results from a comparative study show how the medical profession attempt to lay claim to the jurisdiction of management, which arguably can be interpreted as continuation of this strategy. In contrast, the medical profession in the UK is an archetypal “liberal profession” as it has struggled hard to maintain its independence from the state. The dominant strategy of the medical profession in the UK is independence, self-employment, and a relative detachment from administration (Kirkpatrick et al., 2009).

Furthermore, there are differences in medical professionals' involvement in management at the organizational level. Unlike the UK, in Denmark senior medical professionals are heavily involved in the strategic as well as operational management of hospitals, and the Danish level of engagement in management also appears to be greater than in the UK. Apparently medical professionals in the UK were initially defensive and later ambivalent about management reform in hospitals, whereas in Denmark there has been an attempt to define hospital management organization as a natural territory of medicine (Kirkpatrick, Dent, and Jespersen, 2011). Within hospitals the evidence suggests that levels of commitment to management roles are greater in Denmark (Kirkpatrick et al., 2009).

The above exemplified differences in management change across two different health system contexts illustrate what implications the national differences in contextual factors may have for the outcome of medical professional involvement in management and how they may shape both collective strategies of medical professionals and their incentives to engage in management within hospital organizations (Kirkpatrick et al., 2009, Kirkpatrick, Dent, and Jespersen, 2011). For example, in terms of medical professionals' involvement in management change processes in hospital organizations, we might expect that the medical professionals will have opportunities to be deeply involved in the management model change process locally within the hospital organization, developing local management solutions, as we might expect that the change process will be driven from a consensus-orientated and bottom-up approach. In terms of medical professionals' response to changing hospital management models in hospital organizations, we might expect the medical professionals to be interested and engaged in protecting their structural positions within the hospital organization by maintaining or even enhancing their managerial control of their medical practice based on their institutionalized autonomy to design their own management models, if structural change, such as an introduction of a new hospital management model, especially at department level, is to be introduced. In terms of the outcome of change in hospital management models in hospital organizations, we might expect that the medical professionals will engage in, negotiate, favour and commit to design a variant of any alternative model that would still support their traditional dominance in order to protect and preserve their traditional legitimacy and dominance within the hospital organization. On this basis we might expect that the outcome of a hospital management re-organization and change process will evolve towards a hospital management model which will preserve the medical professionals' traditional structural dominance and legitimacy as the advantaged groups (the medical professionals) will pursue consolidation and control over the distribution of resources within the hospital department.

Taking this into account, the Nordic health system context represents an interesting case, as we might expect that this context with a tradition for consensual policy making, strong position of professional associations, "institutional autonomy" of

medical professionals and their strong influence in practice, might also have an impact on the opportunity for medical professionals to capture, colonize, alter and interpret their management roles and models locally in hospital organizations, which has been less the case in the Anglo-Saxon health system context where, for example, NPM reform has been more strongly driven from the top and has restricted opportunities for medical professionals to dominate management work locally.

Given this, it is interesting to explore in depth how medical professionals adapt, negotiate and interpret management changes in hospital management models in hospital organizations over time, and especially within an underexposed context such as that of the Nordic health system. Here we might expect medical professionals to have both the opportunity to play a more innovative role in the local management change process and also more autonomy to interpret, negotiate and design their own management models, which may increase their level of engagement in hospital management. In this dissertation I take as empirical point of departure the Danish health system context as an illustrative case for the Nordic countries, as Denmark is arguably the Nordic country in which management reforms and health care change have been introduced most softly.

The aim of this dissertation is to understand and explain how medical professionals adapt, interpret and negotiate hospital management over time in relation to changing hospital management models in hospital organizations in the Nordic health system context, illustrated by the Danish health system.

The dissertation is specifically guided by the following research questions:

- *How medical professionals adapt a hospital management model within a hospital organization in the Danish health system?*
- *How can we explain this adaption process?*
- *How has the hospital management archetype configuration changed over time within a hospital organization in the Danish health system?*

The research is based on a longitudinal case study of a re-organization of hospital management in a hospital organization within the Danish health system as an illustrative case for the Nordic health system context.

Regarding its contribution to research, the dissertation advances the literature on professional responses to NPM reforms, showing alternative pathways of change in the more consensus orientated Nordic health system context by providing detailed and rich descriptions of the process by which medical professionals adapt changing hospital management models within hospital organizations in a Nordic (Danish) health system context. Regarding the theory of organizational change and transformation, this dissertation contributes to the concept of archetype theory

(Greenwood and Hinings, 1988, 1993), as it reveals insights into the process of movements between archetypes at a micro institutional level. It does this by examining how a management archetype template within a hospital organization becomes adapted or institutionalized by medical professionals through an organizational management change process. Furthermore, this dissertation contributes to the concept of intra-organizational dynamics (Greenwood and Hinings, 1996) by revealing insight into the micro institutional level of analyses of internal dynamics within organizations. In this respect, I have focused on the process by which individuals as medical professionals have adapted, interpreted and negotiated changing management archetype templates within a hospital organization. Furthermore, the dissertation contributes to the limited research literature that has applied the concepts of archetype theory and intra-organizational dynamics to professional health care service organizations empirically (Kitchener, 1999, Mueller et al., 2003, McNulty and Ferlie, 2002, 2004). Regarding contribution to practice, this dissertation reveals how it is crucial for medical professionals (especially consultants) to take an interest in and feel commitment to creating management changes in their organization. Such interest and commitment is necessary before any management change process in a hospital organization can be propelled or driven towards a defined end point, which the medical professionals should also agree upon. In this regard the dissertation also reveals that it is particularly important that medical professionals are or become aware of managerial and organizational issues that challenge their overall professional work and performance. Finally, the dissertation reveals how medical professionals, by virtue of their position of authority in hospital organization in a Nordic health system, have the ability and capacity to steer a managerial change process in the direction they deem advantageous to their authoritative status and professional work. In this regard, the dissertation also reveals how medical professionals as individuals and as a group possess the power and capacity for action to shape and design a hospital management model they find advantageous within a hospital organization in a Nordic health system.

1.1. THE STRUCTURE OF THE DISSERTATION

The dissertation is structured as follows. In chapter 2, the literature review, I provide an overview of the literature on change in hospital management organization, including literature about enhancing medical professionals' engagement in hospital management organization, and I identify gaps in previous research. Lacking from the literature is explicit consideration of how to understand and explain how medical professionals adapt, interpret and negotiate hospital management over time in relation to changing hospital management models in hospital organizations in the Nordic health system context, illustrated by the Danish health system. The research questions emerging from the review of the literature are outlined.

Chapter 3, the theoretical framework, discusses the rationale for applying the concepts of archetypes (Greenwood and Hinings, 1988, 1993) and of intra-organizational dynamics (Greenwood and Hinings, 1996), as a theoretical lens for analyzing how medical professionals adapt, negotiate and interpret hospital management models in hospital organizations and how we can explain this adaption process. Then the chapter offers an overview of recent literature that has applied the concept of archetype theory to studies of changes in professional health care service organizations. Finally, the research questions are elaborated based on the theoretical framework.

In chapter 4, I discuss the overall design and methods used to investigate the process of medical professional managers' adaption of management in relation to changing hospital management models within a hospital organization. First, the rationale for conducting a longitudinal embedded single case study is explained. Second, the chapter discusses the role of the theoretical framework which is applied. Afterwards, the generalizability of the findings based on a longitudinal embedded single case design is discussed. Chapter 4 also provides an introduction to the case setting that forms the foundation for this research and describes how the study is conducted in practice, including a description of access to the investigated organization and my role as a researcher. The data collection methods – based on interviews with informants, observations, and access to documentation – are described and the strategy for data analysis is presented.

Chapter 5 presents the managerial history of the Department of Cardiology's hospital management model. The intention of the formal change of the management model in the Department of Cardiology is presented, including different managerial issues, empirical challenges and benefits of the existing management patterns. In chapter 6, I describe the professionals' reactions to the management changes in the Department of Cardiology, especially the reactions of the medical professionals. The outcomes of the management adaption processes in 2010 and 2013 are also described. First, I describe how the process of change of the management model with "functional partnerships" was more "formally" implemented in 2010 in the department: how the recruitment process for the functional partnerships was perceived by the professionals; how the professionals perceived the management idea and the initiation of the process; how the professionals perceived and adapted the functional partnerships in 2010; and how the management archetype template developed in 2010. Second, I describe how the process of change of the management model with "section management" teams was implemented in 2012 and 2013, including: some of the professionals' perceptions of the management change process; how the recruitment process of the section management teams in the Department of Cardiology was perceived by the professionals; how the professionals perceived and adapted the section management teams in 2013; and finally, I describe how the management archetype template unfolded in 2013. In

chapter 7 the contributions to research, theory and practice are discussed, as well as caveats and future directions for research, and the conclusion of the dissertation.

CHAPTER 2. LITERATURE REVIEW

2.1. INTRODUCTION

This chapter is a review of the current research literature on changing hospital management models, including enhancing the role of medicine in management of hospitals.

First, the more general spread of management reforms globally is described. In section 2.3 changing hospital management models more specifically are described and section 2.4 presents the recent literature on enhancing the role of medicine in management of hospitals. In section 2.5, comparative studies of the implementation of the Johns Hopkins Hospital Model are described. Section 2.6 highlights the characteristics of both the Anglo-Saxon health system and the Nordic health system contexts. Section 2.7 describes the Danish literature on medicine and management. In the final section the research questions are put forward.

2.2. THE SPREAD OF MANAGEMENT REFORMS GLOBALLY

This section describes the general spread of management reforms globally, including how professional organizations globally have undergone radical change due to different kinds of driving forces of change, push and pressure, which has made an impact on the consistent picture of an archetypal professional organization.

Since the early 1980s a wave of public management reforms has swept across most of the OECD countries, and most of the rest of the world (Hood, 1991; Pollitt and Bouckaert, 2000/2004; Greve, 2007). The reform wave has been termed New Public Management (NPM), characterized by its use of management inspiration from the private sector, and the use of market mechanisms and neo-institutional economics in the public services. Pollitt and Bouckaert (2000/2004:8) define NPM reforms as “deliberate changes to the structures and processes of public sector organizations with the objective of getting them (in some sense) to perform better”.

There is a broad theoretical consensus that NPM is not a comprehensive theory but must rather be characterized as a strategy or trend (Ferlie et al., 1996; Hood, 1991; Greve, 2007). Nonetheless, there seems to be a consensus on the elements of NMP and what the overall purpose of the NPM reforms is (e.g. Greve, 2007, Pollitt and Bouckaert, 2000/2004). Analytically the elements of NPM can be distinguished into two parts, one relating to the internal organization and management of public sector organizations and one relating to the strengthening of market-like mechanisms, even though countries may have combined these elements in very different ways (Pollitt and Bouckaert, 2000/2004, Brock, Powell and Hinings, 1999). The purpose

of the NPM reforms includes in general a focus on making savings in public expenditure, making the operations of government more efficient, setting goals of improving the effectiveness of public service, including quality, and increasing the chances that the policies which are chosen and implemented will be effective (Pollitt and Bouckaert, 2000/2004).

Following the descriptions of the worldwide NPM trend and the variants of the public management reforms and marketization of public services, professional organizations globally have undergone radical change due to different kinds of driving forces of change, push and pressure, such as deregulation of the professional markets, increased competition both within and between professions, financial constraints and cost pressures, changes in government policy, globalization, demands from international clients and technological change (see e.g. Brock, Powell, and Hinings, 1999). The consequences have been more explicit financial expectations, and more rigorous budget control, which seems to have given more power to accountants and managers in professional organizations, including a more explicit focus on control of costs, including managing resources more effectively through new managerial systems (Brock, Powell, and Hinings, 1999). This restructuring of the professional organizations has had an impact on the consistent picture of an archetypal professional organization (see e.g., Mintzberg, 1979, 1983; Brock, Powell, and Hinings, 1999).

2.3. CHANGING HOSPITAL MANAGEMENT MODELS

This section describes the changing organization of hospital management models more specifically in relation to the general NPM reform pressure for professional organizations. This includes a description of the emergence of an alternative hospital management model from The Johns Hopkins Hospital in Baltimore, USA, as well as the global spread and adoption of this model.

In relation to the general pressure for NPM reform of professional organizations, many OECD countries have undertaken substantial changes to their systems of health care administration (Jacobs, 2005, McNulty and Ferlie, 2002, Sehested, 2002). Specifically, an increased attention to reform of management in health care has emerged due to pressure from rising costs, the pace of technological innovation, heightened competition for patients and resources, the quality of managed care, and demographic shifts towards an ageing population (Neogy and Kirkpatrick, 2009, Montgomery, 2001). In particular, hospitals have become targets for these reforms given the high proportion of resources they absorb and the apparent difficulty of coordinating different priorities of care, cure and administration (Kirkpatrick et al. 2013).

Within this context an alternative hospital management model has emerged for how hospitals might enhance their performance (Kirkpatrick et al., 2013). The model

originated in the mid 1970s from the Johns Hopkins Hospital (JHH), a teaching hospital in Baltimore, USA (Heyssels et al., 1984, Harrison and Pollitt, 1994, Kirkpatrick et al., 2013).

The model moves away from the practice of governing hospitals through parallel hierarchies with doctors represented by a senior medical committee and nurses represented by a head/lead nurse. Instead all doctors and nurses report through a unitary chain of command to a clinical director, who is in turn accountable to the chief executive or general manager of the hospital (Kirkpatrick, 2013). In organizational terms the JHH model involves a break from the traditional functional structure with medicine, nursing and other functions organized separately, by grouping the professional operational core into resources, with specialties and doctors aggregated in clinical units (Kirkpatrick, Bullinger, Lega, and Dent, 2012). As a result, the hospital becomes a "holding company" for a series of specialty hospitals or semi-autonomous divisions (Harrison and Pollitt, 1994, Kirkpatrick et al., 2012). At the middle tier, the units are managed by teams headed by a medical chief, supported by lead nurse and administrator. The teams are given the responsibility for the budgets, direct costs, operational performance and delivery against targets and human resource management (Kirkpatrick et al., 2013).

The idea of this alternative model is to reduce the cost of inpatient care by mimicking practice in the corporate sector (Heyssel et al., 1984). Furthermore, the establishment of clinical units is an attempt to improve the integration of coordination of clinical service and to strengthen the authority of managers but also benefit from the potential for economies of scale and scope. Lastly the model represents a strategy of co-opting doctors and other clinical professionals into management (Kirkpatrick et al., 2012, 2013).

Empirically various translations of this alternative model of hospital management or ideal template have been spread and adopted across health systems around the world over the past 30 years (Kirkpatrick et al., 2013, Neogy and Kirkpatrick, 2009) and perhaps most clearly in the UK where key elements of this model have been translated into the "clinical directorate model" (Kirkpatrick et al., 2012, 2013). However, elements of the JHH model have also been translated into health systems in the USA, Canada and European countries including Italy, France and Denmark (Kirkpatrick et al., 2013, Neogy and Kirkpatrick, 2009, Fitzgerald and Dufour, 1998).

In relation to this global spread and adoption of the JHH model and the focus on strengthening the management capabilities of hospitals, a larger body of international research literature about changing hospital management models has evolved. The main purpose of this body of literature has often been to debate and explore enhancing the role of medicine in management of hospitals, with a special emphasis on the strategy or pressure of co-opting doctors and other clinical

professionals into management (Jacobs, 2005, Neogy and Kirkpatrick, 2009). This is elaborated below.

2.4. ENHANCING THE ROLE OF MEDICINE IN MANAGEMENT

This section describes the recent literature about enhancing the role of medicine in management of hospitals in relation to the changing hospital management models. This includes presentations of the discussions about the balance of power between the medical profession and management in hospitals and of the debates about how to define this phenomenon or conceptualize this trend for doctors being co-opted into management.

With a focus on internal organization, several studies have looked at the blurring of boundaries between managerial and professional jurisdictions in relation to the increased participation of clinical professionals in formal hospital management and their response to and adaption of managerial roles in changing hospital management models (Waring and Currie, 2009). Within this context, there are discussions about the balance of power between the medical profession and management in hospitals. The focus has been on exploring the clinical professionals' response, interpretation and adaption of changing hospital management models (see e.g. Montgomery, 2001, Doolin, 2001, Neogy and Kirkpatrick, 2009, Waring and Currie, 2009). However, the literature has reported different findings.

Regarding this blurring of boundaries, on the one hand, some studies demonstrate doctors' willingness to engage, embrace or be co-opted into new and more formal management responsibilities and management models. Some even argue that the medical professionals gain more formal power, enhancing their jurisdictional area by extending their dominance through co-opting management practice into medical roles, for example, through the roles of clinical director and medical director (Jacobs, 2005, Fitzgerald and Ferlie, 2000, Kurunmäki, 2004, Mo, 2008, Kjekshus and Spehar, 2012, Kirkpatrick et al., 2009, Neogy and Kirkpatrick, 2009, Waring and Currie, 2009, Hartley and Kautsch, 2014). On the other hand, some studies report resistance or hesitance embedded in the medical profession regarding involvement in management in the way anticipated by policy makers (Abbott, 1988, Kitchener, 2000, Doolin, 2001, Jacobs, 2005, Domagalski, 2007, Ackroyd, Kirkpatrick and Walker, 2007, Waring and Currie, 2009, Bode and Maerker, 2014, Sartirana, Prenestini, and Lega 2014). Additionally there are some studies which state that doctors in general maintain their occupational closure of the medical domain, their high level of autonomy, which makes them capable of resisting attempts to enhance the managerial control of medical practice (Fitzgerald, 1994, Fitzgerald and Dufour, 1998, Fitzgerald and Ferlie, 2000, Kitchener, 2000, Doolin, 2001).

Another side of the same coin is a debate that has aimed to define this phenomenon or conceptualize this trend for doctors to be co-opted into management. There has been some debate about a "hybridization" process of clinical professionalism, since in most health care systems the position of doctors and nurses has changed towards co-opting management and leadership roles (Fitzgerald, 1994, Fitzgerald and Ferlie 2000, Kitchener, 2000, Montgomery, 2001, Llewellyn, 2001, Doolin, 2001, Kurunmäki, 2004, Fitzgerald and Dopson, 2005, Jespersen, 2005, Jacobs, 2005, Mo, 2008, Domagaliski, 2008, Kirkpatrick et al. 2009, Neogy and Kirkpatrick 2009, Noordegraaf 2007, 2011, Waring and Currie, 2009, Wikström and Dellve, 2009, Berg, Byrkjeflot and Kvåle, 2010, Spehar and Kjekhus, 2012, Kuhlmann et al., 2013, Byrkjeflot and Jespersen 2014, Spehar, Frich, Kjekshus, 2015, McGivern et al., 2015). Chiefs of staff and heads of services or departments have existed in hospitals for as long as there have been medical staff. However, NPM reforms have put on the agenda discussions about the process of "re-stratification", creating a more distinct and formal pattern of stratification within the professions themselves – with medical elites managing change among the rank and file (Freidson, 1985, Waring and Currie, 2009) –, including discussions about the extent to which such re-stratification results in "polarization" between levels of clinical managers and ordinary clinicians (Kirkpatrick et al., 2009, Jacobs, 2005, Bode and Maerker, 2014, Vinot, 2014), but also the emergence of a "professional-managerial class" (Jacobs, 2005).

As presented above, the object of this research literature about enhancing the role of medicine in management in hospitals has been to study the management roles and responsibilities of the clinical professionals in relation to changing hospital management structure and organization. In particular, researchers have paid attention to their reactions and responses to their increased participation and engagement in hospital management. The research has provided valuable insight into how the ideas originating from the JHH model may have influenced management development in hospitals more broadly, but it also reflects various outcomes regarding clinical professionals' response to and adaption of the hospital management template (e.g. Kurunmäki, 2004, Jacobs, 2005).

Furthermore, the research literature has concentrated primarily on the *outcome* of the process of management model implementation. However, we still know very little about *how* the global management model (the JHH model) or templates have been adapted, negotiated and interpreted over time, especially in-depth details about the implementation *processes* of doctors' involvement in management in hospitals (Kirkpatrick, Dent, and Jespersen, 2011). Furthermore, we need research on why various outcomes occur regarding clinical professionals' adaption of hospital management models and on what kind of factors that could influence this process of implementation of management models.

Findings from a few comparative studies of implementation and institutionalization of hospital management models across different health systems (Dent, 2003, Dent, 2005, Jacobs, 2005, Kirkpatrick et al., 2009, Neogy and Kirkpatrick, 2009, Kirkpatrick et al., 2012, Kirkpatrick et al., 2013) suggest that contextual factors such as the wider institutional and regulative context, but also more distinctive national or regional variants of priorities, have significant importance in explaining variations of translation of hospital management models like the JHH model across countries. As the development of medical manager roles is a fundamental part of the JHH model, these specific contextual factors arguably must also matter in relation to how we understand more specifically the process of how clinical management is enacted and adapted by doctors over time in relation to changing hospital models within different health systems. Below I will briefly present some of the findings from some of the mentioned comparative studies in order to highlight the findings that may have implications for understanding the processes of clinical professional adaption of hospital management structures.

2.5. IMPLEMENTATION OF THE JHH MODEL

This section describes some findings of comparative studies of how management ideas as the JJH model have been implemented differently across European health systems and how they might explain varying outcomes of this implementation.

A few comparative studies of hospital management models in European health systems (Dent, 2003, 2005, Jacobs 2005, Kirkpatrick et al., 2009, Kirkpatrick et al., 2012, Kirkpatrick et al., 2013, Neogy and Kirkpatrick, 2009) have focused on how management ideas and models similar to the JJH model have been imposed and implemented differently across health systems and how one might explain the varying outcomes.

Studies based on the health systems of four European countries (England, Denmark, Italy and France) have explored how similar hospital management ideas and models (JHH) inspired by the NPM reform trend have been translated into these four European health systems (Kirkpatrick et al., 2013). The studies find that even though there have been differences in the timing and pace of the health reforms, versions of the JHH model have been adopted in all four countries. However, the degree of broader convergence should not be over-emphasized, according to the studies (Kirkpatrick et al., 2013, Kirkpatrick et al., 2012 and Kirkpatrick et al., 2009). On the one hand, it is argued that similar priorities and objectives inspired by the general global NPM reform ideas and templates have been driving forces of reform, which has led to broadly convergent moves to restructure hospitals along corporate lines à la the JHH model (Kirkpatrick et al., 2009, Kirkpatrick et al., 2013). On the other hand, the comparative studies also highlight that the translation process of the JHH model has resulted in different interpretations and practices across health systems. This is reflected in different national outcomes of the health

management reforms and the JHH model, including different responses by the clinical professionals (Kirkpatrick et al., 2013). Similar findings are also reflected in studies by Neogy and Kirkpatrick (2009) and by Kirkpatrick et al. (2009). These studies report different outcomes in terms of the implementation of hospital management ideas and the JHH model/template but also in relation to doctors' involvement in management across several health systems (England, Italy, Denmark, the Netherlands, Germany and France).

Based on these insights, Kirkpatrick et al. (2013) argue that we still know very little about how global hospital management models (JHH) or templates have been interpreted differently across the health systems. Especially, they emphasize the lack of in-depth details of these implementation processes. Furthermore, they argue that we need research on why variations might occur between health systems and the factors that influence this process of implementation of hospital management models, including clinical professionals' responses thereto.

Building on the comparative studies of the four countries, Kirkpatrick and colleagues (Kirkpatrick et al., 2013, Kirkpatrick et al., 2012) study how the given variations of the implementation of the JHH model can be explained. By elaborating a multi-dimensional framework for comparison of health systems, the comparative study (Kirkpatrick et al., 2013, Kirkpatrick et al., 2012) spell out three key variables of institutional factors that might explain and/or influence variation: (1) The nature of political governance of the public service, including the health and hospital sector, (2) the nature of organizational settlements with key professions (countervailing power of clinical professionals) and (3) the nature and process of public management reforms (administrative cultures). By exploring the dynamic interplay between these three key variables, their study finds that differences in the wider institutional and regulative context might help to explain the given variations in the translation of the JHH model. Another finding is that distinctive national or regional variants of priorities have been driving the reforms, resulting in different translation outcomes (Kirkpatrick et al., 2013).

The results from the comparative studies illustrate that contextual factors, such as the wider institutional and regulative context, but also more distinctive national or regional variants of priorities, have significant importance in explaining variations of translation of hospital management models as the JHH model across countries. As the development of medical manager roles is a fundamental part of the JHH model, as mentioned, these specific contextual factors arguably must also matter in relation to how we understand more specifically how clinical management is enacted and adapted by doctors in relation to changing hospitals models within different health systems. Based on the assumption that local history, traditions and institutions form the background for how actors in a given setting engage with new templates (Kirkpatrick et al., 2012), I will argue that the wider institutional and regulative context, but also the more distinctive national or regional variants of

priorities, have implications for the willingness and ability of clinical professionals to engage with hospital management, and that these contextual factors also are potentially crucial in shaping the response from clinical professionals over time. With this in mind, it is interesting that most of the empirical research on medical professionals' adaption and response to changing hospital management models are primarily studied in one context area – the Anglo-Saxon health system context where central top-down reform initiatives have been dominant. This indicates that it will be valuable to get an in-depth knowledge of medical professionals' adaption of changing hospital management models from less studied context settings and their dimension to change as, for example, in the Nordic health system context, where management change has been introduced in more soft ways, which I will explain and discuss in the section below.

2.6. ANGLO-SAXON AND NORDIC HEALTH SYSTEMS

This section shows how most of the empirical research on medical professionals' adaption and response to changing hospital management models is conducted in an Anglo-Saxon health system context. I then present some of the general characteristics of the Anglo-Saxon and the Nordic health system contexts and some differences in how the NPM management reform change process has been imposed differently in those two contexts, in order to highlight why it is interesting to study medical professional involvement in changing management models in a Nordic health system context.

Most of the empirical research on medical professionals' adaption and response to changing hospital management models is conducted in an Anglo-Saxon health system context, e.g. the USA, UK, Canada and New Zealand (Doolin, 2001, Montgomery, 2001, Domagalski, 2007, Fitzgerald, 1994, Fitzgerald and Dufour, 1998, Fitzgerald and Ferlie, 2000, Montgomery, 2001, Kitchener, 2000, Llewellyn, 2001, Fitzgerald and Dopson, 2005, Jacobs, 2005, Kirkpatrick et al., 2009, Neogy and Kirkpatrick, 2009, Waring and Currie, 2009, Hartley and Kautsch, 2014). A few empirical studies have been conducted outside this Anglo-Saxon context, for example, from Finland (Kurunmäki, 2004), Norway (Mo, 2008, Spehar and Kjekshus, 2012), Germany (Jacobs, 2005, Bode and Maerker, 2014), Poland (Hartley and Kautsch, 2014), France (Vinot, 2014) and Italy (Jacobs, 2005, Sartirana, Prenestini, and Lega 2014). This may indicate that we primarily have empirical knowledge about the outcome of medical professionals' response to hospital management models from an Anglo-Saxon health system context point of view. Based on the results of the comparative studies presented above, which highlight that institutional and regulative contexts, but also more distinctive national or regional contextual factors, may have implications for the translation of the changing hospital management models, it may be valuable and useful to enhance our knowledge about how medical professionals adapt and interpret changing hospital management models in other contextual settings, such as the

Nordic context, which vary from the Anglo-Saxon according to a number of funding and institutional conditions (Magnussen, Vrangbærk, and Saltman, 2009) This will be presented below.

The Nordic countries (Finland, Sweden, Denmark, Norway and Iceland) are commonly perceived as quite similar when viewed from a broader international perspective. Their similarities are based on a common history, culture, economy and social structure, as well as geographical closeness, comprising the development of similar informal institutions based on common shared customs, traditions and norms (Magnussen, Vrangbæk, and Saltman, 2009). A similar approach to social welfare, the dominant role of the state in the formation of welfare policies and a corresponding extensive public sector can be explained by the common history of the countries (Magnussen, Vrangbæk, and Saltman, 2009). A "Nordic welfare state model", based on the principle of universalism and broad public participation, is often referred to, and the intention of this model is to promote an equality of the highest standard through: "a broad scope of social policies, universal social benefits, services free or subsidized at the point of delivery, a high proportion of gross national product spent on health and social services and emphasis on full employment, equal income distribution and gender equality." (Magnussen, Vrangbæk, and Saltman 2009:4).

The Nordic health care systems are closely related to the development of this welfare state and are built on the same principle of universalism and equity, which has led to "promoting equal access to health services, low levels of cost sharing and high levels tax-based financing (…), public ownership of hospitals and decentralized responsibility for managing the services" (Magnussen, Vrangbæk, and Saltman, 2009:4). Although differences exist between the Nordic countries with respect to the structural and institutional layout, the similarities are in a degree that still makes it possible to talk about a distinct Nordic model of health care (Magnussen, Vrangbæk, and Saltman, 2009). In all, the Nordic model of health care can be characterized by:[1]

- Funding predominantly by taxes
- Decentralized public governance structure
- Elected local governments that can tax
- Public ownership (or control) of delivery structure
- Equity driven, with focus on geographical and social equity
- Public participation (Magnussen, Vrangbæk, and Saltman, 2009:13)

[1] "In essence, to the extent that it is possible to speak about a Nordic Model for health care, it must be tempered with the recognition that the Nordic countries have in practice developed different combinations of service delivery policies and programmes." (Magnussen, Vrangbærk, and Saltman, 2009:13). They also take different approaches to reform and the timing of reform (ibid.:15).

Regarding decentralized public governance structure, it is highlighted by Magnussen,Vrangbæk and Saltman (2009) that the strong emphasis on equity has been combined with a tradition of decentralization to regional democratic control, which has led to the institutionalization of a multi-level public governance structure with democratic decision-making at local, regional and national[2] levels in order to ensure transparency and to promote efficiency as decisions would fit the local preferences and needs. This is believed to improve the legitimacy of the public delivery systems (Magnussen, Vrangbæk and Saltman, 2009). Another argument has been that the local and regional democratic government was an effective way to promote local innovation of organizational and management models: “The decentralized structure would thus in essence serve as a series of local laboratories for developing solutions that might subsequently spread throughout the system” (Magnussen, Vrangbræk and Saltman, 2009:11). Local governance with elected politicians has traditionally played an important role in the design, implementation and monitoring of health policy.

The multi-level governance structure with a tradition of centrally supervised local governance and the combination of elected political bodies with the ability of these local bodies to raise taxes has traditionally distinguished the Nordic countries from the more centralized tax-based national health service (NHS) in the United Kingdom, a system that also belongs to the family of public integrated systems. It is argued by Magnussen, Vrangbæk and Saltman (2009) that the extent to which tax rates are centrally set and regulated effectively reduces the scope for both local decisions and financial accountability.

What distinguishes the Nordic countries from other tax-based and/or decentralized systems, such as the UK, within the Anglo-Saxon health system context, is its focus on political multi-level governance through elected political bodies. The Nordic model has transferred the power to a local political level[3], combined with the ability of these local units to raise taxes. For example the UK has a more centralized tax-based health system in the NHS. It is argued by Magnussen, Vrangbæk and Saltman (2009) that the extent to which that tax rates are centrally set and regulated effectively reduces the scope for both local decisions and financial accountability.

In summary the Anglo-Saxon health system differs from the Nordic health system according to a number of funding and institutional conditions. What is noteworthy

[2] The governance structure of the Nordic countries is decentralized with the responsibility for service provision resting on regional, county or municipal level but within a framework of centralized supervision, regulation or coordination (Magnussen, Vrangbæk and Saltman, 2009).

[3] The local level of governance is supervised centrally (Magnussen, Vrangbæk and Saltman, 2009).

is that the literature (Magnussen, Vrangbæk and Saltman, 2009) does not go into much detail on the issue of management changes within these systems. A few findings from comparative literature about the development of medicine and management in hospitals in countries such as Denmark, a Nordic country, and the UK, a country in a Anglo-Saxon health system context (Kirkpatrick et al., 2009), illustrate different management changes within these contexts, as I will describe below.

2.6.1. DIFFERENCE IN MANAGEMENT CHANGE

In this section I illustrate different management changes within the UK, a country in an Anglo-Saxon health system context, and Denmark, a country in a Nordic health system context.

Comparison of how the NPM management reform process has been imposed shows that in Denmark the willingness of the medical profession to cooperate has been relatively high, partly because reforms have not posed a direct threat to the profession (Sehested, 2002). In this regard Denmark has been characterized as "a 'consensual regime' where focus is on corporatist style bargaining and consultation, and only limited use of market like mechanisms" (Kirkpatrick et al., 2009:653). For example, change has been introduced in soft ways, as illustrated in a Danish government report: "Our task is to inspire the hospital sector to develop alternative solutions, aimed at the double theme of service level and use of resources" (Indenrigsministeriet, 1984:124). In the Danish health system, a tradition of democratic consensus decision making has been reinforced by a multi-level governance structure characterized by "strong political decentralized and local authority ownership and administration of hospitals" (Kirkpatrick, Dent, and Jespersen, 2011:495). This has materialized a tradition for devolved and consensual policy making instead of imposed top-down reforms as seen implemented in the UK. This has meant that professional associations traditionally have had a strong position and especially the medical professionals within the hospital organizations have been enjoying considerable "institutional autonomy" to extend and shape their involvement in management and how it is implemented locally. In other words, there has been a reliance on medical professionals themselves to drive through required change in practice, which has made their influence especially strong (Kuhlmann et al., 2013, Kirkpatrick et al., 2009, Kirkpatrick, Dent, and Jespersen, 2011).

In contrast, the UK medical profession has experienced a downgrading of its tradition of consensual decision making and corporatist relations. New management regimes have been imposed with minimal consultation and the medical profession has been "*targeted as scapegoat whenever politically convenient*" (Kirkpatrick et al., 2009). This has arguably fostered an environment where doctors have been less supportive to reforms and also participated less in the management of health

organizations. The UK has specifically elected to break with traditions of consensus administration by recruiting general managers from outside. It is argued that this action has institutionalized a separation between medical and management roles (Kirkpatrick et al., 2009). The development of an internal market has also exaggerated the tendency to challenge the dominance of medicine, by strengthening the general managers (Kirkpatrick et al., 2009).

Difference in the state-professional formation shows how Denmark has a "continental" model of professionalism which pursues status and power *through* the institutions of the state. Comparative studies also show how the medical profession attempts to lay claim to the jurisdiction of management, which arguably can be interpreted as continuation of this strategy. In contrast, the medical profession in the UK is an archetypal "liberal profession" as it has struggled hard to maintain its independence from the state. The dominant strategy of the medical profession in the UK is independence, self-employment and a relative detachment from administration (Kirkpatrick et al., 2009).

In terms of the medical professionals' involvement in management at the organizational level, unlike the UK, senior doctors in Denmark are more involved in strategic as well as operational management of hospitals and the Danish level of engagement in management does also appear to be greater than in the UK. Apparently medical professionals in the UK were initially defensive and later ambivalent about management reform in hospitals, whereas in Denmark there has been an attempt to define hospital management organization as a natural territory of medicine (Kirkpatrick, Dent, and Jespersen, 2011).Within hospitals, the available evidence suggests that levels of commitment to management roles are greater in Denmark (Kirkpatrick et al., 2009).

The above exemplified differences in management change across the different health system contexts illustrate what implications the national differences in contextual factors may have for the outcome of medical involvement in management and how they may shape both collective strategies of doctors and their incentives to engage in management inside organizations. Given that much of the Anglo-Saxon literature on clinical professionals' response to changing hospital management models has primarily emphasized the reaction and response of the medical profession, and has not emphasized other management shaping activities, it is interesting to focus on the more underexposed Nordic health system context, where the medical profession did not have to respond to change driven from the top, but has been involved on a larger scale in negotiating the management change at different levels in the health system, and showing interest in management.

Taking this into account, the Nordic health system context represents an interesting case, as we might expect that this context, with a tradition of a consensual nature of policy making, the strong position of professional associations, the medical

professionals' "institutional autonomy" and their strong influence in practice, might have an impact on the opportunity for medical professionals to capture, colonize, alter and interpret their management roles and models locally in hospital organizations. This contrasts with the Anglo-Saxon health system context where change, for example, NPM reform, has been more strongly driven from the top and has led to changes that have restricted opportunities for medical professionals to dominate management work locally.

For example, in terms of medical professionals' involvement in management change processes in hospital organizations, we might expect that the medical professionals would have an opportunity to be deeply involved in the management model change process locally within the hospital organization, developing local management solutions, as I we might expect that the change process will be driven from a consensus-orientated and bottom-up-based approach. In this regard we might assume that the introduction of an alternative hospital management model, will affect the medical professionals' hitherto unique managerial dominance. However, we might expect that the medical professionals would not reject an alternative management model but instead be interested and engaged in and committed to a management model development process in relation to preserving their traditional high degree of involvement in hospital management and their structural dominance. In other words, we might expect they will recognize and acknowledge the advantages in working with an alternative model that will still support their traditional dominance and legitimacy. More precisely, we might expect that the medical professionals as the dominant group will use their dominating structures to both obtain and utilize power but also to remove discordant structures because of the risk of challenge to the legitimacy of their status quo. This might be done by embracing an alternative model within the power structure that favours their dominance of hospital management models. On this basis we might assume that the medical professionals will play a key "entrepreneurial" role in challenging the dominant model, even though the medical professionals' position can be characterized as being of a relative advantage within the model. Through their commitment they will have the opportunity to enhance their position for pushing for modification or change that will favour their position within an alternative management model (Powell et al., 1999:15 in Kirkpatrick and Ackroyd, 2003:735).

In terms of medical professionals' response to changing hospital management models in hospital organizations, we might expect the medical professionals to be interested and engaged in protecting their structural positions within the hospital organization by maintaining or even enhancing their managerial control of their medical practice based on their institutionalized autonomy to design their own management models, if structural change, such as the introduction of a new hospital management model, especially at department level, were introduced.

In terms of the outcome of hospital management model change in hospital organizations, we might expect that the medical professionals would engage in, negotiate, favour and commit to design a variant of an alternative model that would still would support their traditional dominance in order to protect and preserve their traditional legitimacy and dominance within the hospital organization. On this basis we might expect that the outcome of a hospital management re-organization and change process would evolve towards a hospital management model which will preserve the medical professionals' traditional structural dominance and legitimacy as the advantaged groups (the medical professionals) will pursue consolidation and control over the distribution of resources within the hospital department.

The aim of this dissertation is to explore in depth how medical professionals adapt, negotiate and interpret management changes in hospital management models in hospital organizations over time, and especially within an underexposed context such as the Nordic health system context where we might expect that medical professionals may possess both the opportunity to play a more innovative role in the local management change process, and more autonomy to interpret, negotiate and design their own management models, which may increase their level of engagement.

In this dissertation I take as empirical point of departure the Danish health system context as an illustrative case for the Nordic countries, as Denmark arguably is the Nordic country in which management reforms and health care change have been introduced most softly (Byrkjeflot and Jespersen, 2005). Below I will present the recent literature about change in medicine and management within the Danish health system and hospitals.

2.7. DANISH LITERATURE ON MEDICINE AND MANAGEMENT

Despite the Danish medical associations and medical professionals being substantially involved in the diffusion of NPM elements in the hospital field, compared with other European countries (Bentsen, 2000, Jespersen, 2005, Kirkpatrick et al. 2009, Borum 2002), and furthermore enjoying considerable scope to shape the ways in which management initiatives has been implemented on the ground (Jespersen, Nielsen and Sognstrup, 2002, Jespersen, 2005), we know surprisingly little about what happens in practice when the medical management development is in the hands of the medical professionals themselves at hospital department level and they are left to their own devices to pick up and interpret Danish hospital management models. This gap in the literature is described in the section below, where I present the historical context of the reforms in the Danish hospital sector and review the Danish research conducted on the impact of these reforms and the responses of the professions and professionals.

2.7.1. REFORMS IN THE DANISH HOSPITAL SECTOR

In this section I describe the historical context of management reforms in the Danish hospital sector.

Denmark began modernizing the public sector a while before the NPM trend became recognized in the Danish context (Greve, 2007). There are no comprehensive studies of the influence of NPM in Denmark; however, Denmark is an example of a country where NPM reforms primarily have provided new organizational and managerial forms and where the market orientation has had a minor impact (Greve, 2007). Elements of NPM are practised in all branches of the Danish public sector, however, it is proposed that the Danish health care sector is the area in which the NPM elements might have been the most powerful (Greve, 2007).

In the 1970s, 80s and 90s, debate about the hospital's traditional organization and management models slowly began to emerge. Government reports and commissions attempted to identify and promote prioritization, coordination (structure and effectiveness) and innovation to improve the health care system as a result of the sector's tendency to uncontrolled growth (Perspektivplan I (1971), Perspektivplan II (1973), Produktivitetudvalgets Betænkning 1984 Sygehuskommision, 1997). A few empirical studies of management and cooperation forms in hospitals were also generated (Københavns Hospitalsvæsen, 1974, Borum, 1976, Thomsen, Christensen and Hatting, 1986). However, larger scientific empirical studies of hospitals' organizational and managerial organizations and focus on re-organizations thereof appear not until the late 1990s. These studies are strongly supported by the establishment of the FLOS Centre (Research Centre for Management & Organization in Hospital Service) in the period 1999–2004 (Borum et al., 1999, Borum, 2004). Historically the FLOS Centre established the foundation for examining hospital management models and managerial developments through a structural lens. From a new institutional theory approach, studies from the late 1990s and 2000s primarily examine the formation and spread of new governance and management models at hospital field and organizational level. The general formation and spread of the Troika model, the upcoming centre management model, the establishment of the function-bearing-unit model and later the spread of the unitary clinic management model within hospitals are different kinds of organizational and managerial structurations that are objects for scrutiny in these studies (Borum and Bentsen, 1999, Bentsen, 2000, Vinge, 2000, Bentsen et al., 1999, Jespersen, 2005).

In contrast to the mentioned descriptive studies about the formation and spread of new governance and management models (structures) in the hospital field, where it is apparent that the (medical) professional associations have played an important role in the development and structuration of professional management models at

field and hospital level, there are a few studies from the mid 1990s that examine the medical professionals' adaption of the medical manager role at hospital and department level, including a focus on the issues relating to how medical managers, who are in the field of tension between production and strategic management, think and act in relation to their own management duties on hospital and department level, what are the essential elements in their behaviour and how they act when they have the opportunity to establish new routines and break with old ones (Alban, Knudsen and Thomsen, 1990, Lykkesfeldt and Christensen, 1994, Utzon, 1997).

2.7.2. THE IMPACT OF MANAGEMENT REFORMS AND RESPONSE

In this section I describe the research conducted on the impact of these management reforms and responses of professions and professionals.

At the beginning of the 2000s three empirical studies set the medical manager role in hospital management on the research agenda. Bentsen (2001) focused on medical management where the attention is at management in relation to health care professionals and primarily to the medical group. Through a new institutional lens, the study examines the micro institutional level where the medical manager as an institutional entrepreneur is the object. More specifically Bentsen (2001) focuses analytically on how medical managers break with institutionalized behaviour and traditions and what kind of management tasks are prioritized and related to the external world. Bentsen (2001) concludes that there are indications that the medical managers are enhancing their medical management role by combining elements of both medical and management challenges through their activity patterns.

Sognstrup (2003) sought through a theoretical lens of new institutional theory and theory of professions to understand how professions and professionals influence the realization of two formal management models: the joint clinical management model and the unitary clinic management model in the Danish health system. More precisely that study examined how the medical and nursing professions acted at the hospital field level by creating and protecting so-called professional management projects and how the departmental management reflects their respective professional management projects under two different sets of institutional conditions. Sognstrup (2003) concludes that the professionals' management project plays a significant role no matter what model is formulated by politicians and administrators.

Jespersen (2005) focuses on the impact of the character of the hospital field and the interaction between the institutions in the field regarding formation, distribution and interpretation of organizational and management reforms. Furthermore Jespersen (2005) focuses on how managers' and professionals' interpretations of and attitudes towards organizational and management reforms can be understood and explained, including how the professional manager's role can be interpreted and what kind of

difficulties and opportunities the role offers as link between the professional world and the modern management world. The results demonstrate that the medical managers construct and interpret their management role primarily through the management project of their profession within the given frame of the management model. Regarding management duties they are strongly oriented towards professional development and quality. Finally, the medical manager is characterized as a hybrid manager, who mediates between the professional world and the management world.

In general[4] there are limited Danish studies on medicine and management within hospitals. The studies can be divided into two main themes of interest. The first and also most widely applied theme of studies has been interested in structural change and the formation and spread of new governance and management models in the hospital field and at the organizational level. The second and less applied theme has been about the medical management role, including the appearance of and issues about a hybrid medical management role, and medical managers' involvement in management models. Theoretically the Danish literature of medicine and management in general has been using a new institutional approach at the field and organizational level, and has in a minor degree focused on the dynamics over time at the institutional micro level.

Summing up, lacking from the Danish literature are studies of how medical professional managers adapt and interpret hospital management models over time in relation to changing hospital management models within a Danish hospital context. This is despite the fact that the general picture revealed by the studies of medicine and management illustrates that the (medical) professional associations, as well as the medical professionals in the hospitals, have played an important role in the development and structuration of professional management models at field and hospital level.

2.8. RESEARCH QUESTIONS

The aim of this dissertation is to understand and explain how medical professionals adapt, interpret and negotiate hospital management over time in relation to changing hospital management models within a hospital organization in the Nordic health system context, illustrated by the Danish health system.

[4] In addition to the Danish empirical studies, there are a few books, anthologies and textbooks about hospital management and changes in the hospital field. However, the literature does not contribute new empirical knowledge about hospital management and doctors' involvement in management and hospital management model development (see Hildebrandt and Schultz, 1997, Bentsen et al., 1999, Hildebrandt et al., 2003, Borum, 2004, Bendix et al., 2008).

The dissertation is specifically guided by the following research questions:

- How do medical professionals adapt a hospital management model within a hospital organization in the Danish health system?

- How can we explain this adaption process?

In the next chapter I introduce theoretical concept of archetype theory elaborated by Greenwood and Hinings (1988, 1993), as well as their concept of intra-organizational dynamics (Greenwood and Hinings, 1996), to help us understand and explain how medical professionals adapt a hospital management model within a hospital organization in the Danish health system.

CHAPTER 3. THE THEORETICAL FRAMEWORK

3.1. INTRODUCTION

In this chapter, I discuss the rationale for applying the concept of archetypes elaborated by Greenwood and Hinings (1988, 1993), as well as their concept of intra-organizational dynamics (Greenwood and Hinings, 1996), as a theoretical lens for analysing how medical professinals adapt changing hospital management models in hospitals organizations and how we can explain this adaption process. Moreover, I present the use of theory of archetypes to study changes in professional health care service organizations. While the framework offers a promising theoretical lens, it has not been applied fully, as empirical studies of organizational change in professional health care service organizations are limited.

This chapter on the theoretical framework is structured as follows. First, the concept of archetype theory developed by Greenwood and Hinings (1988, 1993) is detailed. Hereafter, I move on to explain how organizational change can be understood with the concept of tracks. Then, I present the concept of intra-organizational dynamics developed by Greenwood and Hinings (1996) in order to provide insights into the process of organizational changes and how we can explain the changes of the archetype configuration. The following section offers an overview of recent literature that has applied the concept of archetype theory to studies of changes in professional health care service organizations and a presentation of how I apply the theoretical framework in this dissertation.

3.2. THE CONCEPT OF ARCHETYPES

In the section below I will describe how the main contributors to the theory of archetypes (Greenwood and Hinings 1988; 1993, 1996) have defined and clarified the main ideas and assumptions of the archetype theory.

The concept of archetype theory draws on elements from both old and new institutionalism (Greenwood and Hinings, 1988, 1993, 1996). Historically, interest in change has been at micro level, focusing on incremental change within archetypes, where issues such as influence, coalitions, competing values, power and informal structures have been the analytical objects (Greenwood and Hinings, 1993). This old institutional perspective emphasized the ways in which the formal, rational mission of an organization was diverted by the operation of group interests and the details of an organization's interactions with its environment over time, and pays attention to the beliefs and actions of those who have the power to define

directions and interests. The individual organization was the unit of analysis (Greenwood and Hinings, 1996:1031).

Later the literature of new institutionalism emerged in contrast to the old institutional perspective. It focused on legitimacy, the embeddedness of organizational fields, the centrality of classifications, routines, scripts, and schemes (Greenwood and Hinings, 1996:1023, DiMaggio and Powell, 1983, Meyer and Rowan, 1977). Concerning organizational change, this new institutional theory approach was not regarded as a theory of change, but more as a theory or explanation of organizational similarity (isomorphism) and stability of organizational arrangements in a given field (DiMaggio and Powell, 1983, Greenwood and Hinings, 1996:1023).

However, the neo-institutional literature and in particular a group of scholars who advocate for the theory of archetype (Brock et al., 1999, Cooper et al., 1996, Greenwood and Hinings, 1988, 1993, 1996, Kirkpatrick and Ackroyd, 2003) has given rise to one of the most influential approaches to analyse change in professional service organizations. Greenwood and Hinings (1988, 1993) argued that there appeared to be a growing attraction to the uncovering of the phenomenon of "organizational archetypes" and a growing attention to their transformation and development in order to understand continuity and change within organizations (Cooper, Hinings, Greenwood, and Brown, 1996).

Drawing on the work of Miller and Freisen (1984), the concept of a design archetype is initially elaborated and defined by Greenwood and Hinings (1988, 1993). Greenwood and Hinings define a design archetype as:

> a set of ideas, beliefs and values that shape prevailing conceptions of what an organization should be doing, of how it should be doing it and how it should be judged, combined with structures and processes that serve to implement and reinforce those ideas. (1988:295).

Greenwood and Hinings later elaborated the definition of design archetypes as "a set of structures and systems that consistently embodies a single interpretative scheme" (1993:1055, Kirkpatrick and Ackroyd, 2003:733).

The central idea is that organizational structural arrangements, practices and processes both influence and are also shaped by deeper underlying beliefs and values that are shared by members of the organization, constituting an archetype[5] (Greenwood and Hinings, 1988, 1993, Kirkpatrick and Ackroyd, 2003:733). The idea of underlying "clusters" of ideas, values and beliefs is conceptually elaborated

[5] Generic differences of archetypes have consequences for performance, power, decision making, conflict, morale and job satisfaction (Greenwood and Hinings, 1988).

as an "interpretive scheme" that relates to how organizations define their domain, principles of governance and criteria for evaluation. As Greenwood and Hinings (1988:299) put it: "…interpretive schemes contain beliefs and values about domain, organizational form and criteria for performance evaluation". The notion of "interpretive scheme" is thus an essential part of understanding and defining the design archetype. As Greenwood and Hinings (1988:295) argue, a particular interpretive scheme coupled with associated structural arrangement constitutes an archetype: "The structural elements and organizational processes making up the design type are strongly underpinned by province of meaning and interpretive schemes which bind them together in an institutionally derived normative order."

One of the key points in emphasizing a "holistic nature" of the relationships between the mentioned elements is based on the idea of coherence between the organizational elements (Greenwood and Hinings, 1988). Cooper, Hinings, Greenwood and Brown (1996) emphasize that the interpretive schemes have the crucial role of providing coherence and meaning to organizational structures and design. They describe how ideas and structures constitute each other and themselves through interaction in a process of structuration, which leads to the understanding that archetypes themselves need to be understood as structures in process, as parts of a historical process by which organizations and the people who work in them obtain their identity (Cooper, Hinings, Greenwood and Brown, 1996:643).

As the archetypal coherence comes from a consistent relationship between an interpretive scheme and an organization's structure and systems (Greenwood and Hinings, 1993:1056), the underlying concept of coherence raises the questions of classification of organizations. Greenwood and Hinings (1993:1054) argue that: "The idea of coherence between the elements of organizational arrangements is central to typologizing, and classification of organization is made according to differences and similarities in overall patterns" (Greenwood and Hinings, 1993:1054). More specifically, Greenwood and Hinings (1988:295) suggest that the classification and identification of organizational archetypes becomes "a function of the isolation of clusters of ideas, values, beliefs coupled with associated patterns of organization design."

In other words, to be able to define and differentiate analytically between various types of archetypes it becomes important to study the coherence of the structure, systems and interpretive scheme of an archetype.

3.3. THE CONCEPT OF TRACKS

In this section I will describe how Greenwood and Hinings (1988, 1993, 1996) explain organizational change using concepts from archetype theory. Specifically the concept of tracks is presented.

Archetype theory is concerned with the dynamics of large-scale changes, which involves movement from one archetype to another (Greenwood and Hinings, 1993:1952). Greenwood and Hinings (1993) argue that it is necessary to conceptualize the scale of change in order to understand – analytically and empirically – strategic transformations or organizational re-orientations, for example, the re-orientation of hospital management models. In order to understand the scale of change the concept of "tracks" is important, which I will explain below.

The process of identifying archetypes is important, but what is of central concern when studying transformational organizational change is "mapping and explaining the incidence, nature and cause of movements and the absence of movement between archetypes" (Greenwood and Hinings, 1988:303). Such movements and inertia may be labelled "tracks" (Greenwood and Hinings, 1988). Tracks are thus defined as "the maps of the extent to which organizations move from the constraining assumptions of a given archetype and assume the characteristics of an alternative archetype" (1988:294). In other words, "[t]he temporal relationship between an organization and one or more archetypes defines an organization's track" (Greenwood and Hinings, 1988:313).

Based on these definitions, the concept of tracks involves the preparatory identification of archetypes, which requires the uncovering of ideas, beliefs and values (constituting the interpretive scheme) reflected in structural arrangements (1988:309). Focusing on the notion of "interpretive schemes" as part of the archetype, Greenwood and Hinings (1988) argue that it enables the identification of directions of change but it also gives the opportunity for explanations of why organizations confronting similar contextual "crises" may respond by moving along different tracks. A key aspect of analysing tracks is that it becomes possible to analyse which design archetypes/arrangements have become de-coupled from the prevailing interpretive scheme. Tracks are then suggested as configurations of structural de-coupling and recoupling to alternative interpretive schemes (1988:303/313). In other words, the particular track of an organization will be a function of the degree of coherence between structures, systems and interpretive scheme, coupled with the pattern of commitment to the interpretive scheme and the incidence of interest dissatisfaction of powerful groups (1988). In all, organizational tracks reveal whether there is any loss of structural coherence and any movement of the underpinning interpretive schemes over time (1988:303).

3.3.1. CONVERGENT, RADICAL AND SEDIMENTATION TRACKS

Not all organizations undergo transformations in the same manner. For example, not all organizations go through the same set of stages, depart from similar positions, or have common destinations (Greenwood and Hinings, 1988:303). This understanding means that we must allow for a complex array of tracks. In this section three main types of tracks are presented.

Radical and convergent tracks of change

Greenwood and Hinings (1996) argue that organizational behaviour is not only responses to market pressures, but also to institutional isomorphic pressures. Institutional pressures lead organizations to adopt the same organizational forms, which means that the institutional context provides "templates of organizing" (DiMaggio and Powell, 1991:27 in Greenwood and Hinings, 1996:1025). The idea of templates for organizing regards the aim to recognize archetypal patterns in the display of structures and systems. Thinking of organizational arrangements in terms of templates or archetypes provides a definition of radical and convergent change, according to Greenwood and Hinings: "Convergent change occurs within the parameters of an existing archetypal template. Radical change, in contrast, occurs when an organization moves from one template-in-use to another." (Greenwood and Hinings, 1996:1026). The definition of radical change or "frame-bending" change "involves the busting loose from an existing 'orientation' … and the transformation of the organization" (Greenwood and Hinings, 1996:1024). The definition of convergent or incremental change is described as: "Convergent change is fine tuning the existing orientation" (Greenwood and Hinings, 1996:1024). Greenwood and Hinings (1996) are mainly interested in understanding radical change.

Furthermore, Greenwood and Hinings (1993) seek to provide an explanation of both the incidence of radical change and of the extent to which such change is achieved through evolutionary or revolutionary pacing. Revolutionary and evolutionary changes are defined "by scale and pace of upheaval and adjustment". According to Greenwood and Hinings, evolutionary change "…occurs slowly and gradually" (1996:1024) and revolutionary change "…happens swiftly and affects virtually all parts of the organization simultaneously" (1996:1024). The explanation has three themes. First, organizational resistance to change derives from the normative embeddedness of an organization within its institutional context. Second, the incidence of radical change and the pace by which such changes occur will vary across institutional sectors, in particular, in the extent to which sectors are tightly coupled and insulated from ideas practised in other sectors. Third, incidence of radical change and the pace by which such change occurs will vary within sectors because organizations vary in their internal organizational responses, because organizations vary in their internal organizational dynamics.

However, Greenwood and Hinings (1993) suggest that changes involving movement between archetypes are highly unusual. Organizations are rather characterized by convergence towards prevailing archetypal form and inertia and they tend to remain within the assumptions of the existing archetype. Radical change as the passage from one archetype to another – "frame bending" (1988, 1993,) – is exceptional. Derived from these descriptions, Greenwood and Hinings (1993) suggest that organizations tend to remain within an archetype rather than move between archetypes.

Sedimentation track of change

Building on the theory of archetypes proposed by Greenwood and Hinings (1988, 1993), Cooper, Hinings, Greenwood and Brown (1996) argue that Greenwood and Hinings (1988, 1993) have a uni-linear view of change and organizational tracks and stress transformational change in the form of one archetype that sweeps away an earlier one. However, Cooper et al. (1996) argue that the notion of "sedimentation" is useful in order to understand how one archetype can be laid down on top of another, which will be explained in this section.

According to Cooper et al. (1996), Greenwood and Hinings focused on dramatic change (1988), assuming that most change involves organizational transformation (a shift from one archetype to another). Cooper et al. (1996:624) thus sought to explore the emergence of an organizational archetype, which appears not to be secure and which results in sedimentation structures and ideologies. Their basic argument is, that "organizational change represents not so much a shift from one archetype to another, but a layering of one archetype on another" (Cooper et al., 1996:624). They use the geological metaphor of sedimentation: "Sedimentation points to the persistence of values, ideas, and practices, even when the formal structures and process seems to change and even when there may be incoherence" (Cooper et al., 1996:624). It allows them to consider a dialectical rather than a linear view of change. Furthermore, Cooper et al. (1996) argue that the metaphor of sedimentation is useful in order to emphasize that "unresolved excursions" may be a very frequent and important track, for example, in organizations with competitive commitments (different kinds of commitment to archetypes/interpretive schemes). The emphasis is on making sense of organizational practice as new ways of doing things, and making sense of both the order and disorder that will characterize organizational life in times of change (1996: 644). Cooper et al. (1996) argue that the process of change is not necessary transformational or incremental, but rather sedimentational (Cooper, 1996:624). Table 1 presents the types of tracks and changes including their outcome.

Table 1Types of tracks

Tracks: Type of change	Outcome	Indications
Convergent archetypal change	Fine tuning the existing archetypal orientation	The movement in the set of hospital archetype structures and systems that consistently embodies the hospital interpretive scheme, is limited

Radical archetypal change	Transformation of the archetypal organization	Occur when the traditional hospital management archetype moves from one template in use to another
Sedimentation or hybridized archetypal change	One archetype can be laid down on top of another Hybridization	The traditional hospital archetype template in use occurs, side by side with a new management interpretive scheme

Radical change is theorized to occur with a transformation in the dominant archetype, while convergent change is regarded as fine-tuning within the parameters of an existing archetype. Sedimentation change occurs with one archetype being laid down on top of another.

3.4. THE CONCEPTS OF INTRA-ORGANIZATIONAL DYNAMICS

In this section the concept of intra-organizational dynamics is presented. This includes a presentation of the components of precipitating and enabling dynamics of a model of organizational change elaborated by Greenwood and Hining (1996).

The concept of archetype theory presented above is an example of a theoretical framework which aims to explore and describe the process of movement within and between institutionalized archetypes or, in other words, the process of "interpretive de-coupling and recoupling" of archetypes (Greenwood and Hinings, 1988:303). However, this approach does not explain why some organizations adopt radical change, whereas others not, despite experiencing the same institutional pressures. This focus on the process by which individual organizations retain, adopt or discard templates (archetypes) has been addressed by Greenwood and Hinings (1996).

With a specific focus on the interplay of contextual forces and intra-organizational dynamics, Greenwood and Hinings (1996) emphasize how external processes of deinstitutionalization should be understood (organizations in sectors) together with the internal dynamics of interpretation, adoption and rejection by the individual organization. Moreover, in order to understand how institutionalized practices break down and are replaced by new ones, it is interesting to focus on the inner

mechanisms and dynamics of change that control and propel the movements between archetypes. By presenting a model, based on the existence of archetypes, Greenwood and Hinings (1996) encompass exogenous (market context, institutional context) and endogenous (interests, values, power dependencies, capacity for action) dynamics of the process of change (1996:1033) in order to understand both persistence and change.

How organizations respond[6] to institutional prescriptions is a function of these internal dynamics. How organizational adaption, interpretation and responses to such external pressures as, for example, the idea/templates of the JJH model, is understood by the dynamics of the intra-organizational behaviour and the normative embeddedness of the organizations (hospital management models) within their context (health system). However, the focus in this dissertation is not on how a hospital management organization has responded to external pressures by, for example, adopting a new organizational management model/form by which it can achieve success in the marketplace. The aim of this dissertation is to understand and explain the process by which individual medical professionals over time within a hospital organization adapt a hospital management model. In order to grasp the adaption process, the focus will primarily be on the components of the endogenous dynamics of intra-organizational behaviour. In the section below I will describe the relevant components from this model.

3.4.1. PRECIPITATING DYNAMICS

The endogenous components in the model for understanding organizational change as the precipitating dynamics are the roles of “interest” and “value commitments”, which will be explained in this section.

Greenwood and Hinings (1996) expect organizations to vary in the extent to which they are characterized by interest dissatisfaction; however, dissatisfaction does not provide direction of change: “Intense pressure for change arising from dissatisfaction with accommodation of interests will not lead to radical change, unless dissatisfied groups recognize the connection between the prevailing template (which shapes the distribution of privilege and disadvantage) and their position of disadvantage.” (1035). However, groups often not recognize how existing organizational design is a disadvantage to their interests. Instead it is the recognition and possibility of an alternative template that creates pressure for change.

[6] In order to understand different organizational responses, organizations are conceptualized as heterogeneous entities composed of functionally different groups pursuing goals and promoting interests.

The pattern of value commitments within the organization becomes important in explaining radical change. Greenwood and Hinings (1996:1035) outline four generic patterns of value commitments:

- Status quo commitment, in which all groups are committed to the prevailing institutionalized template-in-use.
- Indifferent commitment, in which groups are neither committed nor opposed to the template-in-use.
- Competitive commitments, in which some groups support the template-in-use, whereas others prefer an articulated alternative (The articulated alternative would have its origins in the institutional context.)
- Reformative commitment, in which all groups are opposed to the template-in-use and prefer an articulated alternative.

The patterns of value commitments will vary between organizations partly because of their different locations within the institutional sector, according to Greenwood and Hinings (1996:1036). For example, if organizations are more peripheral and thus less embedded in the sector, they are less committed to prevailing practices and readier to develop new ones. Organizations that are more centrally located within the institutional field have a more intense commitment to the status quo. Among organizations, those with high structural differentiation tend to have greater conflict among the groups of specialists (Greenwood and Hinings, 1996:1036). Each group may adhere to a different set of norms, which produces competitive commitments.

The concepts "interests" and value commitments" are described as discrete precipitators of pressure for change by Greenwood and Hinings (1996). They are also linked, as values can become taken for granted and serve to mute or temper expressions of dissatisfaction. The role of value commitment is thus essential, because there is no link from interests to radical change, only from interest to convergent change. Radical change will only occur if interests become associated with a reformative pattern of value commitment (Greenwood and Hinings, 1996:1037). Furthermore; the intensity of the pressure for change will vary in relation to the value commitment. A more reformative commitment will be associated with revolutionary change and, in contrast, a more competitive commitment will encourage a more evolutionary pace of change (Greenwood and Hinings, 1996:1037).

3.4.2. ENABLING DYNAMICS

The endogenous components in the model for understanding organizational change that act as enabling dynamics are the "capacity for action" and "power dependencies", which will be explained in this section.

Internal pressures for change derive from interest dissatisfaction and the pattern of value commitments. However, radical change is only enabled in combination with appropriate "capacity for action" and supportive power dependencies (Greenwood and Hinings, 1996:1037).

"Power dependencies" is defined by Greenwood and Hinings (1996) as "*some groups and individuals are listened to more keenly than others ... Some have more potential or less potential for enabling or resisting change*." (1038). The organizationally defined groups within organizations use favourable power dependencies to promote their interests, which means that groups will vary in their ability to influence organizational change, because they not possess the same amount of power. Some groups have more potential to enable or resist change and others less.

The precipitating dynamics of "interest" and "value commitments" can only be understood in relation to differential power (Greenwood and Hinings, 1996:1038). It is argued that the prevailing archetypal template in an organization "gives" power to some groups and not to others, which constitutes differential access to and control over key decision processes within organizations. Groups in positions of privilege and power (dominant coalition), that are in favour of a proposed change, can promote radical change if they are aware of the weaknesses of existing template arrangements and of potential alternatives (Greenwood and Hinings, 1996:1038/39). They express that change will only occur where power-dependenciesare combined with either a competitive or reformative pattern of value-commitment (Greenwood and Hinings, 1996:1039).

The second enabling dynamic, "capacity for action", is defined by Greenwood and Hinings (1996) as "*the ability to manage the transition process from one archetype template to another*" (1039). The ability to manage the transition process depends on having the skills and competencies required to function in the recognized new destination, and it depends on having the ability to manage how to get to that destination. Greenwood and Hinings (1996:1040) suggest that the capacity for action embraces both the availability of these skills and the resources within an organization and their mobilization, where mobilization in this sense is the act of leadership. Also, experience with change increases capacity for action. Radical change would not occur without the capacity for action, which makes the component an enabling dynamic. However, the capacity for action cannot foster change solely because there has to be a motivation for change driven by the precipitation dynamics such as the role of interest and value commitments (Greenwood and Hinings, 1996:1040). Regarding the speed at which radical change is accomplished, Greenwood and Hinings (1996) argue that a clear recognition of the new destination and of how to get there may give an organization the confidence to push ahead rapidly with change. On the other hand, lack of clarity

and lack of expertise may promote lack of sureness and slower, almost experimental steps.

In summary, power dependencies and capacity for action are necessary but not sufficient conditions for radical organizational change, which means that the "components" of the dynamics alone will not lead to radical change, but they can and enable or constrain it (Greenwood and Hinings, 1996:1041).

3.5. APPLICATION OF CONCEPTS IN STUDIES

In this section I refer to recent studies which have applied concepts of archetype theory, including concepts of the intra-organizational dynamics in professional health care service organizations. Then I present how I find the theoretical framework of archetypes and intra-organizational dynamics useful in this study. In order to study the complexities of the organizational management transformation in a hospital management model, including the medical professionals' adaption process, I find it relevant to apply some of the theoretical concepts and aspects as presented by Kitchener (1999), Mueller, Harvey and Howorth (2003) and McNulty and Ferlie (2002, 2004).

Archetype theory has been applied to a range of professional fields, including law, accounting, consulting and medicine (Greenwood and Hinings, 1988, 1993, Cooper et al., 1996, Denis, Langley and Cazale, 1996, Kitchener, 1999, McNulty and Ferlie, 2002, 2004, Mueller, Harvey and Howorth, 2003). However, few studies have applied archetype theory to professional health care service organizations and most of them are empirically based on change in the British NHS/Anglo-Saxon health system context in the early 2000s (Kitchener, 1999, Mueller, Harvey and Howorth, 2003, McNulty and Ferlie, 2002, 2004).

Kitchener (1999) applied archetype theory when analysing transformational change in British NHS hospitals in the early 1990s. That study specifically applied archetype theory in order to define the existing archetype in the UK hospital field, the "professional bureaucracy hospital archetype", and to analyse and define the intended archetype, the "quasi-market archetype" (Kitchener, 1999: 184). Kitchener concluded that the intention of the national political reforms, the introduction of a quasi-market, had not led to the transformation of UK hospitals. Instead Kitchener (1999) highlights that the concept of sedimentation is more accurate when describing the process by which the hospitals have changed.

Mueller, Harvey and Howorth (2003) also applied the concepts of archetype theory, when studying a new governance structure in the British NHS. Archetype theory is also specifically applied in order to frame and define the existing archetype and intended archetype of governance structure. However, their analytical focus was not an overall transformation of hospital governance archetypes and the outcome of the

intended transformation, e.g. presented by Kitchener (1999), but it was a more internal focus on how the archetype configuration is interpreted and negotiated during the transformation process.

McNulty and Ferlie (2002, 2004) also applied concepts of archetype theory, when studying the complexities of organizational transformation in the UK health care system. The study describes and reflects on the experience of the Leicester Royal Infirmary, a large NHS teaching hospital, which in the 1990s sought to achieve transformational change, using the change model of Business Process Reengineering (BRP). However, McNulty and Ferlie (2002, 2004) did not apply the archetype theory in order to frame and define existing and intended archetypes and the outcome of the transformation process as such (Kitchener, 1999, Mueller, Harvey and Howorth, 2003). Their idea was to apply archetype theory in order to analyse the challenges of effecting a transformatory shift to a new form of process organization in a large and complex organization. They mainly focused on the possibilities, problems and processes involved in effecting organizational transformation, which the organizational change literature had not particularly focused on. McNulty and Ferlie (2004:1394) argued that empirical studies of organizational change and transformation require that the analysis of the content and process of change should not be abstracted from the context that gives change its form, meaning and dynamic. Therefore McNulty and Ferlie (2002, 2004) applied Greenwood and Hinings's (1996) neo-institutional model of radical change; because it embraces a greater interest in change and in doing so is recognizing macro and micro relations and interactions. Furthermore, they argue that the concept of intra-organizational dynamics is more accommodating of agency than earlier institutional theory (McNulty and Ferlie, 2004:1993).

In summary, Kitchener (1999) examined the extent to which a traditional hospital archetype actually changed towards another intended archetype configuration. Mueller, Harvey and Howorth (2003) examined through a more internal focus how the archetype configuration was interpreted and negotiated during the transformation process. McNulty and Ferlie (2002, 2004) examined the challenges of effecting a transformational shift to a new form of process organization in a large and complex organization.

3.5.1. APPLICATION OF THE CONCEPTS

Below I outline how I have applied the concepts of archetype and the concepts of intra-organizational dynamics.

Traditionally, the theoretical emphasis has been outlined at different levels of analysis within archetype theory. At the macro level, or the institutional field level, the changing environment, as interpreted by actors, produces ideas about the need for change, good practice and general process for deinstitutionalization (Oliver,

1992). This environment creates opportunities for new ideas or "interpretive schemes" to emerge (Kirkpatrick and Ackroyd, 2003). The purpose on this level is to discover which organizational forms or archetype templates are legitimated in the institutional sector. At the meso level, or the organizational level, the purpose often is to examine the extent to which those organizations approximate the sectors archetype in the individual organization. At this level, there will be more variety, but pressures for archetypal conformity will operate upon individual organizations (Greenwood and Hinings, 1996).

In this dissertation the idea of archetype theory is pushed another step forward to the micro level of analysis. The level of analysis will be within a single organization with a focus on the adaption process of new archetype templates, constructing the hospital management organization. Focusing on the embedded archetype template within an individual hospital management organization this dissertation specifically pays attention to the local process by which the medical professionals adapt and construct a legitimated management template or change the existing one.

The purpose of taking a point of departure in the ideas of archetype theory is that they provide concepts that make it possible to define and construct empirically the existence of an archetype of a hospital management configuration. On the basis of this configuration, it will be possible to uncover the starting point of the studied archetype of the hospital management organization, but also how the archetype of hospital management potentially has changed or moved over time. In other words the concept of an archetype and tracks of change makes it possible to explore and analyse the scale of change within the hospital management configuration.

In order to explore how a hospital management model managerially and organizationally is adapted by medical professionals over time, I need to identify analytically and empirically the configuration of the embedded archetype as a starting point in order to identify if there has been a re-orientation within the archetype of hospital management models over time, based on the intra-organizational dynamics. By defining and constructing the archetype within two points in time, it becomes possible to conceptualize the scale of the change of the hospital management model. Moreover, I use the concepts of intra-organizational dynamics in order to analyse how the medical professionals within a hospital organization have engaged in a recognized alternative interpretive scheme in relation to the hospital management template that dominates the organization, when an emerging and competing archetype template is introduced.

In summary, the concept of archetypes and tracks of change will be useful in studying how a hospital management archetype model in a hospital organization is changed or transformed, including the direction of the specific adaption process of the changed hospital management organization. The concepts of intra-

organizational dynamics will be useful in explaining the process of medical professionals adapting a changing hospital management archetype in a hospital organization over time.

3.6. RESEARCH QUESTIONS

Based on the review of the current research literature on changing hospital management models, including enhancing the role of medical professionals in management of hospital organizations, the following research questions were put forward: How do medical professionals adapt a hospital management model within a hospital organization in the Danish health system? And how can we explain this adaption process? With a point of departure in the above theoretical framework, I refine these research questions below.

Based on the components of the intra-organizational internal dynamics I ask:

- How do the components of the precipitating and enabling dynamics (interest, value commitment, power dependencies and capacity for action) explain the medical professional adaption process of a hospital management model within an organization in the Danish health system?

Furthermore, as the phenomenon is about the process of adaption of a hospital management model archetype over time within a hospital organization, I also focus the extent to which the medical professionals' adaption process has moved the hospital management model archetype towards an alternative management configuration. Based on the concepts of archetype, I therefore ask:

- How has the hospital management archetype configuration (structure, system, and interpretive scheme) changed over time within a hospital organization in the Danish health system?

In the next chapter, I discuss the overall design and methods used to investigate the process of adaption by medical professional managers of changing hospital management archetype templates within an hospital organization in the Danish health system.

CHAPTER 4. DESIGN AND METHODS

4.1. INTRODUCTION

In this chapter, I discuss the design and methods used to investigate the process of adaption by medical professional managers of management in relation to changing hospital management models within a hospital organization in the Danish health system. First, I explain the rationale for conducting a longitudinal embedded single case study. Hereafter, I discuss the role of the theoretical framework which is applied. After this, I discuss the generalizability of the findings based on a longitudinal embedded single case-design. Hereafter I introduce the case setting that form the foundation for this research. After this, I describe how the study in practice is conducted, including a description of the access to the investigated organization and the role as a researcher. Hereafter, I describe the data collection methods, which are based on interviews with informants, observations and access to documentation. Finally, the data analysis strategy is presented.

4.2. RESEARCH DESIGN

In this section, I describe the rationale for conducting a longitudinal embedded single case study. In section 4.2.3 I discuss the role of the theoretical framework I have applied. In section 4.2.4 I discuss the generalizability of the findings based on a longitudinal embedded single case design. Then I provide an introduction to the case setting that forms the foundation for this research. I then describe how I conducted the study in practice, including a description of my access to the organization and my role as a researcher.

4.2.1. THE CASE STUDY

The aim of this study is to understand empirically and explain how medical professionals adapt and interpret management in relation to changing hospital management models over time. I assume that the medical professionals are embedded in a social context where the (phenomenon of) adaption processes of hospital management are embedded in a system that is taken for granted. However, as mentioned, the medical professionals also use their own interpretation as basis for their action, which means that they are constructing the social context they are embedded in. The context of the phenomenon is, from a philosophy of science point of view, essential in order to understand the phenomenon. In this regard it is additionally interesting that the comparative research and results highlighted in the literature review indicate that the national difference in contextual factors may have implications for the outcome of medical professionals engagement in hospital management. On this basis I assume that it is important to take into account the

specific (health system) context conditions in which the medical professionals are embedded, because they may be highly pertinent to the medical professionals' process of adaption of hospital management.

The intention of this study is to investigate how a contemporary phenomenon (the process by which medical professionals adapt a hospital management archetype template within a hospital's organization) unfolds within a social context over time. As a research strategy a case study is well suited for this purpose (Maaløe, 2002, Yin, 2003, Antoft et al. 2007). Yin (2009:13) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life-context, especially when the boundaries between phenomenon and context are not clearly evident."

According to Yin (2003), case study differs from other research designs by considering the context as being important for understanding the explored phenomenon, especially when it is assumed that the phenomenon and context are not always distinguishable in real life situations. In relation to the blurring boundaries of context and phenomenon the case study approach relies on multiple sources of evidence in order not to exclude potential data sources. With a more open research strategy such as the case study where the primary sources are not a priori defined, it is possible to gain a deeper insight into the field of the subject (Antoft et al., 2007). As I am interested in gaining an in-depth insight into how medical professionals adapt and interpret management in relation to changing hospital management models over time within a hospital organization, I have selected a case study research strategy approach.

4.2.2. A LONGITUDINAL EMBEDDED SINGLE CASE DESIGN

As I was interested in investigating the process whereby medical professionals adapt changing hospital management models within a hospital organization, it has been preferable and justifiable to use a longitudinal embedded single case study design, because it gives me an opportunity to study the same single case at different points in time (Yin, 2003). The single case in this case study is defined as the process whereby medical professionals adapted a specific changing hospital management model in a hospital organization in a Danish health system context from 2010 to 2013. It has primarily been conducted two points in time (2010 and 2013) and thereby reveals insight into the specific management change process I am theoretically interested in. The embedded units of analysis reflect smaller management units of professionals who adapt the changing hospital management model, which gave me significant opportunities for making an extended analysis, enhancing the insights into the single case of medical professionals adapting changing hospital management models over time.

I have studied how medical professionals adapt and interpret a changing hospital management model over time within a large department of medicine, the Department of Cardiology (DC), at a public somatic Danish University Hospital, Aarhus University Hospital (AUH). Specifically, the longitudinal embedded single case study took place between May 2010 and December 2014, with data collection occurring from August 2010 until December 2014. The DC provided an excellent empirical foundation for the study of medical professionals' adaption of management in relation to changing hospital management models because in April 2010 the department initiated a re-organization process of its management model. This re-organization process gave me the opportunity to gain insight into how the adaption process of the management in relation to the change in hospital management model evolved in real time and changed over time. In practice it has been possible to collect longitudinal empirical process data from a real-time field study, combined with archival sources. Moreover, the embedded unit of analysis was the local adaption process of management in the joint department management team, but also in the management teams at section level, all of whom are or have become involved in the overall re-organization of the management of the department by spring 2010.

The DC is an internationally renowned and highly specialized department for the diagnosis and state-of-the-art treatment of every aspect of heart disease. The department focuses on integrated patient care; its treatments span from standard non-invasive procedures such as medical treatment of hypertension to highly advanced invasive procedures such as heart transplantation, electrophysiology testing and pacemaker treatment, including biventricular pacemaker and ICD implantation. Furthermore the department is characterized by its excellence in research, education and clinical care. For example, in 2011 the DC was the most research active Danish hospital department, with 121 peer-reviewed scientific articles. In this regard the department is particularly known for the Danami2 study documenting the advantages of PCI treatment (angioplasty). Externally, the DC collaborates with the most well reputed heart centres worldwide. Moreover, a large number of foreign heart specialists visit the department for shorter or longer periods, contributing to an international atmosphere (AUH–DC, 2014).

Such a large, but also scientifically renowned, department is likely to be an insightful case to examine empirically medical professionals' involvement in management and thus how their management model evolves. In particular, it must be assumed that the initiated re-organization of their management model in itself will be a great disturbance and thus a great challenge for a department where the management has successfully been based on a traditional professional management organization (Mintzberg, 1979, 1983) with a strong democratic structure based on a consultant collegium and derived management traditions, which apparently have contributed to the success of the department (Abbott, 1988). I assume the DC might give insights into organizational management changes in an environment that has

primarily focused on traditional clinical management with success, but traditionally has not focused on the more organizational and administrative management approach. We might expect that if changes in the medical management approach and thus the management model could take place here, at a highly esteemed medical department with a strong competitive and independent management culture, which may be the most difficult environment for management change of any health care and hospital organizations in the Danish health system, it could also evolve from other similar places. It is interesting to pursue how the organizational management translates in the DC and why, in order to understand how and why medical professionals adapt changes in a hospital management organization. However, it should be noticed that I do not expect that the DC is significantly different from other large university departments in the Danish hospital and health system. The DC reflects a traditional management model, which is widely used (Jespersen, 2005) and the DC is exposed to the same contextual factors as other major departments in Danish health (Jespersen, 2005). It can therefore be assumed that the medical professionals' adaption of their changing hospital management model is illustrative for the same processes in the Danish health system. Furthermore, I take as point of departure the Danish health system as an illustrative case for the Nordic countries, as Denmark is arguably the Nordic country in which management reforms and health care change have been introduced most softly (Byrkjeflot and Jespersen, 2005). In this regard, the characterization of the Nordic health system presented in the literature review above might be more apparent in the Danish context.

4.2.3. THE ROLE OF THEORY

The theory applied in this longitudinal embedded single case design reflects the use of an approach that has an adaptive character (Layder, 1998) since elements of the interpretive theory case study approach as well as elements from the theory-testing case study approach during the two phases of data collection are used, which I will present in this section.

At the start of the case study process in 2010 my intention was to generate empirical knowledge about how medical professionals adapt and interpret management in relation to changing hospital management models within hospital organizations, on the basis of inspiration from concepts, prior development of theoretical propositions and ideas from research in medicine and management, sociology of professions, new institutionalism, including archetype theory, but also empirical descriptions. This meant that the longitudinal embedded single case study design benefited from prior development of theoretical propositions as a loose guide to the empirical data collection and analysis (Yin, 2003, Antoft et al., 2007). With this point of departure, the case study was initially based on elements of a theory interpretive case study approach, which meant that it was based on a loosely constructed theoretical framework with the intention of generating new empirical

knowledge (Antoft el al., 2007). More specifically, I used the loosely structured theoretical framework to define my case, and to structure and identify patterns in the empirical material, including discussions of whether these patterns had general or unique character (Antoft et al., 2007). When applying the theory interpretive case study approach, theory also played a central role in relation to emphasis on the case elements and concepts that would be relevant to further study within this longitudinal case study, which will be presented in the section on operationalization.

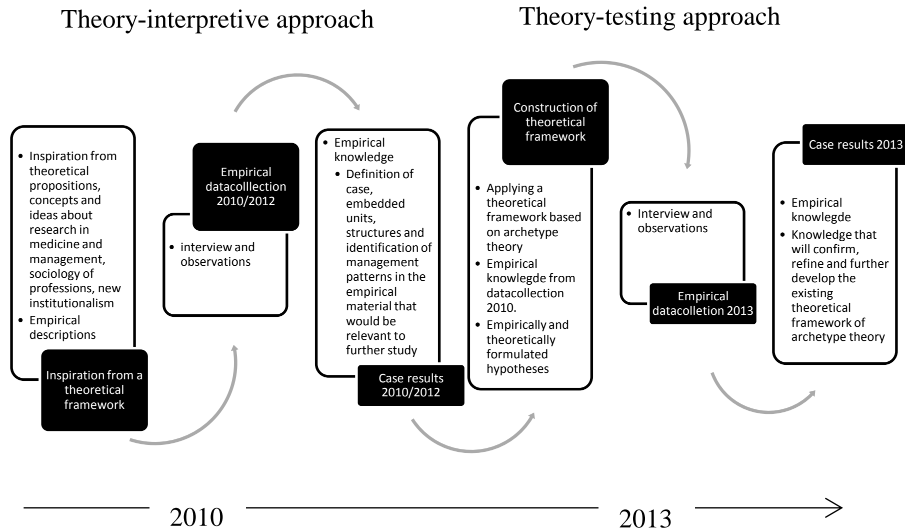
By applying a theory-interpretative approach to the case study when entering the organization in 2010, I had the opportunity to understand the complexity of the case and how it relates to its context, but also to identify possibly research questions and gain a deeper understanding of the case and the embedded units of analysis.

When using the theory interpretive approach, the primary aim in the first phase of the longitudinal case study was to generate new empirical knowledge about the doctors' adaption of management in relation to changing hospital management models. However, with the empirical results from the empirical data collection in 2010 and 2012 it was possible to apply a more deductive approach to the second phase of the data collection in 2013, which ideally contains a more linear vision of the process of generating scientific knowledge.

When collecting the empirical data in 2013 I used elements from a more theory-testing perspective approach. In contrast to the theory interpretive case study approach, where the goal was to contribute and deepen the empirical insight, the more theory-testing approach could contribute with knowledge that could confirm, refine or develop the constructed theoretical framework. With point of departure in more established theories, an appropriate theoretical framework based on primarily archetype theory has been used when conducting empirical data in 2013. The primary aim was to develop and challenge the applied archetype theoretical framework and to contribute with knowledge that could confirm, refine and further develop the existing theoretical framework (Antoft et al., 2007). The theoretical development that takes place when data are discussed in relation to the given theory could allow me to confirm the existing theory and add nuance to the existing theory, because data requires the development of new hypotheses or rejection of the theoretical model's validity in relation to the empirical field which case represent (Antoft et al., 2007:43). Thus it is assumed that the longitudinal embedded single case study can help to find the boundary conditions of the chosen archetype theory validity area (Antoft el al., 2007).

The figure below illustrates the use of both theory interpretive approach elements and theory testing approach elements regarding the role of theory.

Figure 1 The role of theory



In the discussion of the case in relation to the chosen theoretical framework, new findings can contribute to the existing theoretical framework by reinterpreted them in the light of the empirical findings (Antoft et al., 2007). This generalization approach of the empirical findings to theoretical constructs which may be relevant to the wider research community is termed analytical generalization, which I will explain in the section below.

4.2.4. GENERALIZABILITY

Case studies have typically faced criticism regarding scientific generalization (Antoft et al., 2007). Criticism about non-representativeness and lack of statistical generalizability has often been put forward and the question: "How can you generalize from a single case?" has frequently been asked (Yin, 2003:10, Maaløe, 2002:71, Flyvbjerg, 2004:1). One of the main criticisms of case study method has been its legitimacy as a scientific design, where it has been put forward that the results from the in-depth case study are often too context-dependent and that one therefore cannot easily generalize (Flyvbjerg, 2004). However, through a distinction between two types of generalization – statistical and analytical generalization (Antoft et al., 2007, Bøgh Andersen, 2012, Yin, 2003) – it has been argued that case studies are generalizable to theoretical propositions, because the goal of a case study will be to expand and generalize theories and not to enumerate frequencies as is the common goal in statistical generalization, which much of the criticism of case studies is based on (Yin, 2003:10, Antoft et al., 2007, Maaløe, 2002). Yin (2003:37)

put forward: “In analytical generalization, the investigator is striving to generalize a particular set of results to some broader theory”.

Based on the longitudinal embedded single case study, I have used the analytical generalization form. The theoretical framework of archetype theory and intra-organizational dynamics has been used as a template for comparison of the empirical findings in the case study. This means that the generalization is done through a process of forming conclusions (inference) by linking the individual empirical findings with the theoretical concept of archetypes (structure, system and interpretive scheme) but also the concepts of intra-organizational internal dynamics (interest, value commitment, power dependencies and capacity for action) (Antoft et al., 2007). By systematic detailed and rich descriptions and interpretation of the data it has been possible to alternate between interpretation of individual phenomena and the overall interpretation framework for the case study. The systematic description of the empirical findings makes it possible to conceptualize the case through the pre-established theoretical concepts and thereby develop analytical construct*s*[7] which helps me to identify the boundary conditions (limitations) of the area of validity of the applied theoretical frameworks (Antoft et al., 2007, Maaløe, 2002).

4.2.5. RESEARCH SETTING

Based on the argument that the boundary between the phenomenon and its context is seldom clearly evident (Antoft and Salomonsen, 2008), a central ambition of the study is to locate the relevant context of the phenomenon. In order to take into account the meaning of contextual conditions and the boundary between the context and the phenomenon, I will seek to reveal the case-boundaries of the phenomenon, which means that I as a researcher analytically create and construct the case-boundaries. They should therefore be conceptualized as a social construction created by me (Antoft and Salomonsen, 2008). The research questions set the boundaries for the selected case (Antoft and Salomonsen, 2008:5). Below I will reveal some of the “boundaries”[8] or, in other words, the setting of the case, but also highlight what I assess to be the external and internal boundaries/contextual settings.[9]

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[7] This means that generalizability on the basis of case studies is highly dependent on the selected case (Antoft et al., 2007).

[8] Antoft and Salomonsen (2008:5f) define the boundaries as “specific periods of time, as a set of the organizations e.g. the cultural and institutional aspects, the formal structures which, at least formally, delimit the organization from their environments”.

[9] The following description is not a finite description of the contextual conditions, but is an analytical construction drawn up on the basis of empirical data and dialogue with stakeholders/actors from the empirical field.

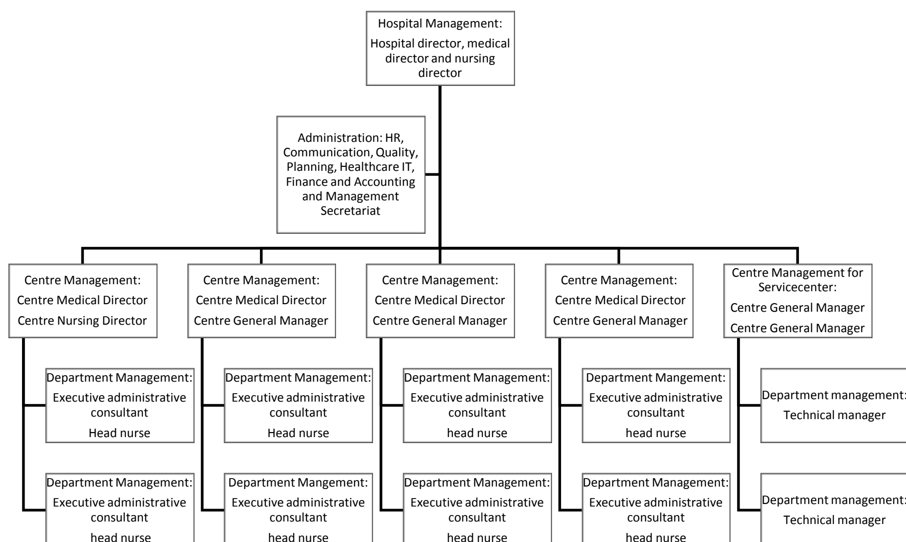
4.2.5.1 Internal contextual factors

In this section, I elaborate and explicitly reflect on the internal context of the case. However, I will argue that there are additional organizational layers of “internal contexts”, which I will reveal in this section.

As mentioned earlier, I have studied how medical professionals adapted and interpreted a changing hospital management model over time within a large department of medicine (Department of Cardiology, DC) at a public somatic Danish University Hospital, Aarhus University Hospital (AUH). AUH, which represents the wider internal context of the department, provides health services to a particular region in Denmark, the Central Denmark Region. AUH has about 10,000 employees (9,327 full-time positions) and 44 clinical departments divided into five clinical centres. The AUH has 1150 beds and in 2013 there were 820,051 out-patient visits (777,256 out-patient; 42,795 emergency), 102,269 discharges, 82,094 surgeries, 43,623 endoscopies and 4,647 births. AUH has an annual budget (2014) of more than US $1 billion (AUH, 2014). The selected department, the DC at AUH, has about 510 employees and about 40 consultants. In 2013, the DC had 42,508 out-patient visits and 13,474 discharges; it had 26,472 bed days with an average length of stay at 2.0 days (AUH – DC, 2014).

The management of AUH is organizationally structured with three overall levels of management. At hospital level, the AUH have an executive board structure with a hospital director who has an administrative background, a medical director and a director of nursing. They constitute the top management at AUH. The management model is a so-called Troika model (Bentsen, 1999), consisting of three different professionals, which makes the hospital management a multidisciplinary unit, with knowledge of both finance and medical care. The hospital management has the overall responsibility for the treatment and care of patients and the general operation of the hospital (AUH, 2014). The AUH has a centre level of management. The hospital is structured in five clinical centres and one service centre. Each centre has two directors of the centre and as a multidisciplinary team with an administrative general manager and a manager with a professional background, they constitute the centre management. The managers of the centres refer to the hospital management board, and together with the other centre managers they form the hospital’s strategic management. Finally, the AUH has a department level. The clinical departments are in general managed by a joint department management team, and generally an executive administrative consultant and a head nurse hold these positions. All the departments have a professor with a special responsibility for the clinical research associated to the joint department management team. AUH refers to the Central Denmark Region, which is a politically led organization with a Regional Council and a Board of Directors.

Figure 2 Aarhus University Hospital management organization



Besides the organizational formal management structure, AUH prescribes the formal management functions and responsibilities of consultants. I have chosen to include the description of the consultants' formal management responsibility at AUH since they historically have managed the front line and have had and still have a significant role and position in the daily management of AUH, including the department level. Initially the role of the consultant is defined as a management role: "The consultant position is a management position. Every consultant must in cooperation with the executive administrative consultant clarify his or her management space." (AUH, 2007:4).

The policy states that every consultant must have a formal job description containing functional descriptions of the management content related to his or her clinical, organizational and interdisciplinary responsibilities, and also the relationship of management with the consultant colleagues as well as the other functional managers (AUH, 2007). The consultant's responsibilities may include four partially overlapping categories: medical clinical management, organizational/strategic management, personnel management and research management. It is highlighted that the weighting of the individual management categories may be individually different. Situations can occur where consultants have management responsibility than other consultant colleague. In this situation it is defined that good collegiality implies that the consultant respect this management function (AUH, 2007). Furthermore it is stated that the consultant, in cooperation

with the executive administrative consultant/joint management team, must develop a competence development plan. It is also compulsory for the consultants to participate in leadership development courses offered by the AUH.

The four categories of management responsibilities are further specified. Medical clinical management responsibilities include visitation, diagnosis and treatment of patients; planning, control and monitoring; clinical management and supervision; and finally a focus on development of clinical quality. Organizational and strategic management responsibilities include the development and implementation of visions, values and strategies for optimizing the organization; development of external relations and the department's position externally; and the budget regarding the department's objectives, productivity and activities. The personnel management responsibilities include focus on the employees' development. Consultants should spot, attract and retain talent and they should ensure an attractive place of work and training. Research management responsibilities include that the consultant should add value through his or her own expertise and knowledge; ensure quality through new knowledge; engage in individual research; and engage in medical supervision (AUH, 2007). Furthermore, the consultant is obligated to prioritize time on the management responsibilities.

In summary, the hospital management model at AUH is formally described as a model where the management in general is shared between professionals at all levels in the organization. At hospital level the board consists of three directors, forming a Troika model (Bentsen, 1999). At centre level the management team consists of two professional managers with shared management responsibilities and at department level a joint department management team with shared general management responsibilities are the most common models. General administrative managers only join in at hospital level, and partly at centre level.

4.2.5.2 External contextual factors

In this section, I elaborate and explicitly reflect on the defined external context of the case. Drawing on a framework for comparison of European health systems elaborated by Kirkpatrick et al. (2012, 2013) I will highlight different institutional and contextual factors or independent key variables which might influence how the medical professionals adapt and interpret management in relation to the changing management model in the DC. It is not the purpose of this dissertation to test or verify whether the specific key variables influence the specific adaption and interpretation process of the changing management model, but rather to illuminate some contextual factors that might influence the dynamic process of organizational change, so I can be aware of different contextual factors in the process of analysing the phenomenon.

First I will highlight elements of the political governance of the Danish hospital sector. Then I will highlight elements of the organizational settlements with key professions in Denmark and finally I will highlight elements of the process of the public management reforms in a Danish context. I do not intend to use the framework to give a full description of these developments in the Danish context, but rather to highlight institutional factors that may be important for medical professionals in the process of adaption of hospital management models.

Political governance of the Danish hospital

The Danish government level has been particularly weak in the health field. In general the context of implementation of NPM reforms in the Danish hospital field has been characterized by a strong tradition of decentralization and professional autonomy. Compared with other countries (Jespersen, 2005, Kirkpatrick et al., 2009), Denmark has decentralized a large part of the public health care service under regional political and economic control, which means that the government initiated reforms depend on the local interpretations of the regions at hospital level. Hospital owners themselves have then translated reforms based on inspiration from governmental recommendations or committee reports (Jespersen, 2001, 2005). Secondly, the professionals have traditionally had a strong position in health policy (Jespersen, 2007). The degree of marketization of the hospital sector is limited, however, to matters such as implementation of agreed performance metrics as Diagnosis-Related Groups (DRGs).

Organizational settlements with key professions in Denmark

At the hospital field level, medical professionals have traditionally had a strong position in health policy, which means that the Danish hospital field is largely characterized by strong professional groups, who at field level seek to influence all reforms with their individual interests and viewpoints, and typically through trade unions and professional societies (Jespersen, 2005, 2007).

Using their position in the system of management at the organizational level and their professional autonomy at the executive levels, medical professionals in Denmark have sought opportunities to prevent or promote desired reforms (Bentsen et al., 1999, Jespersen, 2007). At organizational level the management of Danish hospitals has traditionally been dominated by doctors with a chairman of the consultant council as the dominant figure at the hospital level, followed by the administrative consultant at the department level. The nurses have traditionally not been a part of the hospital management beyond the nursing field (Jespersen, 2007). However, a national report from the Productivity Committee in 1984 proposed management changes and strengthening of the financial management through more accountable managements, where both professions were represented (Jespersen, 2007). There was, however, no clear recommendation from the committee. Through the late 1980s and early 1990s a fairly similar model was introduced in the counties, as a part of a process of formalizing responsibility of the professions (Jespersen,

2007). The model consisted of a Troika management model at hospital level, which included a medical director, a nursing director and a director with legal-economic responsibility. Together they were responsible for the hospital management, which meant that the Troika model formally broke with the professional line management which had previously been applicable (Jespersen, 2007). At department level in almost all Danish hospitals at the beginning of the 1990s, the joint department management model, consisting of an executive consultant and a head nurse, was established, with the principle of department budgets and decentralized responsibility for financial management (Jespersen, 2005). The head nurses obtained a unique position as equivalent to the executive consultants. A hospital commission in 1997 suggested, however, that a new principle of unitary management be introduced at all levels as a means to ensure quality and consistent patient care. This initiative led to a discussion in the field about management structures, but it also highlighted that the position of management responsibility should be unambiguous. The strategic draft by the government of hospital policy from 2000 to 2002, but also the economic agreement from 2000, stressed the necessity to work for a more unambiguous position of management responsibilities at all levels.

In a Danish context, the professional organizations have been very interested in management models at the national level. Before 1984, management positions were the exclusive preserve of doctors, and even today most actors in the field continue to view doctors as the natural managers, especially at department level. The Medical Association has over a period accepted models where the doctors collaborated with nurses and administrators trained in hospital management, but the hospital commission's proposal of unambiguous management in 1997 opened a new arena for doctors. The Medical Association argued in that period that the unambiguous managers at hospital level could only be doctors. The outcome of this discussion about unambiguous management has not been clarified since then, however.

Through a consensus based tradition, the dominant professional groups have dominated the diffusion of NPM elements in the hospital field (Jespersen, 2005, 2007). This means that professional associations and doctors within individual Danish hospitals have enjoyed considerable scope to shape the ways in which management initiatives have been implemented on the ground (Jespersen et al., 2002: 653). In this sense, the scientific medical knowledge elite has been practising a large degree of occupational closure which has been especially important in the development of hospital structures and quality management (Zeuthen Bentsen, 2000, Sognstrup, 2003, Borum, 2004 in Kirkpatrick et al. 2009).

The process of the New Public Management in Denmark

In the literature, there has been a growing recognition of the fact that distinctive institutional background, structure, reform tradition and starting point for the reform

process has influenced the way NPM reforms have evolved in each country (Pollit and Bouckaert, 2004). Countries around the world have each followed their own distinct way to introduce NPM. In addition, each country has had a mix of strategies to preserve the public sector structure, modernize and minimize the public sector, and implement market mechanisms in the public sector (Pollit and Bouckaert, 2004, Greve, 2007).

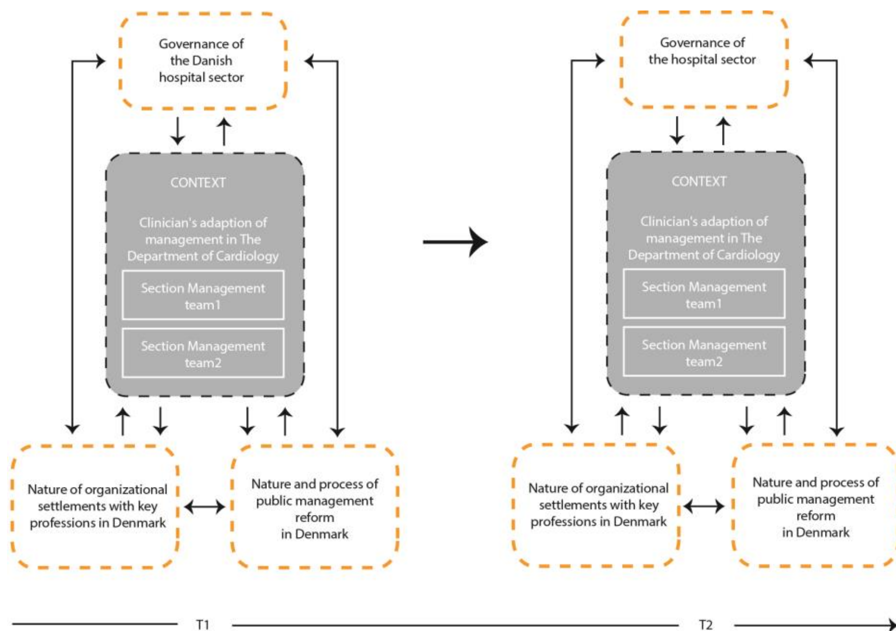
Denmark began modernizing the public sector some time before the NPM trend became recognized in the Danish context (Greve, 2007). The modernization process of the public sector began back in 1983 and successive national governments have each had their own versions of the modernization programme (Ejersbo and Greve, 2005). Nonetheless, there are no comprehensive studies of the influence of NPM in Denmark (Greve, 2007). However, elements of NPM are practised in all branches of the Danish public sector and seem integrated in the way of managing and leading public organizations today. It is argued that Denmark is an example of a country where NPM reforms primarily have provided new organizational and managerial forms and where the market orientation has had a minor impact (Greve, 2007), which has created new challenges for the way to engage in public management (Greve, 2007). In other words, the Danish public sector has been impacted by the NPM trend and today the NPM trend seems to be institutionalized in the operation and functioning of the Danish public sector and administration. According to Greve (2007), it is in the health care sector that NPM elements might have been most powerful.

Jespersen (2007) found that there was no comprehensive analysis of the diffusion of NPM reforms in the Danish hospital field. This is despite the fact that most elements of the NPM strategy have been tried more or less wholeheartedly in Denmark (Vrangbæk, 1999). The reforms have not been implemented authoritatively by any law or order, but have relied more on decentralized negotiated policy making, in contrast to other countries where top-down implementation strategies have been imposed by central authorities (Vrangbæk and Christiansen, 2005, Kirkpatrick et al., 2009, Neogy and Kirkpatrick, 2009, Magnussen, Vrangbæk and Saltman, 2009). The general implementation model in Denmark has been a model where hospital owners themselves have translated reforms based on inspiration from governmental recommendations or committee reports (Jespersen, 2001). Changes in management models, with a stronger focus on performance management, rewards and control of individuals, were introduced as part of the Danish modernization programmes. After a period of 15 to 20 years of NPM inspired organizational and management reforms in the Danish hospital field, Jespersen (2007) observed that the Danish variant is characterized by predominantly focusing on acquiring and developing organizational and managerial forms from the private sector, and the use of market-like governance has been limited.

In summary, the implementation of NPM reforms in the Danish hospital field can be characterized by the strong tradition of local implementation and professional autonomy.

The figure below is an illustration of the longitudinal embedded single case study with the external contextual factors added. The figure is inspired by “Basic types of design for case studies” by Yin (2003:40) and “A framework for comparison of the hospital sector” by Kirkpatrick et al. (2012).

Figure 3 The longitudinal embedded single case study



4.2.6. CONDUCTING THE STUDY

My engagement with the DC began in spring 2010 and it finished in winter 2014. The department management team of the DC had initiated a formal re-organization process of its management organization, comprising decentralization of management responsibilities, due to different kinds of internal and external challenges. In this process of organizational management changes in the DC, the department management team requested a researcher to take a scientific approach to this process of transformation in their management model, in order to understand the various managerial and organizational challenges. This meant that the

department management team of the DC was very open minded in sharing their knowledge, and the challenges they faced as an organization, their objectives for the future and how the department management intended to overcome these managerial challenges through a re-organization/structuration.

Studying the process of organizational management changes over time was not a straightforward process for an outsider like me (Maaløe, 2002), however, through my requested presence but also partial financial recruitment in the DC as a PhD student, I gained formal access to empirical knowledge about their re-organization.

The department management team was my legitimate gatekeeper into the organization and valuable agents, as they were open minded to share information and invited me to attend relevant management meetings; however, the door into the DC was half closed/half open in practice. In general the size of the DC was a challenge to my access, since information about my project did not get into all the corners of the organization. I solved this by sending descriptive emails around to the appointed functional managers, who then helped me further into the organization. Another challenge was that, on the one side, the DC appeared open through my legitimate presence as a PhD student requested by the department management team. On the other side, it had a somewhat negative effect on me in that there apparently was a general unwilling attitude directed against the department management team, or perhaps “management”, based on the organizational management difficulties. Since I was “the idea” of the department management team, and thereby apparently represented the management team and their agenda at first, I assume that made it even harder for me to get “into” the organization (Maaløe, 2002). First of all, I had a challenge in making myself and my research purpose visible in the DC, in order to gain access to the right information and informants at the lower levels in the DC. In this context it was a challenge to understand the overall managerial challenges and thereby to locate by myself the right informants because, even though the DC had employed me, it was not simply given which informants and what kind of information would be relevant to this research project. However, on the positive side, this meant that I avoided a sort of selective bias, since the department management team did not interfere in the research focus or selection of informants.

When I describe the access to the informants as partially open in the beginning (2010), it was because initially I was collecting data at the department management’s request and not on the managerial frontline (medical consultants) or the employees’ request, which meant that I had to earn their trust. Furthermore, I will argue that the topic of the research was a sensitive one (difficult management issues), and that the employees at the lower levels had a tendency to portray the department as strong and seamless in action. However, through introductory informal meetings with the department management team, I sought to understand the key challenges the department had organizationally and managerially from their

point of view, in order to locate the most relevant informants. Also through my partially observational presence at different strategic management meetings and management workshops, through historical documents about strategic management meetings in the DC, but also through e-mail correspondence with located key informants, I improved the opportunity for more in-depth empirical access to relevant data.

As over time I managed to talk informally with individual informants who participated in the various management arrangements, but also later through the first collection (2010) of interviews with professionals involved in management, their confidence in me as an external/outside person increased and their reservations diminished. I felt that over time I came to be considered as truly a PhD student of the DC, who "naturally" had to be helped in the collection of empirical data (which presumably reflected the culture of nurturing the younger PhD students/colleagues in the DC, where research is highly esteemed), and thus I met with a benevolent attitude from the informants. They became more open minded and they quietly accepted my presence and responded willingly to my questions. My assumption is also that the organization matured in terms of understanding their own management issues, which made it easier for them to feed me as a researcher, who was interested in their managerial issues. After three years with an on-and-off presence in the DC I conducted the last but largest set of interviews (spring 2013), and at this point in time I felt a wide open door to the professionals' knowledge, including their time but also willingness to share their true thoughts and assessments about the management re-organization and organizational managerial dilemma, which definitely had a positive impact on the quality and validity of the data. It has been clear to me that getting access to the DC has not been a coherent process. I have had to prepare access and to collect data in a continuous process, not in separate stages, as I have gained insight into the DC and its relationships. This has required me to revise and adjust my starting point.

It was obvious that I would encounter problems, as "many organizations are reluctant to be studied, probably because many are uncertain of the examiner's intentions" (Maaløe, 2002:185). Additionally, staff may fear being needlessly robbed of time by "releasing a stranger" in the organization who wants to talk to everyone (Maaløe, 2002:185) However, as a result of my presence in the organization on-and-off over several years, it became clear to the informants that my work might have relevance for them and the passage of time has also consistently worked to my advantage in order to create confidence in me (Maaløe, 2002).

It should also be noted that conducting interviews in the DC was sometimes conditional on anonymity. Furthermore, a few relevant informants refused to participate in interviews because they found the topic too problematic or sensitive. Limited time because of the workload also created difficulties in relation to the

collection of data as the DC was not always able to provide the time needed for an interview among the frontline staff, however, this was not a big problem considering the important life-saving work they perform.

Throughout the period of data collection, I have been aware of having to act as an outside researcher, not influencing the process I was investigating. But it has been a difficult balancing act since, on the one hand, I should interact with the informants in the field to instill confidence, confidentiality, closeness and openness, in order to get insight into and information about sensitive management issues and sensitive personal issues (to understand the organizational members). On the other hand, I should keep a certain distance, not overly influencing or disturbing the informants' perception of reality with my "academic" statements about my own work (Maaløe, 2002). Nor should I encourage friendships, since I should act soberly with any informant and maintain a degree of scepticism in the different situations in order to keep a critical distance as a researcher (Maaløe, 2002).

Before I entered the field, I had a clear purpose of not assisting the DC in its re-organization process, by providing managerial tools, models, or principles, since I could not be too involved in this process since the goal was to collect valid data. However, I could not act totally as a "fly on the wall", for instance, in my observation studies at the management meetings, since I interacted with the informants and also a couple of times I was asked by the department management team to revise the managerial history of the DC for the managers involved in the process in plenum. However, even though such an act is a concrete interference in the actual management process; I would argue that the overall data collection benefited from these acts. The informants became aware of my presence and purpose, and they confirmed or disproved in plenum my perceptions of the changes in their management model.

The above reflections reflect that I have been acting in the spectrum between being an observant observer and being partially involved in the process of change in the management model in DC (Maaløe, 2002:147f).

The advantage of being an outside researcher was that it was possible to get organizational members to share their insights since I did not have any personal stake in the outcome, and moreover I did not became too involved in the DC as an outside researcher. It should be noted that being an outside researcher does not mean that I had the character of being an objective researcher. In the next section about the data collection methods I explain how I tried to overcome this challenge.

4.3. DATA COLLECTION METHODS

In this section I present the data collection methods. Case studies are built on different data collection sources, including interviews, observations and written material (Maaløe, 2002; Yin, 2003). The rationale for using multiple sources of evidence is that it increases the construct validity (Yin, 2003:97). With data triangulation the potential problems of construct validity for establishing correct operational measures for the concept being studied can be addressed since multiple sources of evidence essentially provide multiple measures of the same phenomenon (Yin, 2003:99). A finding or conclusion in any case study is likely to be much more convincing and accurate if it is based on several different sources of information (Yin, 2003). In this section I will describe the data sources and methods used in this study.

4.3.1. INTERVIEWS

The primary data source in this study was research interviews. Kvåle and Brinkmann (2007:19) defines the research interview as: "An interview, which aims to obtain descriptions of the interviewee's life-world in order to interpret the meaning of the phenomena described." Maaløe (2002) defines a research interview similarly as:

> It is a conscious quest to make the other to (a) associate personality, the person's background, experience, insight and understanding of the roles he/she plays, with (b) the social worlds he/she is a part of. The interviewer must thus lead to sense the world of the interviewee conditions. (180)

The interview method is useful when an in-depth understanding of a phenomenon is the intention (Brinkmann and Tangaard, 2010). The central characteristic of a research interview is that it is a dialogue with clarification as the goal (Maaløe, 2002). In other words, it is a form of conversation which has a structure and a purpose, at the expense of everyday conversation and spontaneous exchange of views. Furthermore, it is not a conversation between equals, since the researcher defines and controls the situation; including introducing the interview subject and critically pursuing it (Kvåle and Brinkmann, 2007). Both Maaløe (2002) and Kvåle and Brinkmann (2007) argue that a research interview can be characterized as a conversation in which the researcher seeks to help the interviewee to lead the researcher to a greater understanding. In spite of this, it is the interviewee who is the centre of the interview and the interview should be on the informant's premises. In the next section I will explain how I used the interview method in the study.

In this study I primarily conducted interviews with relevant informants in the DC in August 2010 and then again in March 2013. In this study I conducted a total of 31

interviews with 43 informants. I used a semi-structured interview form each time. The strength of semi-structured interviewing is that it results in systematic data that are comparable (Kvåle and Brinkmann, 2007). During the semi-structured interviews I kept notes and audio-recorded each interview.

Because the specific changes in the DC were about a re-organization of the management structure, in 2010 I interviewed the professionals directly involved, including the department management team, involved doctors and nurses in the newly-established management teams below the department management team level, but also indirectly involved professionals such as ordinary doctors and nurses, in order to gain insight into the department's managerial history, institutionalized existing management patterns, empirical issues, possible theoretical issues, challenges and benefits. Specifically, I interviewed the department management team which consisted of the executive consultant and the head nurse, three functional partnerships (management teams) each consisting of a consultant and a nurse, at a lower level of the department management team. I also conducted two group interviews with three doctors in each group who were not involved in management of the DC as such (though they had their consultant responsibilities), and one group with three nurses without management responsibilities. In all, 17 professionals were interviewed in 2010, including four doctors with management responsibilities, four nurses with management responsibilities, six doctors without management responsibilities and three nurses without management responsibilities.

In 2013 I again interviewed the professionals directly involved, including the department management team, doctors and nurses involved in the management teams below the department management team level, but also the indirectly involved such as ordinary doctors and nurses, in order to gain insight into how the process of change in the management model had occurred, including how the doctors had adapted a new managerial form. It should be noted that it was essentially the same informants I interviewed in the second phase of data colleting. Specifically, I interviewed the department management team which consisted of the executive consultant and the head nurse, four section management teams at a lower level of the department management team, including four doctors and six nurses who were associated with each section. Furthermore, I interviewed five doctors without management responsibilities and six nurses without management responsibilities. The professionals without delegated management responsibilities represented all the different sections. In all, 23 professionals were interviewed in 2013.

Furthermore, in 2012 and 2013 I conducted three interviews outside the DC. An interviewed a general manager representing the centre management team of the Heart Centre at AUH, but also I conducted an interview with the medical director at AUH, as a representative of the hospital management team. The aim of the two interviews was to broaden my understanding of the organizational management

context in relation to the managerial re-organization in the specific department. My intention was to get an overview of how AUH is organized overall in terms of management, including how centres and departments generally organize themselves, which also included a focus on the managerial history of AUH. Furthermore I conducted an interview with a Human Resources Manager for Organization at the regional level in 2013 before the final round of interviews in the DC. The aim of the interview was to obtain an indication of how widespread and formalized the section management level was in hospitals in the region but also how formalized the consultants' managerial role was in department management models.

When I began my study in 2010, I used relatively loosely semi-structured interviews with the purpose of obtaining as much background information as possible. The aim was to preserve as much openness as possible by allowing the professionals to express their own views and not to exclude interesting and important elements beforehand. However, the interviews were loosely structured around an interview guide with themes and questions about, for example, the DC's historical management organization, challenges and benefits, but also expectations of the future management organization with the newly-established formal middle level of management. In 2012 and 2013 I again used semi-structured interviews in relation to the three interviews outside the DC. The interviews were loosely structured around the topics of the management history of AUH, its management organization in general and doctors' formal involvement in management in general.

As I gained more insight into the organization over time, I revised the interview guides so that the interviews I conducted in 2013 became more theory-driven and more detailed than in 2010. With point of departure in themes and questions, but also analytical results from the first round of interviews from 2010 and 2012, and in the operationalized indicators elaborated from the theoretical framework, I structured the interviews using a semi-structured interview guide. The revision of the interview guide allows drawing pictures of the whole as it looks (Maaløe, 2002).

The semi-structured interviews I conducted in 2010, 2012 and 2013 were, as mentioned, conducted with an interview guide, which ensured that all relevant topics were covered, yielding comparable and systematic data. How these topics are identified is explained in the data analysis section. Moreover, the semi-structured interview makes it possible for the researcher to ask questions that arise spontaneously during the interview. As a result, I was able to pursue interesting aspects during the interview that I had not considered as important during the preparation and the questions (Kvåle and Brinkmann, 2007).

Before each interview, I sent an e-mail to each informant. In this e-mail I presented myself and what my purpose was in the DC. Then I presented the overall focus for

the interview but also the overall interview themes regarding the re-organization of the management model in the DC. This strategy helped me to sharpen the interviewee's awareness of the key themes I wanted insight into, but also to create confidence around the purpose and topics, thus minimizing some of the uncertainty that may arise in the meeting between the interviewer and informant regarding what the interview will cover.

After finishing the interviews in 2010, 2012 and 2013, I transcribed the interview recordings. Thereafter I e-mailed each transcription out to the respective informants, so they had the opportunity to point out if there were passages they did not want to be quoted and also to correct any errors.

4.3.2. OBSERVATIONS

In this study I have used the observation method as complementary to the qualitative research method of interviews.

As defined by Maaløe (2002:158), "participant observation within the framework of an organization must seek to identify" who does what for/against/with whom, when and how "and under what conditions". I use this definition regarding what an observer should seek to identify when conducting observations, but I did not include my own work experiences as a part of the data, which meant that I was not a "participating" observer. Maaløe (2002) highlights that case studies in organizations are similar to studies of families. The individual informants mean something to each other, both functionally and personally, which I was aware of in the collection of observations. Based on this definition of the observation method, I will present the observations I have made in this study.

During my study of how medical professionals adapt and interpret management in relation to changing hospital management models over time in the DC, I was invited by the department management team to observe some of their strategic management meetings and workshops with the doctors and nurses who were involved in the management process. The department management team had, in the spring of 2012, engaged an external advisory consultant company to help them facilitate the process of re-organizing the management model in the department, including developing a more formal management layer under the department level. Out of this collaboration arose several management workshops[10] each with a duration of a few days, where the overall focus was the re-organization of the department in terms of management.

[10] The workshops were all held at hotels outside the Department of Cardiology in order to gather the participants and avoid the distractions and interruptions of their daily work.

I attended three of these strategic workshops, but also one preliminary strategy meeting with largely the same group of participants and the intention of observing these strategic workshops/meeting was to gain insight into what organizational managerial issues were verbally articulated by the participants. What else seemed to drive this verbal conversation was that the doctors and nurses involved all were put together physically in the same room, which meant that they were able to look each other in the eye as managing partners, also across the various teams. These meetings spawned various discussions about each team's managerial space and responsibility within the teams, but also management opportunities across the teams, as management level in the whole department. These discussions took place both internally and in plenary at the meetings. These observations could help me to understand the broader picture of the DC legitimate managerial organization, but also the extent to which doctors interpret their role and involvement in management, as well as where, when and how they were involved in management organization in the DC. In other words, the boundaries and tensions for the doctors' management involvement were highlighted through the verbal discussion and debates about how to re-organize the DC. As a result different kinds of empirical issues and challenges were expressed through these meetings, especially what the managers found important and problematic. Through this kind of direct dialogue the interpretation of management issues is visualized, which they not are in the day to day work at the DC, because the managers not naturally meet and therefore not necessarily confront each other with their managerial dilemmas as such. These workshops provided an opportunity to gain insight into issues which came to a head. This was very valuable in order to validate the information I collected through the interviews about the medical professionals' adaption of management in the management re-organization.

I loosely structured the observations using a guide with various key topics similar to the management topics in the interview guides. The observation guide was used as a kind of frame or reminder to me of what was relevant to note or dwell upon if it was discussed or emerged from the dialogues, since the observations sometimes reflected quick conversations and chaotic discussions. It was not the intention to use the observation guide as a sort of checklist where the purpose was to collect material stringently about every topic.

During the observation studies I kept notes, however I did not audio- or video-record the observations, since I sensed the content of the discussions at the meetings could be rather confidential and the topics discussed sensitive, which I did not want to influence unnecessarily, for example, by preventing the atmosphere from remaining open and free.

4.3.3. DOCUMENTARY MATERIAL

Based on the concept of functional sources (Bøgh Andersen et al., 2012: 122), the documents included in this dissertation provided relevant information to answer the specific research question. The documentary material was selected as a function of the research question being studied.

I did not have access to extensive documentation of the process of the changing management model in the DC, since what was drawn up in writing through the process of management changes was limited. Internally, in the DC I had access to management strategies for the DC in different editions, the annual journal of the DC from 2007–2008, agendas from different workshops and strategy meetings, and a few written general functional descriptions of the doctors' responsibilities. The external advisory consultant company also provided the involved professional managers with PowerPoint presentations from the presentations at the different strategic management workshops, which in practice also had a function as minutes from the workshops. Externally, I had access to different kinds of formal documents about management at Central Denmark Region, AUH and the consultants' management responsibilities.[11] The limited documentation reflects that the process of changing the management model was primarily documented through agendas and minutes held at strategic management meetings and workshops.

These documents were used as background information, supplementing the interpretation of the statements of the various members of the DC. The written material allowed me to build up a general understanding of the department's formal organizational structure including formal descriptions of management responsibilities and structures. The written material was also useful to gain an overview of the formal strategic process the doctors has been involved in when changing the management model in the DC. The agendas, PowerPoint presentations and minutes from the workshop also informed me about the different kinds of organizational and management dilemmas and key issues that affected the daily work of the professionals, which also provided me with useful information about the internal and external pressures experienced within the DC.

[11] Websites at AUH provided the access.

4.3.4. OVERVIEW OF DATA SOURCES

The table below presents the material collected in the period from 2010 to 2014.

Table 2 The material collected in the period from 2010 to 2014

Timeline	**August and September 2010**	**April 2011**	**April 2012**	**June 2012**	**August 2012**	**November 2012**	**March 2013**	**December 2014**
Hierarchical organizational levels of data-collection		Merger of two Cardiology Departments						
Hospital management level					1 semi-structured interview with the Medical Director at AUH			
Administration level (Support staff)							1 Interview Semi-structured interview with a HR-manager	
Centre management level					1 semi-structured interview with the centre management at AUH (a general manager)			
Department management level	1 semi-structured group interview with the executive consultant and the head nurse		Observation: A strategic management meeting with the representatives of the department management team and the 8 functional management teams	Observation: A workshop with the representatives of the department management team and the 4 sections management teams		Observation: A workshop with the representatives of the department management team and the 4 sections management teams	2 semi-structured interviews: 1 with the executive consultant and 1 with the head nurse	Observation: A workshop with the representatives of the department management team and the 4 sections management teams
Section management level	3 semi-structured group interviews with section management teams (a consultant and a nurse)						10 semi-structured interviews with section management teams (4 consultants and 6 nurses)	
Doctors without management responsibilities at an overall department level, however with traditional consultant management responsibilities	2 semi-structured group interviews (2 x 3 doctors)						6 semi-structured interviews with doctors from different sections	
Nurses without management responsibilities	1 semi-structured group interview (3 nurses)						5 semi-structured interviews with nurses from different sections	

The tables below presents the data sources in the period from 2010 to 2014.

Table 3 Group interviews

Group interviews			
Date	**Data Source**	**Description**	**Duration**
July 5, 2010	Interview	Unstructured interview with the department management team	2 hours long
August 23, 2010	Interview	Semi-structured interview with a section management team	1 hour long
August 23, 2010	Interview	Semi-structured group interview with three doctors	1 hour long
August 23, 2010	Interview	Semi-structured group interview with a section management team	1 hour long
August 24, 2010	Interview	Semi-structured group interview with the department management team	2 hours long
August 24, 2010	Interview	Semi-structured group interview with a section management team	1 hour long
September 1, 2010	Interview	Semi-structured group interview with three ordinary nurses	1 hour long
September 7, 2010	Interview	Semi-structured group with the three doctors	1 hour long
March 30, 2012	Interview	Unstructured interview with the department management team	2 hours long
September 10, 2013	Interview	Unstructured interview with the department management team	2 hours long
September 30, 2013	Interview	Unstructured interview with the department management team	2 hours long

Table 4 Observations

Observations			
Date	**Data Source**	**Description**	**Duration**
April 18, 2012	Observation	Observation of a meeting with representatives of the department management team and 8 functional partner teams	2 hours long
June 22, 2012	Observation	Observation of a workshop with representatives of the department management team and 8 functional partner teams	10 hours long
November 1, 2012	Observation	Observation of a workshop with representatives of the department management team and 4 section management teams	10 hours long
December 2, 2014	Observation	Observations of a meeting with representatives of the department management team and 4 section management teams	7 hours long

Table 5 Individual interviews

Individual Interviews			
Date	**Data source**	**Description**	**Duration**
August 17, 2012	Interview	Semi-structured interviews with the Medical Director of AUH	1 hour long
August 17, 2012	Interview	Semi-structured interview with the centre management of the Heart Centre	1 hour long
March 4, 2013	Interview	Semi-structured interview with a doctor	1 hour long
March 4, 2013	Interview	Semi-structured interview with a section manager (nurse)	1 hours long
March 4, 2013	Interview	Semi-structured interview with a section manager (nurse)	1 hour long
March 4, 2013	Interview	Semi-structured interview with a nurse	1 hour long
March 4, 2013	Interview	Semi-structured interview with a doctor	1 hour long
March 5, 2013	Interview	Semi-structured interview with the head nurse of the	1 hour long

		department	
March 5, 2013	Interview	Semi-structured interview with the executive consultant of the department	1 hour long
March 5, 2013	Interview	Semi-structured interview with a section manager (nurse)	1 hour long
March 5, 2013	Interview	Semi-structured interview with a section manager (nurse)	1 hour long
March 5, 2013	Interview	Semi-structured interview with a doctor	1 hours long
March 6, 2013	Interview	Semi-structured interview with a section manager (nurse)	I hour long
March 6, 2013	Interview	Semi-structured interview with a section manager (doctor)	I hour long
March 6, 2013	Interview	Semi-structured interview with a nurse	1 hour long
March 6, 2013	Interview	Semi-structured interview with a nurse	1 hour long
March 7, 2013	Interview	Semi-structured interview with a section manager (doctor)	I hour long
March 7, 2013	Interview	Semi-structured interview with a doctor	1 hour long
March 11, 2013	Interview	Semi-structured with a doctor	1 hour long
March 12, 2013	Interview	Semi-structured interview with a section manager (nurse)	1 hour long
March 12, 2013	Interview	Semi-structured interview with a section manager (doctor)	1 hour long
March 13, 2013	Interview	Semi-structured interview with a nurse	1 hour long
March 14, 2013	Interview	Semi-structured interview with a doctor	1 hour long
March 14, 2013	Interview	Semi-structured interview with a nurse	1 hour long

4.4. DATA ANALYSIS STRATEGY

In this section the strategy for data analysis is presented. First, I present the strategy for analysis of content. Then I present how I elaborated and constructed codes through an operationalization of the key-concepts, which is based on the theoretical framework.

4.4.1. CONTENT ANALYSIS

In the process of analysis "one divides a phenomenon into its smaller components and studies the components' relationships and functions" (Jacobsen, in Bøgh Andersen, 2012: 172). One approach and technique to perform analysis of qualitative material is coding the content of interviews, observations, documentary material etc.; in other words, "coding is analysis" (Miles and Huberman, 1994:56). Applying a "coding scheme" to the empirical data is called content analysis (Miles and Huberman, 1994). Coding of content is where "texts"[12], such as transcribed interviews, are analysed by attaching labels that represent text content to specific pieces of text (Jacobsen in Bøgh Andersen et al., 2012). According to Miles and Huberman (1994:258), it is an advantage to use content analysis when studying processes that occur over periods of time, because one can assess the process in social groups, as in this case, the process of management adaption in the medical group. Using the content analysis strategy I will be able to examine my data collected during the period from 2010 to 2014. How I interpret the different texts depends on the theoretical framework constructed (Miles and Huberman, 1994), which I will explain below.

With point of departure in the research questions elaborated above, which are based on the concepts from the elaborated theoretical framework, my data analysis strategy is primarily based on a deductive analytic approach. This means that my data analysis strategy is based on the theoretical key concepts and assumptions from the theoretical framework and the main purpose is to explore these established key concepts and their limitations and thereby refine these conceptualizations. However, in the first part of the analysis, the focus is on elements such as the motivation and intention for and the historical background of the re-organization of the hospital management organization within the hospital department. This means that the key concepts and their relations have been less followed in advance and that the approach and the coding of the empirical material has been more open when analysing the empirical data from 2010 in order to gain new insights and empirical knowledge so as to understand and define my case, structure and identify patterns in the empirical material. Regarding the empirical material from 2013 the strategy has been more closed coding based on the key concepts, but has also included the abstracted codes which have been analysed and constructed when analysing the data from 2010 (Jacobsen in Bøgh Andersen, 2012). In the section below I will explain how I have coded the data material.

[12] Based on the interpretative approach, social action and human activity is treated as text. E.g. human actions can be interpreted as symbols expressing layers of meaning. Interviews and observational data can be transcribed into written text for analysis (Miles and Huberman, 1994:239).

4.4.2. CODING OF DATA MATERIAL

In this section I present how I have elaborated and constructed the codes.

Content analysis is defined as "any technique for making inferences by systematically and objectively identifying special characteristics of messages" (Holsti, 1968:608, cited in Miles and Huberman, 1994:240). It should be noted that the "objective identification" in this dissertation is understood as my construction of both the coding scheme and my analytical assessment of the text and how it can be labelled or not with the constructed code.

The analysis of the texts is accomplished by means of explicit "rules" called "criteria of selection" (Miles and Huberman, 1994). These criteria must be established before the actual analysis of the data. Based on the theoretical framework and thereby a more deductive reasoning, I elaborated these "criteria of selection" which means that I defined key concepts[13] based on the theoretical framework and operationalized empirical indicators of these key concepts. These indicators should be clear, understandable and reliably defined so other researchers will be thinking about the same phenomena as they code (Miles and Huberman, 1994:65). Each category of indicators I labelled with different codes. Miles and Huberman (1994:56) have defined codes as "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study". Using codes I can quickly organize chunks of texts, so I can easily find the segments relating to a particular research question, construct or theme I have elaborated (Miles and Huberman, 1994). This means that I can empower and speed up the analysis (Miles and Huberman, 1994:65). It is the intention that the key concepts of interest or "categories" that emerged will reflect all relevant aspects of the research interest as far as possible. This strategy represents a closed coding strategy, which just implies that I code the text on pre-defined codes based on the theoretical framework, problem areas and the research questions. However, with a deductive and more closed coding approach I will still be aware of whether the text includes meaningful dimensions, themes[14] or contextual factors which could be beyond the key concepts elaborated from the theoretical framework, which means that I analytically also subscribe to a more inductive and open coding approach during the coding process, accepting new emerging themes and codes in order to provide fruitful findings. Through the coding of content it becomes possible to connect, compare and classify the pieces of text in relation to each other. The

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[13] As defined by Miles and Huberman (1994): "Concepts involve words grouped together into conceptual clusters (ideas) that constitute, in some instances, variables in a typical research hypothesis".

[14] As defined by Miles and Huberman (1994): "A theme is a simple sentence, a string of words with a subject and a predicate."

intention of using this type of analysis strategy is to provide a means for identifying and organizing the data.

For coding the empirical material I have used the electronic qualitative data analysis software NVivo. The aim of using NVivo has been to draw on a program that could facilitate the work of systematizing the empirical material in various interesting categories I have operationalized based on the theoretical concepts of archetypes and intra-organizational dynamics (Binderkrantz and Andersen, 2011).

Concretely, I transcribed the 31 interviews, and then I uploaded them in the software program. Thereafter I constructed maps of sources with group interviews and individual interviews. Then I constructed different nodes[15] (containers for coding of categories) based on the theoretical concepts of structure, system, interpretive scheme, interest, value commitment, power dependencies, and capacity for action. I also created nodes based on the different groups of professionals (doctors and nurses) involved in the management change process, and on the different management teams and management levels (e.g., the joint management team, the functional partnerships, the section management teams). This construction made me able to systematize, organize and identify the different management groups and the professionals' expressions and perceptions of the different theoretical concepts. However, I also had to be aware of contextual factors and themes during the coding process other than the developed theoretical based nodes. Overall, I found NVivo very useful in the process of coding the large amount of empirical data I had generated over time in order to identify the complex patterns of management change.

The tables below presents the selected theoretical concepts, the theoretical definitions and the elaborated empirical indicators I have operationalized on the basis of the theoretical framework, but also some examples of illustrative quotations.

Table 6 Interest

Theoretical concept	Theoretical definition	Empirical indicators	Example
Interest	"A matter of activity that is of special concern to	Descriptions or behaviour that expresses how clinicians and nurses translate their interests	"We grow a lot; we're a huge department, so it's happened over many years. For all the time I've been here, we have grown and grown and grown

[15] A node is a collection of references about a specific theme, place, person or other area of interest.

	one group"	into favourable management structures. Descriptions or expressions of different interest in management positions and structures based on different sub-specialties. Descriptions or expressions of how the professionals embedded in the hospital management organization recognize the prevailing management template. Is it a disadvantage or not? And are they also aware of an alternative management template?	and grown. And the recognition that we are no longer able to make all the decisions as a collective might have been slow, but we have to accept that some have to be delegated, and I think it's a natural consequence, that's the way it has to be." (FP, Consultant F, 2010).

Table 7Value-Commitment

Theoretical concept	Theoretical definition	Empirical indicators	Example
Value-Commitment	Values: "A conception of the desirable" (Value-) Commitment: "Supports or reflects that the prevailing institutionalized template in-use is	Descriptions or behaviour from clinicians or nurses that support or reflect that the norms and principle of the prevailing management template in-use is desirable to both the medical professionals and the nurses.	"An additional management layer in a hierarchic structure… By this I mean if you go through with it as intended, that you have to have powerful FPs who have to have a strong hold on their consultant colleagues which they are FPs for, and that would be an extremely demotivating factor in a system which we perceive as a prima donna management system. Where people have to

	desirable Supports or reflects indifferent commitment to the template in-use. Supports or reflects loyalty to different kind of template in-use. Supports or reflects loyalty to an articulated alternative template.”	Descriptions or behaviour that support or reflect indifferent (desirable-) commitment to the norms and principles of the management template in-use form the medical professionals and the nurses. Descriptions or behaviour that support or reflect loyalty and desirability to different kinds of management template in-use from the professional groups. Descriptions or behaviour that support or reflect loyalty to norms and principles of an articulated alternative management template in the hospital department by all the professional groups	be innovative and be just a little bit anarchistic and not just stand in a single file, because if they stand in single file they stop working longer and being innovative and researching and being motivated.” (Consultant J, 2010).

Table 8 Power-dependencies

Theoretical concept	Theoretical definition	Empirical indicators	Example
Power-dependencies	"Some groups and individuals are listened to more keenly than others. Some have more potential or less potential for enabling or resisting change."	Descriptions or expressions of professions or professionals which have an authority position and legitimated power in the department to define which group or professional there should be listened to more keenly and has the power to decide what kind of management activities or behaviour there should be performed.	"Some accept it, I think, and others will say, that it is only the executive administrative consultant who can manage them. You can't have a colleague who manages you. So there are those, who will confess to it and accept it and also say, that it is good, that we undertake it. The others are free to do the clinical work, they haven't any interest in it and trust in us and stuff like that. But there are also some who have a sort of a reactionary, conservative, old-school attitude towards it, and it shouldn't be like that, we are all managers when you are a consultant." (SM, Consultant E, 2013).

Table 9 Capacity for action

Theoretical concept	Theoretical definition	Empirical indicators	Example
Capacity for action	"…the ability to manage the transition process from one template to another"	Descriptions or expressions of how medical professionals and nurses with management responsibility possess the availability to	"You have to consider that the ones who have become functional partners aren't those, who on the highest levels are drawing the sub-specialty. They are the administrative managers, people who you have

	"…having the skills and competencies required to function in that new destination, and its having the ability to manage how to get to that destination"	embrace three sets of leadership activities within the hospital department: charismatic activities, instrumental activities and institutional activities.	been able to force into doing it, or who might have wanted to. However, there are still some old geezers, who think they should have a major influence on the professional evolution in their area of expertise, making the other one a lackey, who is sent out to make a sub-specialty thrive."(Consultant J, 2010).

Table 10 Structure

Theoretical concept	Theoretical definition	Empirical indicators	Examples
Structure	"…the differentiation of tasks and positions, the formulation of rules and procedures, and the prescriptions of authority."	Descriptions of how professionals perceive how the authority is shared in the department. For example: Do the authority structures fall into a combination of a traditional professional collegium and an administrative hierarchy? Do the authority structures reflect a centralized authority structure? Do the professionals	"... we talked about who should be doing what and then we agreed in the group of consultants that it was [X], who should possess the authority to manage the administrative issues and responsibilities." (Consultant J, 2010). "It was the administrative consultant who was in charge of the head nurse, and it was a very consultant-dominated leadership." (Executive Administrative Consultant, 2010).

		perceive themselves as colleagues as equals or is the authority structure inherent in seniority and expertise positions forming a "clan-authority structure"? In other words, do descriptions reflect that the authority structure amongst the professionals is stratified? Is the authority structure based on a hierarchical chain of command, where the authority of a position forms the valid legitimate structure? Is the authority structure ambiguous or unambiguous to the professionals? Is the authority shared or concentrated on one manager or position or do the professionals have autonomy to control and manage their own practical work? Is the authority structure in the department formally delegated and if so, what kind of tasks and decisions are formally delegated?	

Table 11Systems

Theoretical concept	Theoretical definition	Empirical indicators	Examples
Systems	"…decision systems, or policy and resource allocation mechanisms, and human resource systems, such as recruitment, appraisal and compensation"	Descriptions or expressions of who has the legitimate authority of decision making regarding both resources allocation mechanisms but also about recruitment and appraisal decisions. E.g. who has the formal authority of budgets and financial decision making, and does this authority deviate in practice? Descriptions or expressions of how the "rationality" within the decision system unfolds. For example: Is the decision system within the hospital management archetype e.g. characterized by being transparent, systematic, planned decisions based on analysis or is the decision system more characterized by *ad hoc* and randomly taken decisions?	"… we had like a joint management and a joint decision making process within the consultant group in its entirety. (...) We held a meeting for an hour each week, Monday morning from 9 to 10, where we discussed administrative issues and reached an agreement and a consensus culture. So it was very informal. The head nurse (…) she managed to… or had meetings with her ward nurses. And so we coordinated a few half-days a week – we talked about things." (Consultant J, 2010).

		Descriptions or expressions of how actors interact but also perceive the decisions systems. For example: Are decision systems characterized by being individual, and directive or collective and consensual within the hospital management archetype where professionals possess the legitimate autonomy and authority to make decisions? Descriptions of how the decision system unfolds in either a reactive or proactive way in order to gain a competitive advantage.	

Table 12 Interpretive scheme

Theoretical concept	Theoretical definition	Empirical indicators	Examples
Interpretive scheme	"…interpretive schemes contain beliefs and values about domain, organizational form and criteris for performance evaluation."	Descriptions or expressions of e.g. ideas, values, meanings, or beliefs about what the professionals with management responsibility in the hospital department should be doing in relation to management and the management model in the department. For example: Is the management (especially the executive consultant) of the department e.g. the "representatives" of the traditional professional collegium and their collective decision making or should the management team also manage in accordance with their own management agenda and beliefs in relation to handling the cross-pressures their position contains between the employees and the context of the department? Descriptions or expressions of values, meanings or beliefs about how the hospital management model should	"... It's obviously because you as a medical professional would only be led to a certain degree. You even think you are so damned clever medically that there are limits to how far you want to be managed. Because then your medical competences take over, and then you think that there is nobody in this world who is better than me for this. And so that is the limit. And that is what happens in such a highly specialized department like this." (Consultant G, 2010) "It is quite obvious (…) that we had different clinical interests and different clinical responsibilities. But to keep the group as such, and not say that some in the group are managers, and some are middle managers, and some are not managers, it provides a much better, in my opinion, cohesiveness and fighting spirit, and a much greater understanding of the different group or sub-

		be appropriate organized. For example: Should the managers e.g. be professionals rather than general managers? Is that reflected in descriptions of administrators having a low status and position? Should the management in the department e.g. consist of a management team with an executive consultant and a head nurse, or should it be an unambiguous management form with only an executive consultant? Descriptions and expressions of values and beliefs of how performance evaluations should be judged. Descriptions of who has the authority, legitimate power or capacity to elaborate legitimate standards and performance measure but also maintain and judge these elaborated standards. For example: Is it the professionals as the doctors and nurses who elaborate and preserve service standards, or should they be elaborated and validated by bodies	specialty issues." (Consultant J, 2010)

		and authorities outside the department? Should it be the specific hospital that elaborates performance management measures and evaluation criteria for the department? Do the descriptions of the evaluation criteria (as a term) reflect that it covers different types of criteria as medical professional and economic criteria? For example, is there an idea or belief that professional standards of service should primarily be developed (defined), maintained and judged by professionals with no interference from others without the professional and technical knowledge, while financial and administrative evaluation criteria could and should be developed and judged/ monitored by the administrative hierarchy of the hospital? Are professional qualifications emphasized in relation to recruitment and career development or are there other ideas and beliefs that turns out to be relevant when e.g. recruiting personnel?	

CHAPTER 5. THE INTENTION OF MANAGEMENT CHANGE

5.1. INTRODUCTION

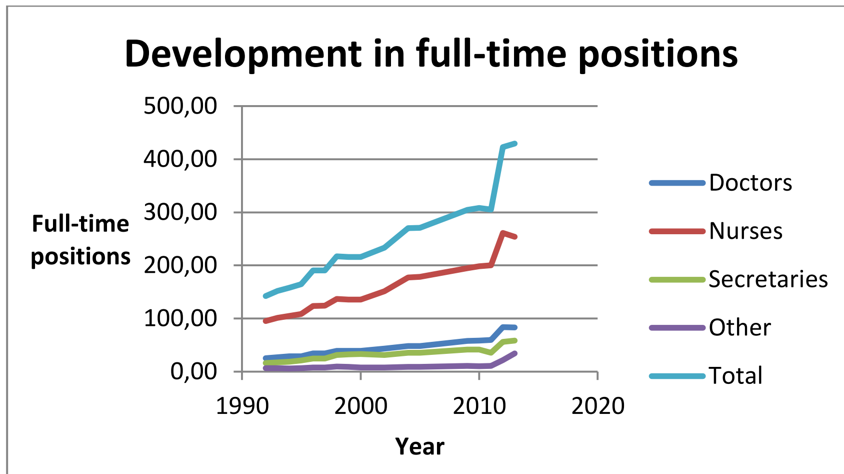
In this chapter I describe and present the managerial history of the DC's hospital management model. Based on this analysis I construct and define the prevailing management archetype template within the DC in order to establish an understanding for the starting point or *outset* of the management archetype template in 2010. Thereafter, I describe and present the intention of the formal management change of the management model of the DC, including different managerial issues, empirical challenges and benefits about the existing management patterns.

5.1.1. THE GROWTH OF THE DEPARTMENT OF CARDIOLOGY

Before presenting the managerial development in the DC before 2010, it is important to describe and present how in the last 25 years the DC has experienced a strong growth in both sub-specializations and increasing number of professionals in the department, which has had an impact on the development of the management organization.

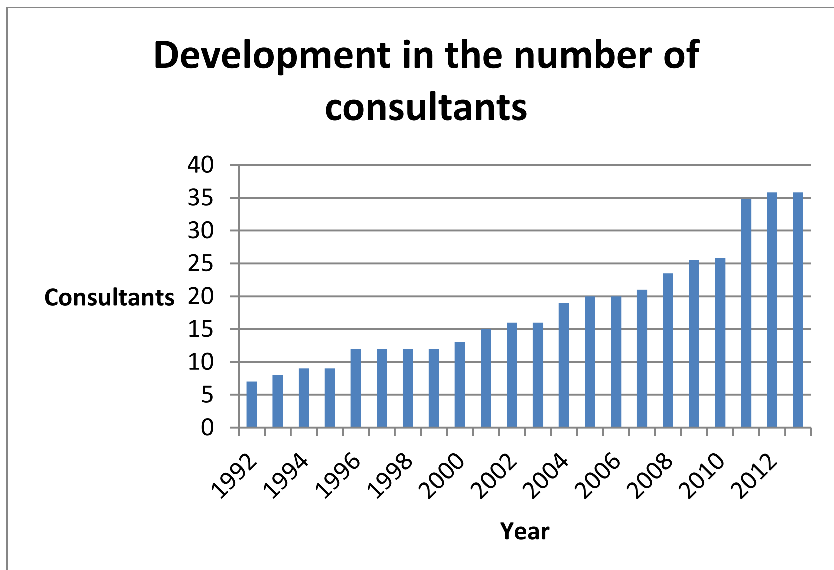
An increasing development in the cardiology specialty from the late 1980s has resulted in an increasing number of employees in the DC. In 1992 the DC had 142 full-time positions, including 25 doctors, 95 nurses and 16 secretaries. Ten years later, in 2002, the numbers had increased to 233 full-time positions, including 43 doctors, 151 nurses and 31 secretaries. In 2010 the number of employees increased further to 308 full-time positions, including 58 doctors, 199 nurses and 41 secretaries. In 2013 the DC had 429 full-time positions, including 83 doctors, 254 nurses and 58 secretaries. The development in the number of full-time positions in the DC is illustrated in Figure 4 below and is based on the DCs own data which I used to create the figure.

Figure 4 Full-time positions in the Department of Cardiology, AUH



The number of consultants also increased during the same period (1992–2013). In 1992 seven consultants were employed in the DC, in 2010 there were about 26 consultants and finally in 2013 there were 36 consultants. The development in the number of consultants in the DC is illustrated in Figure 5 below and is based on the DCs own data which I used to create the figure:

Figure 5 Number of consultants in the Department of Cardiology, AUH



Based on this contextual information about the growth of staff numbers in the DC I present the managerial history of the DC's hospital management model below.

5.2. THE MANAGEMENT MODEL IN THE LATE 1980S

In this section I describe and present the management organization of the DC at AUH from the late 1980s to the early 1990s. This section is based on reflections, retrospections and subsequent rationalizations from interviewed doctors (consultants and junior doctors) and nurses.

5.2.1. THE AUTHORITY STRUCTURE

The DC was first established at Aarhus Municipal Hospital in 1984. The department was then relocated to the then Skejby Hospital at Skejby, Aarhus (later Aarhus University Hospital) in 1988. At that time the DC was a less important department, with just five affiliated consultants.

The authority structure manifested itself at that time through a traditional medical professional collegium consisting of the five consultants. According to all the doctors interviewed in 2010, each consultant in the collegium possessed a position of authority that was inherent in their seniority and expertise, which in relation to the interviewed doctors meant that all the consultants within the collegium possessed a position of authority by virtue of their medical professional position.

However, an authority structure also existed within the collegium of consultants. According to the interviewed doctors, all the consultants in the collegium perceived each other as colleagues and equals. This authority structure was also based on the inherent seniority and expertise each consultant possessed, which was established and developed through their specific clinical work. According to all the consultants interviewed in 2010, in principle there was no other consultant above or besides regarding each consultant's autonomy to control and manage his or her own clinical work, which qualified their position within the collegium of consultants. However, even though the consultants perceived themselves as colleagues and equals, a stratified authority structure did materialize within the collegium of consultants, since the most skilled and professionally recognized consultant(s) were the one(s) who drove the medical and more administrative managerial processes, and therefore also the more administrative aspects of the management responsibilities. The following quote illustrates that the most skilled and experienced consultant possessed the top authority position amongst his colleagues.

> "... there was a professor (...) he was in charge. He was the most skilled, and there was an extreme respect around him." (Executive Administrative Consultant, 2010).

The following quote also underlines the stratification amongst the consultants in the collegium. The consensus culture about management issues within the collegium was dependent on certain consultant(s), recognized among their own (skilled and experienced) colleagues, who legitimated any given decision.

> "One of the things we talked about a lot in the consultant group was the thing about consensus. There was only consensus if any of the really powerful was present." (Executive Administrative Consultant, 2010).

The authority structure amongst the consultants also implied a (however informal in relation to a formal administrative hierarchy) medical-professional stratification of the authority structure in the department, as the junior doctors had less to say due to their lower degree of expertise in relation to more skilled doctors and consultants. In other words, the junior doctors did not participate in the collegiate management meetings amongst the consultants.

In relation to the nursing profession within the DC, the collegium of consultants possessed the overall position of authority, and the nurses acted as a subordinate professional group. More precisely, the authority structure reflected pillars of different management organizations within the DC, forming an overall authority structure where the consultants of the collegium had the primary authority position. More precisely, the authority structure was a traditional pillar management structure with both a stratified medical group and a stratified nursing group.[16] There was no doubt that the collegium of consultants had the final say and did not consider the nursing management assessments as applicable in the overall management of the DC. What was important was, however, that in practice there was established a managerial cooperation between the most skilled consultants of the group of consultants and the managing (head) nurse, but the cooperation had more the character of *ad hoc* communications on administrative and operational issues than regular management cooperation.

> "Well, from the very beginning we had what was called an 'administrative consultant' at the time, and a head nurse, but it was not a formal department management team. At that point in time it was the administrative consultant who was the head of the department, at least in managerial administrative terms." (Consultant G, 2010).

This medical professional stratification of the authority structure formed a "clan-authority structure" in the department, where the most experienced and skilled doctors, i.e., the medical consultants, possessed legitimate autonomy in their professional clinical management responsibilities but also regarding the more

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[16] In the group of nurses the authority structure was shared through a traditional hierarchy with a head nurse at the top and subordinate nurses with administrative management responsibilities.

administrative management responsibilities within the department. The group of nurses possessed a less strong position.

In summary, the authority structure in the DC was divided into pillars of professions. The collegium of consultants possessed the overall authority in the department. However, different kinds of administrative and professional issues were informally debated, discussed and coordinated regularly between the head nurse and the most skilled consultants in the department. The head nurse managed the nurses through a classic hierarchy of nurses with management responsibilities at lower levels, without interference from the doctors. What is important to understand is that, in the day-to-day routine and operations, the management of the department functioned through the abovementioned pillars of management organization, however, the collegium of consultants had the final say regarding general medical and administrative management decisions in the department.

5.2.2. THE DECISION SYSTEM

In this section the focus is on how the decision system of the DC in the late 1980s was perceived by the interviewed doctors and nurses, including the rationale of the system as they expressed it, and how it operated in either a reactive or a proactive way to gain competitive advantage.

The decision system in the management organization in the late 1980s was perceived as a transparent, collective and proactive system that was managed by the collegium of consultants, as I will describe below.

The interviewed doctors and nurses were clear on how the decision system could be characterized in the DC in the late 1980s. The collegium of consultants possessed the legitimate authority to make collective decisions about resource allocation, including decisions about the budget of the DC and financial decisions. However, each consultant also possessed the authority to make decisions regarding resources within her or her “own” clinic/specialty. This meant that the collegium of consultants became a forum where the resource allocation of the DC was negotiated collectively.

Regarding the rationale of the decision system of the DC, it was argued by the majority of the consultants interviewed that the decision system was at least transparent; it was clear to every doctor in the DC who possessed the authority to make decisions. The tasks and responsibilities were more or less delegated through negotiations amongst the consultants.

> “...in the old days the tasks were delegated, and it is completely true, because it was also like that when I became a consultant. When we sat around the table, and then you were told, ‘You take care of this...’. Then

> we said, 'Yes', because you could pretty much do no more, – it was like a part of the whole deal." (Consultant K, 2010).

In other words, it was clear to whom each doctor should go if he or she needed help regarding operational decision making, because it was clear who possessed decision power for the different kinds of tasks and responsibilities in the DC, as the quote below illustrates:

> "You had some delegations of different things (tasks, ed.). For example, the doctors' 'working plan'. It was delegated. It was not the consultant who took care of it, it was another. I think it actually worked very well. But it was also because we had a unified system, where it (the tasks, ed.) was clearly delegated and it was open and clear to everyone that it was delegated. And then it was to this consultant you approached with thoose kinds of tasks and challenges. Then there were other things you turned to the head of the department (ed.) with". (Consultant J, 2010).

Furthermore, I will argue that the decision system possessed a rather proactive decision culture, because each consultant who was responsible for a given task possessed a mandate (based on collegial acknowledgement of his or her expertise and seniority) and was thereby "given" an authority position from his consultant colleagues to perform and lead that sub-specialty. This meant that each consultant with delegated responsibility was somehow flexible and could make quick decisions because he had a mandate from the collegium of consultants to carry out decisions within a given area, and was then not dependent on reaching a decision collectively regarding daily work.

The proactive decision system was also reflected in an expression of how the decision making was carried out on a daily basis in the clinics of the DC. For example, the daily decisions about the organization of the work in the clinics were managed by each consultant:

> "... Changes in work organization within one's group, – you would not involve the management in that (...) It … is not a problem, if you have to make little changes to some work organizations. You just agree about that (...) Well, if it is about organization and working things, then you would do it yourself (as a consultant, ed.)" (Consultant J, 2010).

In other words, "management" decision making regarding the organization of clinical work was negotiated and agreed upon in the consultant's own clinical group and not perceived as the subject of management (for the whole DC). This emphasizes that the clinics were very self-managing and self-organizing and that "management" was only relevant if there were difficult and major issues pressing on the whole of the DC. The quote below illustrates the clinical and administrative

responsibility/"management" of each clinic/specialty regarding economic decisions and resources.

> "Well, all that buying (…) for millions(…) – it has been lying out there with the people who had the professional responsibility, but they were in some way accountants and should be able to document that they made an effort, and got it as cheap as possible and got credit for research and things like that." (Consultant J, 2010).

What is also noteworthy is that this decision system, based primarily on the medical professionals' management decisions, according to the interviewed consultants, did support, contribute and develop the DC to become high-profile cardiology department nationally and even internationally. In other words, the decision system was strongly influenced by the consultants' position of authority. This decision power motivated the consultants to proactive behaviour regarding developing the DC to an international level. This meant that the low degree of administrative tasks was adapted to the medical management priorities. This perception is illustrated in the quote below:

> "The benefits of the old system was… I think the very reason that this department is so high-profiled both internationally and nationally – and specialized –, is because the DC has never compromised on its professionalism and the (administrative, ed.) bureaucracy had to adapt to this professionalism. It is not so that there have not been any bureaucratic decisions taken, and that it has not been possible to change things, but the first remark – it is professionalism. So it is not that you take the time to go against the decision system, because you are too occupied with/concerned about your clinical and academic work. So you have to adapt so you can continue to work with your professional work." (Executive Administrative Consultant, 2010).

I would argue that in the late 1980s the DC was dominated by a two-layer decision system. The first layer, which was also most formal layer, consisted of the collegium of consultants, which managed and negotiated the larger decisions about resource allocation, including recruitment and appraisal decisions, and the second layer was the consultants and their clinics, which managed the day-to-day activities and issues regarding organizational work, including budgets and financial decisions related to their specialty/clinic. Based on this description, I will argue that the decision system can be described as a flat decision-making system, with a high degree of autonomy in the decision making.

In summary, the decision system was perceived by the consultants I interviewed as a transparent, collective and proactive system that was primarily managed by the collegium of consultants. It was expressed by all the consultants that one of the

benefits of this system was the high degree of clinical management decision making which powered the department's national and international success.

5.2.3. THE INTERPRETIVE SCHEME

This section presents different recollections of what the professionals with management responsibility in the DC were expected to do and what it was believed they should do, how the management should be appropriately organized, and finally how performance evaluations should be judged in the prior management organization of the DC.

Regarding the former management organization in the DC, interviewees recalled that the management responsibility was shared amongst the consultants with the most seniority and expertise. The professional management of the DC, which included the administrative responsibility, was taken care of and negotiated within the collegium of consultants, as described above.

The interviewed doctors and nurses were of the belief that the authority and management decisions about clinical and administrative issues should be taken by the consultants collectively though consensus in the collegium of consultants, since it should be those who possessed the legitimate superior authority position in the DC who managed the department:

> "...We just discussed administrative matters through, agreed and reached a consensus culture." (Consultant J, 2010).

In other words they expressed that management was something professionals and especially doctors should do collectively in a consensus orientated manner.

Regarding the perception of the most appropriate way to organize the management of the DC in the late 1980s, according to the interviewed doctors and nurses, it was an organization where the doctors collectively possessed the overall responsibility through a collegium. The respect for each consultant's specialty and expertise resulted in both professional collegiality among the consultants and also collectivity and consensus making regarding the management organization of the DC. On the one hand, it was expressed by the consultants that it was valued that the DC should be functioning "as a whole". The best organization was an organization where they sensed that the department was functioning as a whole in spite of each consultant's own managerial/clinical work. For example, the majority of the consultants described a "whole" organization as a value from the late 1980s about how the management organization should be organized, which is illustrated in the quotes below:

> "... a common management structure and a joint decision structure in the consultant group in its entirety" (Consultant J, 2010)
>
> "... there was clearly the advantage that the department appeared much more as a whole... One whole." (Consultant G, 2010).

However, I would argue that the consultants' belief about the DC "as a whole" was also developed as a counterpart to the value of clinical "self-management" of their clinical work that also characterized the management organization of the DC. The ability or desire to "manage your own medical clinical work" was a strong and important value of the management organization in the DC. The consultants would be allowed to manage their own clinics in a multidisciplinary collaboration with colleagues. For example, a consultant stated:

> "We were allowed to manage our own clinic in a multidisciplinary collaboration with colleagues." (Consultant J, 2010)

There was thus a value of "joint management" where common issues were discussed in a "collective consensual manner" which was also a stated value, in order to support the DC as a whole. Furthermore, the consultants also supported values about "self- management", based on their organization of their own clinical work within the DC, in which they had their own management responsibilities.

Regarding who should make the performance evaluations in the DC, this fell to the consultants with most seniority and expertise. They possessed the authority and decision making power within the DC, and were able to judge the professional standards. In other words, doctors' performance was primarily assessed by their own peers in relation to the degree of expertise. At that point in time the hospital management did not interfere in the clinical performance of the department as such.

In summary, the interpretive scheme reflects values and beliefs that support a management model and organization that is based on consultants' collective and individual authority and a decision system that is also dominated by the consultants' superior position and the nurses' subordinate position.

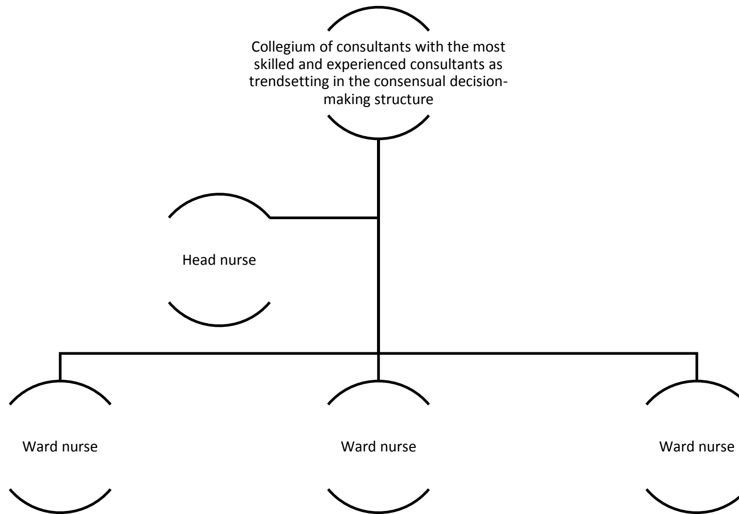
5.2.4. THE ARCHETYPE MANAGEMENT MODEL IN THE LATE 1980S

In this section I construct a picture of the management archetype in the late 1980s.

The picture of the authority structure, decision system and interpretive scheme from the late 1980s in the above sections depicts an archetype model with a clear coherence between the interpretive scheme of the DC and the authority structure and decision system. Below I have drafted an organizational diagram of the prior management model of the late 1980s. The diagram illustrates the traditional archetype of department management in the DC from its foundation in the late

1980s, with a collegium of consultants composed of the most skilled and experienced consultants on top of the authority structure and setting trends in the consensual decision-making structure, and a head nurse in the top authority position over the nurses, but below the consultants' overall authority over the DC.

Figure 6 The management archetype of the late 1980s



5.3. THE MANAGEMENT MODEL IN THE EARLY 1990S

In this section I describe and present the changes in the management organization of the DC at Aarhus University Hospital around the early 1990s. This section is based on reflections, retrospections and subsequent rationalizations from interviewed consultants and nurses about the management organization in the DC in the early 1990s.

5.3.1. THE AUTHORITY STRUCTURE

In the early 1990s seven consultants were affiliated to the DC. The more formal authority position of administrative consultant was collectively and consensually established and chosen by the collegium of consultants due to the need to accommodate an increasing division of labour. The administrative tasks had been growing gradually in the DC because of increased specialization in cardiology. This meant that the complexity of the authority structure increased.

As mentioned in the sections above, the overall authority structure of the DC was based on the collegium of consultants in “ad hoc” or “informal” collaboration with the head nurse of the nurses in the DC. However, in the early 1990s a more formal approach was launched in the collegium as one consultant was chosen to be responsible for the managerial administrative tasks in the DC, as illustrated in the quote below:

> “…we had what was called an ‘administrative consultant’ at the time, and a head nurse, but it was not a formal department management team. At that point in time it was the administrative consultant who was the head of the department, at least in managerial administrative terms.” (Consultant G, 2010).

However, at the beginning of the 1990s there was still no talk about joint department management raising the position of the head nurse formally to the same level of authority as the chosen administrative consultant:

> “It was the administrative consultant who was in charge of the head nurse, and it was a very consultant-dominated leadership.” (Executive Administrative Consultant, 2010).

The authority structure still reflected the traditional professional bureaucracy, with medical consultants possessing the overall authoritative position regarding both medical professional management issues and the more administrative issues of the DC. The nurses also possessed an authority position in the DC but were still subordinate to the group of consultants/doctors.

As in the prior management organization, the chosen administrative consultant “possessed” the overall professional management position of the DC because he gained this position through the collegium of consultants, as expressed in the quote below.

> “... we talked about who should be doing what and then we agreed in the group of consultants that it was [X], who should possess the authority to manage the administrative issues and responsibilities.” (Consultant J, 2010).

This quote illustrates that the administrative consultant with the overall mandate to manage the department and the head nurse was “getting closer” in the “description” as a management team of the DC based on the expressions from the consultants. However, in practice it was still the collegium of consultants, in the absence of the head nurse, who collectively possessed the overall authority position to discuss and make decisions, as exemplified in the quote above. Even though the head nurse had some sort of management position within the DC, the head nurse’s authority was still positioned at a lower level than the collegium.

Even though there was more awareness of the position of administrative consultant, and it became more important and formalized in the DC due to increasing specialization and growth in the number of employees and the derived administrative responsibilities, the authority structure was still characterized by the domination of the collegium of consultants where authority was inherent, based on seniority and expertise.

However, the former and more unambiguous authority structure that consisted of a few consultants within a collegium was changing and had become more complex regarding the administrative tasks. Some of the administrative tasks were delegated and shared amongst the consultants or shared with the representative of the group/collegium (the administrative consultant), who then served as "the voice" of the consultant collegium or as a "voluntary local representative" for the consultants, taking a "stint" for the team of colleagues. On the one hand, the administrative consultant managed different administrative tasks and responsibilities internally, but on the other hand the managerial role of the administrative consultant changed towards having a more outgoing position. The administrative consultant had to represent the DC in relation to administrative collaboration with other departments, the hospital management as well as interest groups and other political bodies. For example, the "representative" administrative consultant possessed a legitimate authority position regarding administrative issues which had to be discussed or debated within the larger organization, such as at the top hospital management level, at the regional level, but also at the state level (e.g. the Danish Health and Medicines Authority), or in relation to external stakeholders such as the medical or patient associations.

This "delegation" of negotiations and administrative tasks to consultants in the collegium also meant that some of the consultants were freed from various administrative tasks. It was tasks that formerly had been shared among the "equal" consultant colleagues, because there was a collective understanding of helping each other with the administrative issues and tasks. This meant that some of the administrative responsibilities and, for example, some of the difficulties in accomplishing these tasks, were removed from some of the consultants' direct awareness. This created some distance or "stratification" between consultants, especially the "administrative" consultant who was getting more involved in administrative tasks of the DC compared with the rest of the consultants, who were involved in those tasks to in a lesser degree.

In summary, the change in the administrative consultant's role due to the increased amount of administrative tasks internally and externally made the stratification of the consultants' authority structure more evident. At that time, it was clear to the consultants that there was an increasing need for a formal administrative management within the DC, which was responsible for the department's overall interests. However, in practice, the collegium of consultants still possessed the real

authority in the department's daily work and they were also legitimizing the position of the administrative consultant.

5.3.2. THE DECISION SYSTEM

In this section the focus is on the changes in the management decision system from the late 1980s to the early 1990s. The expressed rationale of the system of the early 1990s and also expressions of how interviewed doctors and nurses perceived the decision system, is examined. Lastly, how the system develops in either a reactive or a proactive way to gain competitive advantage is described.

The point of departure of the management decision system of the DC in the late 1980s was a perception that it was a transparent, collective and proactive system that was dominated by the collegium of consultants, which I have described in the section above. Even though the administrative consultant in the collegium of consultants increasingly became more involved in both internal and external administrative tasks in the early '90s, the interviewed doctors and nurses did not recall perceiving that the decision system as such was fundamentally changing. It was still characterized by transparency and collective and collegial decision making. For example, the process of employing an administrative consultant reflected that the decision system was characterized by being collective and consensual regarding the overall management and administration of the department, even though the most skilled consultants within the group assumedly had the most say as in the late '80s. In the early '90s the DC had a highly democratic decision-making structure which operated in "Monday meetings" of the consultant collegium in the DC. At these weekly meetings, the consultants discussed administrative and medical issues and the most skilled consultants primarily set the agenda for the meetings. A consultant describes the decision system at that time:

> "… we had like a joint management and a joint decision making process within the consultant group in its entirety. (...) We held a meeting for an hour each week, Monday morning from 9 to 10, where we discussed administrative issues and reached an agreement and a consensus culture. So it was very informal. The head nurse (…) she managed to… or had meetings with her ward nurses. And so we coordinated a few half-days a week – we talked about things." (Consultant J, 2010).

The quote above also underlines that the management organization still possessed a pillar structure regarding the professionals' positions in the overall management of the DC.

Furthermore, the decision system operated in a proactive way, as described for the 1980s, because the dominant medical professional were still in a position where they could make favourable decisions regarding clinical issues. In other words, the

medical professionals still possessed the decision power to make clinical decisions that could favour their position in relation to other specialties they competed with regarding resource allocation at hospital level.

In summary, the decision system in the early '90s was still perceived by the consultants as a transparent, collective and proactive system that was primarily managed by the collegium of consultants, despite the more formal administrative or representative position of the "chosen" administrative consultant.

5.3.3. THE INTERPRETIVE SCHEME

This section presents different expressions of what the management organization of the DC should be doing, how the management should be appropriately organized and finally how performance evaluations should be judged in the early '90s.

The majority of the interviewed consultants recalled that in the early '90s the management responsibility was still very much matter of medical professional concern. In other words, the management of the DC was a matter of common concern amongst the consultants with seniority and expertise. The medical professional management of the DC, which also included the administrative responsibility, still possessed the authority position that was located in the collective collegium of consultants.

Regarding how the clinical professional management should be organized appropriately, it was believed that the authority positions and management decisions regarding clinical and administrative issues should be held by the consultants collectively through consensus orientated negotiations in the collegium of consultants, since it was "natural" that those who possessed the legitimate superior authority position in the DC should be managing the DC, including the more administrative tasks and issues related to the clinical work.

The collegium of consultants did still collectively negotiate and delegate the management responsibility of the DC within the collegium, as described in the sections earlier. The quote below illustrates how they valued negotiation and delegation of management tasks as a way of organizing the management responsibilities:

> "There has always been decentralization. The entire management and the entire department were organized so that you could decentralize tasks. It has been the background so that you and I could work clinically, – we could say: 'This task – this will you handle, and you take care of this', and everybody got a task. And it had both the advantage that you as a manager were relieved, but it also had the advantage that everyone felt involved in management issues." (Consultant J, 2010)

It is argued that the delegation of administrative responsibilities among equal colleagues enhanced cohesiveness of the specialties and “fighting spirit”, creating a greater understanding of the different sub-specialties, despite the consultants’ fundamental interests in and self-management of their individual clinical work in the DC. This point is illustrated in the quote below:

> “It is quite obvious (…) that we had different clinical interests and different clinical responsibilities. But to keep the group as such, and not say that some in the group are managers, and some are middle managers, and some are not managers, it provides a much better, in my opinion, cohesiveness and fighting spirit, and a much greater understanding of the different group or sub-specialty issues.” (Consultant J, 2010)

A desire to be “colleagues as equals” within a “collective” collegium of consultants, despite each consultant’s clinical interest and self-management authority position, was still expressed as essential values and beliefs of the interviewed doctors, which was also reflected in the general consensus decision making in the consultant group. For example was the decision about who should represent the consultants internally and externally concerning the more administrative tasks was a collective matter “among equals”. However, as mentioned, the strong focus on and desire to be “self-managing” of one’s specialty and clinic were also important. Based on their authority position and decision-making possibilities in the collegium, the consultants possessed full jurisdiction over their clinical work which supported their desire to manage their own clinical work.

In summary, the above desires and expressed values and beliefs about the consultants’ authority position and power over the decision system had a robust coherence with the two-layer authority structure that was present in the DC in the early ‘90s, but also the collective consensus orientated decision system of consultants.

5.3.4. THE ARCHETYPE MANAGEMENT MODEL IN THE EARLY 1990S

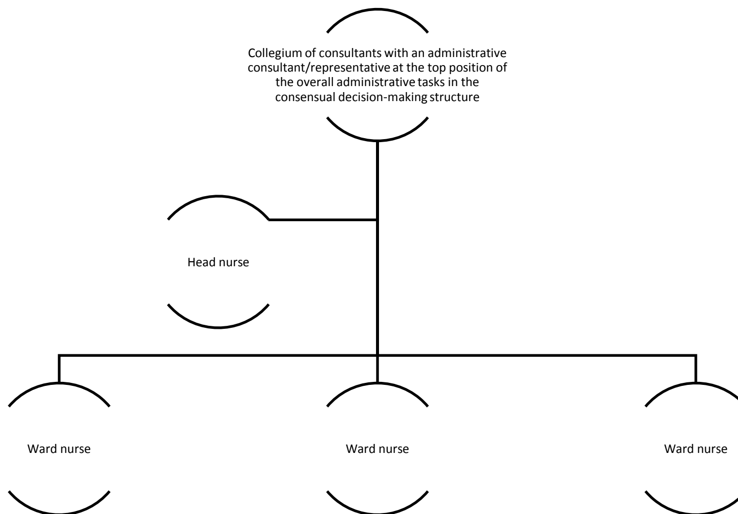
In this section I construct a picture of how the management archetype appeared in the early 1990s.

The picture of the authority structure shows that the decision systems and the interpretive scheme in the above sections is an archetype model from the early 90s where there was still a clear coherence between the interpretive scheme of the DC and the authority structure and decision system. However, in the collegium of consultants, who still possessed the overall authority position of the DC, a more prominent administrative management role began to crystallize, which led to a kind

of negotiated "task stratification" among the consultants without influencing their clinical authority position as such.

Below I have drafted an organizational diagram of how the management model from the early '90s was expressed by the interviewed professionals. The diagram illustrates that the traditional archetype of department management in the DC in the early '90s was a collegium of consultants with an administrative consultant/representative at the top of the overall administrative tasks in the consensual decision-making structure, and additionally a head nurse at the top of the managing section of nurses but below the consultants' overall authority over the DC. In other words, the constellation of the authority position and decision system regarding administrative responsibilities has changed somewhat for the consultants, towards a more formal, representative and in some regards stratified position for the administrative consultant, but a position still held on their mandate.

Figure 7 The management archetype of the 1990s



5.4. THE MANAGEMENT MODEL IN THE EARLY 2000S

In this section I describe and present the management organization of the DC around the early 2000s. This section is based on reflections, retrospections and subsequent rationalizations from interviewed consultants and nurses about the management organization in the DC in the early 2000s.

5.4.1. THE AUTHORITY STRUCTURE

In this section I will describe and present the expressions of how the authority structure was perceived around the 2000s.

In the early 2000s about 13 consultants were affiliated to the DC. This illustrates the fact that during the 1990s the number of consultants increased even more, as a result of even more growth and development within the specialty of cardiology. By around 2000 the collegium of consultants had enlarged to double the size it had been when the department was created in 1987.

The majority of the consultants expressed that the growth in sub-specialties brought an increasing sub-specialization and fragmentation of the clinical work of the DC. In the quote below a consultant describes how in the earlier days it was possible for the consultants to cover and work across different sub-specialties in the DC, but as the amount of sub-specialties increased, and with it the amount of consultants, it resulted in a decreasing flexibility in working with different specialties in the DC. I would argue that this seemed to threaten the cohesion and understanding of the specialties in DC. A consultant described how there was:

> "... a little variation from the beginning and then at the end I pretty much just took care of patients who should needed to be examined. So it also went with the others. Either you were in one or the other group (of specialties, ed). When you then were allocated to such a group, then there would occur some fractions you could say." (Consultant K, 2010)

The development in specialization in the cardiology disciplines and the increasing complexity of the DC had an impact on the management organization of the DC, namely its authority structure. In the early 2000s the position of the administrative consultants became further formalized in the DC due to the need to accommodate an expanding division of labour and administrative tasks.

The majority of the interviewed consultants and doctors recalled that the position of the administrative consultant of the DC became formalized and the term "executive" was added the "administrative" profile of the consultant. In other words, the position was defined and named as an "executive administrative consultant" around the early 2000s. This formalization of the administrative consultant as a manager of the DC was a part of a larger management restructuring[17] of the top management positions of the DC. The "managing" nurse of the nurses in the department also acquired a more formalized management

[17] It is not clear in my data "who" initiated this formalization or where the "idea" of it spread from. I believe it was formalized by the hospital management and communicated to all departments.

position as the "head nurse" position was formally established as a part of the general overall department management of the DC. In other words, the authority structure formally changed in two parameters. The first parameter was about the more ambiguous and more stratified position of the executive administrative consultant among the consultants of the collegium based on using the label "executive". The distance between being "colleagues as equals" appointing a collegial "representative" and becoming an "executive" made the latter role more clearly defined. The second parameter is about the formalization of the position of the head nurse as a formal part of the overall management of the DC. The head nurse was then formally accepted as a part of the department management and not as a subordinate part. The consultants and especially the administrative consultant could discuss more or less important managerial overall decisions with the head nurse by their will:

> "At this time it was defined as 'department management' where the executive administrative consultant, as it came to be called, and the head nurse constituted the department management." (Consultant G, 2010).

The interviewees recalled, however, a less stratified authority and more differentiated structure than the above described still existed informally. In the day-to-day routine the management organization was perceived more as a structure with the executive administrative consultant still being the representative of the DC and primarily regarding administrative issues and where the collegium of consultants still possessed the legitimate authority regarding clinical issues as such. The position of the head nurse was still subordinate to the executive administrative consultant and the collegium regarding the overall management responsibilities in the DC in practice.

An example of this informal authority structure was that the executive administrative consultant was still chosen by the collegium of consultants through consensus decision making. The collegium still possessed the real superior authority in the DC and had the power to decide whom they would recruit as their "executive" or representative. The consultants could collectively (consensually) decide which consultant should be their representative, in the top position in the DC. The quote below illustrates how it was perceived that the hospital management usually did follow the consultants' decisions, respecting their authority position as experts, for example, regarding recruitment.

> "...and when the consultants said it, then it was at that point in time where the hospital management went along with it." (Consultant, 2010).

Based on the above considerations the mandate of the top authority position but also recruitment practices was influenced and given by the collegium of consultants

who possessed the superior authority position through their legitimate professional expertise and seniority.

Nevertheless, the informal authority structure of the "executive administrative consultant form" was not completely comparable with the previous period, when one of the consultants was an administrative consultant. Internal administrative tasks, but especially also external tasks and responsibilities, increased and the importance of being the representative, face and voice of the DC and the one with delegated authority of the DC became more important. Especially important was the economic resource allocation that was decided at hospital level, but also at regional level and centrally. Thus the executive administrative consultant role developed towards not only managing the internal administrative problems, but also increasingly being involved in the debates and negotiations about economic resource distribution and the political negotiations in this connection. The quote below illustrates this increasing pressure on the executive administrative consultant:

> "...more and more tasks came to us from above, and somebody (consultants in the DC, ed.) would of course say, 'This is not so interesting', but you (the executive administrative consultant, ed.) would be increasingly unpopular (with the hospital management) with that attitude. Especially because you sometimes were in a position where you actually also had to get resources to the different specialties. You had, in other words, a dialogue, and it was necessary to try to maintain a good dialogue (with the hospital management, ed.) and therefore you may sometimes have to do some work that you really thought was a little bit uninteresting." (Consultant K, 2010).

In summary, the collegium of consultants did still possess the top authority position in the DC. However, the executive administrative consultant possessed an increasingly important role for the collegium and the DC, as this position had to navigate and negotiate between the interests of the collegium of consultants and the hospital management, making sure of a good dialogue and negotiating opportunities in order to get economic resources through cooperation with the hospital management. This resulted in a position where the executive administrative consultant gained a broader view of the hospital's prioritization and negotiation of resource allocation, which made the collegium of consultants and the DC more dependent on the executive administrative consultant. Regarding the head nurse position, this was formally incorporated in the department management, however, informally; the head nurse position was still perceived as being below the authority of the collegium of consultants.

5.4.2. THE DECISION SYSTEM

In this section the focus is on the management decision system in the early 2000s. The expressed rationale of the system around the 2000s and also expressions of how the doctors and nurses perceived the decision system are examined. Lastly, a focus on how the decision system operated in either a reactive or a proactive way to gain competitive advantage is described.

Regarding the rationale of the decision system around the 2000s, there was still an overall perception that it should be the medical professionals and no another professions or general managers who possessed the legitimate power over the decision system in the DC.

However, in the 2000s the decision system had become more complex than in the 1990s because of the continuously increasing amount of consultants (and other employees) within the DC due to the increased specialization of cardiology. In the 2000s the decision system was perceived as being more blurry, stratified and differentiated amongst the consultants. Formally, the executive administrative consultant and the head nurse possessed the formal decision-making power of the DC overall. Informally, the collegium of consultants still made overall collective and consensus orientated decisions as colleagues on a weekly basis in close collaboration with the executive administrative consultant. The power of decision making was also delegated or entrusted to each consultant, as the consultants, by definition, possessed management competences, skills and capabilities in their own clinics as they had traditionally possessed them since the late 1980s. This meant that important decisions were discussed in the collegium of consultants between the executive administrative consultant and the other consultants. But the consultants also made minor decisions when managing their sub-specialties; decisions that did not necessarily reach the collegium and their weekly meeting. The formalization of the role of the executive administrative consultant stratified the decision system. The executive administrative consultant was held responsible by the hospital management for the department’s various management decisions regardless of whether they were the collective decisions of the collegium of consultants. In other words, the executive administrative consultant in principle and formally had the final say, unlike before when the whole collegium of consultants took collective responsibility for final decisions. The increasing burden of administrative tasks which the executive administrative consultant was required to manage and the necessary delegation and decentralization of different administrative tasks, withdrew some of the consultants and especially the executive administrative consultant from clinical work, and pulled and twisted the collective decision making further apart, which meant that the collective consensus decision making culture became less coherent. There were now various consultants with different degrees and types of administrative tasks, but also more need for communication and dissemination of knowledge about the progress of administrative tasks on more

levels. This development of differentiation of administrative tasks made the collective consensus orientated decision system more incoherent.

The decision system did, however, still operate in a proactive way because the dominant medical professionals were still in a position where they could make favourable decisions regarding clinical issues as the professionals still internally possessed the power to make clinical decisions. However, the external competition with other specialties regarding resource allocation at hospital level had become harder.

In summary, the decision system in the 2000s was perceived as becoming more blurry, stratified and differentiated amongst the consultants. The consultants did not perceive it as being as transparent and collectively orientated as it had formerly been to them, despite the formalization of the positions of executive administrative consultant and head nurse.

5.4.3. THE INTERPRETIVE SCHEME

This section presents different expressions of what was expected and believed of what the management organization of the DC should be doing, how the management should be appropriately organized and finally how performance evaluations should be judged in the 2000s.

The majority of the consultants interviewed recalled that the management authority structure and decision system in the early 2000s was still very much a matter of professional clinical concern. More specifically, the overall management decision system in the DC was a matter of common concern amongst the consultants with seniority and expertise. However, the head nurse had acquired a more formal position around 2000 as a part of the overall management decision making system of the DC, which included a formal collaboration with the executive administrative consultant. This constellation made the pillar management structure in the DC more visible and perhaps also stronger since the head nurse now possessed a formal voice to speak for the group of nurses in the DC. The professional clinical and administrative management of the DC was still perceived to be in the hands of the medical professionals but was more stratified and differentiated than formerly.

It was still valued by the medical professionals that the collegium of consultants possessed the overall power of the decision system with no other professions interfering in their jurisdictional management area. The head nurse and thereby the group of nurses did however formally gain some power in the decision system through the position of the head nurse. This change meant that it was no longer the collegium of consultants and their consensus orientated negotiations alone that had the final say – formally, at least. Formally, the executive administrative consultant and the head nurse possessed the responsibility. Informally, however, the executive

administrative consultant attended the traditional collective and consensus orientated meetings among the consultants without the head nurse, hence the latter was not a colleague as equal in the decision-making process. This meant in practice that it was still believed and valued that the consultants should possess a real influence over the decision making system and the head nurse still “only” possessed the management responsibility of the group of nurses. But it was recognized that the collaboration between the executive administrative consultant and the head nurse was growing stronger and more formalized around the 2000s, especially in the administrative tasks that historically had not been valued among the consultants. In other words the doctors and nurses did appreciate that some professionals now took on this administrative burden for practical reasons.

What is noteworthy is that, despite the formalization of the roles as executive administrative consultant and head nurse as the top managers of the DC, it was still valued that in practice it should be the collegium of consultants who possessed the legitimate decision making power regarding the overall clinical work in the DC. The more overall administrative aspects and issues were sliding out of the consultants’ hands and they became more dependent on the executive administrative consultant and the head nurse than before. This resulted in a decision system where it was recognized that the executive administrative consultant had a stronger and more important voice in the DC regarding administrative tasks and also greater responsibility. This recognition was based on insight into the mutual dependence between the executive administrative consultant’s position and that of the consultants’ regarding the management of administrative tasks. Also the consultants’ strong focus on and desire to be “self-managing” in their specialties was still valued, as self-management was perceived to be the driver of cardiology innovation. Based on their authority position and decision making possibilities in the collegium, the consultants possessed full jurisdiction over their clinical work which supported their desire to manage their own clinical work. The quote below illustrates how the medical self-management was valued and how it was perceived that there are limits for how much they wanted to be managed by colleagues.

> “... It’s obviously because you as a medical professional would only be led to a certain degree. You even think you are so damned clever medically that there are limits to how far you want to be managed. Because then your medical competences take over, and then you think that there is nobody in this world who is better than me for this. And so that is the limit. And that is what happens in such a highly specialized department like this.” (Consultant G, 2010)

In summary, the expressed values and beliefs describe how the authority position and power of the decision system was still coherent in the 2000s. However, the development towards more a formalized management organization with a head nurse and executive administrative consultant at the top of the authority hierarchy

and an increasing amount of administrative management tasks began to break down this coherence.

5.4.4. THE ARCHETYPE MANAGEMENT MODEL IN THE EARLY 2000S

In this section I construct a picture of how the management archetype of around the early 2000s was expressed by the interviewees.

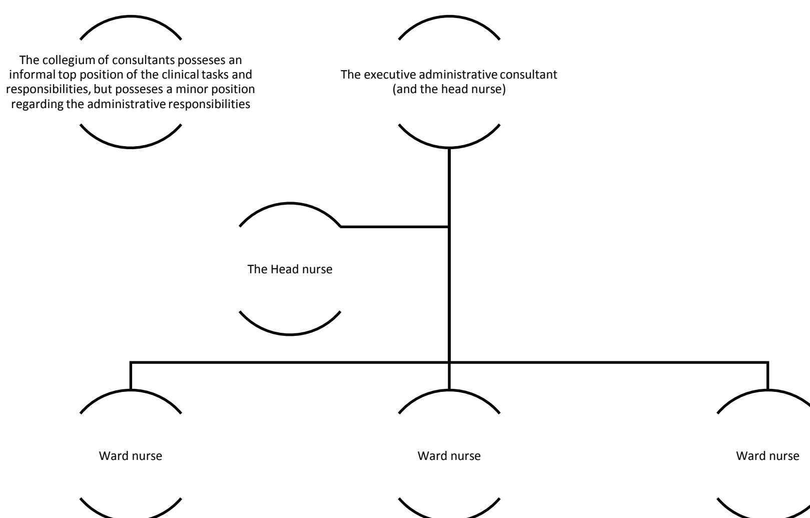
The picture of the authority structure, the decision system and the interpretive scheme in the above sections is an archetype model from around the 2000s where coherence between the formal/informal authority structure and decision system and the interpretive scheme of the DC seems to be beginning to break down, which I will reveal below.

Formally, the executive administrative manager possessed the overall management position in collaboration with the head nurse through a traditional pillar management structure, and they were formally placed at the top of the authority structure. The executive administrative consultant was responsible for the decision making of the DC. However, informally the collegium of consultants still possessed the overall authority position of the DC in daily work, especially regarding clinical work and in a minor degree regarding the administrative work, because the executive administrative consultants had a stronger position regarding those tasks. The executive administrative consultant possessed the formal responsibility for the DC, but regarding legitimate authority power of clinical decisions it was still the experts who possessed the legitimate authority power to make decisions, which the executive administrative consultant was included in on a daily basis as their representative. In other words, a stratification among the medical professionals authoritative position and decision power became more evident with the formally new "executive" role of the consultants' representative influencing the consultants authority position, but in practice the authority structure and decision system was not affected, which also included the consultants' everyday self-management.

Below I have constructed an organizational diagram of how the management model was expressed by around the 2000s. I start from the formally expressed management organization but I also seek to incorporate the informal management status of the collegium of consultants and the DC in general. As illustrated below, the executive administrative consultant and the head nurse possess formally the top authority position. Formally, the collegium of consultants with their collegial consensual decision-making structure is below the top managers. I have placed them "beside" the two levels in the hierarchy because informally they possess the superior authority position and power of the decision system. The head nurse is in the top authority position of the managing section of nurses, but below the consultants in the overall authority structure of the DC. In other words, the constellation of the authority position and decision system regarding administrative

responsibilities had changed towards a more formal stratified hierarchy but also a more blurred management organization, since the executive administrative consultant was a representative for the consultants, but held the position on their mandate. Regarding decision making, the executive administrative consultant made overall decisions based on the interests of the consultants and their collective discussions. The executive administrative consultant got his legitimate decision making position from the mandate of the collegium of consultants but also a mandate from the hospital administration/direction. The consultants were still self-managing in their specialties and clinics. The consultants got their legitimate authority position and decision making power through their expertise and seniority. This meant that the actual practice of the clinical work was still largely functioning as usual with the collective consensus orientated management structure and decision making. However, the specialization of the cardiology clinical work and thus the increased number of specialist doctors challenged the clinical-technical knowledge insight, togetherness, coherence and also organizational cohesion.

Figure 8 The management archetype of the 2000s



5.5. THE MANAGEMENT MODEL IN 2006

In this section I describe and present the expressed management organization of the DC around 2006. This section is based on reflections, retrospections and subsequent rationalizations from interviewed consultants and nurses about the management organization in the DC around 2006.

5.5.1. THE AUTHORITY STRUCTURE

In this section I will describe and present the expressions of the authority structure from around 2006.

In 2006 about 20 consultants were affiliated to the DC. This number illustrates the fact that the amount of consultants had increased further as a result of growth and development in the specialization of cardiology and had once again nearly doubled in size compared with the number of consultants around 2000, and compared with the outset in 1987 there are four times as many consultants. This continued development with growth in specialization and employment of consultants and doctors had a further impact on the development of the authority structure.

Interviewees expressed that the collaboration between the executive administrative consultant and the head nurse became stronger and their common management of the DC became more formalized as it was constituted, defined and framed as a "joint management team". This meant that they were formally a team externally but also internally, and the position of the head nurse was formally acknowledged as a part of the overall management of the DC. The executive administrative consultant at that point in time also engaged in closer collaboration with the head nurse on a daily basis.

However, this departmental management constellation can still be characterized as a "grey management zone" or a blurry management area of formal and informal management practice regarding who possessed the legitimate authority management position in the DC. Informally, in practice, the executive administrative consultant was perceived as a colleague among equals by the consultants, while representing the DC primarily regarding the overall administrative issues. In other words the collegium of consultants held a traditional view of the authority structure in the DC. In practice the head nurse did not possess any management position regarding the consultants in the DC as they were self-managing *per se* (based on their expertise and seniority).

The executive administrative consultant's management position around 2006 was also informally restricted in practice by the collegium of consultants to primary administrative task and responsibilities. The majority of the consultants expressed how the management tasks in practice were being divided into two main types of management responsibilities. On the one hand, there were the overall administrative responsibilities, which the joint management team were responsible for, and on the other hand there were the more clinical and research related management responsibilities which the collegium of consultants mainly took care of. The quote below illustrates how the executive administrative consultant position moved towards being an administrative position and away from being the medical clinical leader of the consultants in the collegium:

> "But the problem for the executive administrative consultant (ed.)… one can say is that the executive administrative consultant (ed.) is more a professional manager… an administrative manager, than he is a medical manager. And it is certainly a problem for him as I see it, because he does not have the medical professional respect in the department." (Consultant G, 2010).

Another relevant element in this quote is the expressed lack of medical professional respect for the executive administrative consultant. The recruitment of the executive administrative manager around 2006 was no longer a matter for the collegium of consultants to decide as it traditional has been. They were no longer in a position to determine who the DC should hire as their executive administrative consultant (representative) of the DC. Their authority position, which previously gave them power and ability to give the executive administrative consultant their mandate and respect, was taken from them managerially by the hospital management above them in the organization. This is very noteworthy because in the DC the consultants traditionally had the authority (and decision power) to recruit whom they wished, ideally internally from within their ranks, as their representative. When the executive administrative consultant was recruited by the hospital and centre level management at the AUH, the traditional authority structure that was based on the expertise and seniority of the consultants seemed to fade away or even break down regarding the recruitment practice of consultants, leaving the collegium of consultants behind. In practice the majority of the consultants questioned if the hired executive administrative consultant (2006) in practice was a representative of the consultants or the hospital management.

In summary, in 2006 the collegium of consultants still dominated the DC through their traditional collegial authority structure, despite the formalization of the joint management team and the formal stratification of the consultants' position of authority. This meant that the head nurse had gained formal management jurisdiction regarding administrative work, but in practice was still subordinate to the consultants of the DC in many aspects regarding clinical management work and partly regarding the overall administrative work, because the executive administrative consultant still in practice possessed full jurisdiction over the administrative management work. This left the head nurse to be a traditional top manager for the group of nurses, heavily involved in management discussions with the executive administrative consultant, but not the collegium of consultants. The more formalized and stratified structure also resulted in an enhancement of the cross-pressure position the executive administrative consultant increasingly had become involved in. Furthermore, the executive administrative consultant became more important for the DC regarding the administrative responsibilities. This development in the administrative work activities by the executive administrative consultants was however not as visible to doctors or other professionals in the department at that point in time.

5.5.2. THE DECISION SYSTEM

This section focuses on the decision system around 2006. The interviewees' expressions about the rationale of the system, and also how they perceived and interacted in the decision system, is examined. Lastly a focus on how the decision system operated in either a reactive or a proactive way to gain competitive advantage is described.

Regarding the rationale of the decision system around 2006, there was still an overall perception that it should be the medical professionals and no another professions or general managers who possessed the legitimate power of the decision system in the DC.

The executive administrative manager of the DC in 2006 argued that the decision making of the DC, despite the construction of the formal "joint management team", was still performed collectively in the collegium of consultants through a democratic and consensus orientated manner as it traditionally had been:

> "Everyone knew that all decisions, important decisions, management decisions, would be taken from 9 to 10 on Monday morning, in the sense that these decisions were taken in the collegium of consultants. It was, at least when I attended, articulated that, 'Here we are democratic and consensus orientated.'" (Executive Administrative Consultant, 2010).

This development in the formal and informal decision system underlines the further increase in complexity regarding the decision system. Informally, the collegium of consultants with a collective, collegial and consensus orientated approach to decision making dominated the overall decision system in the DC around 2006, especially about clinical matters, as is also illustrated in the quote above. However, this collective informal decision system became more blurry as every individual consultant *per se* formally possessed decision making power *qua* their position as "a consultant" with management skills in the DC, which meant that they could make formalized legitimate decisions in their own clinics *qua* their position as a consultant. However, it was also perceived that the executive administrative consultant did still possess a top position in the consultants' stratified decision system, especially regarding administrative issues and as a representative of clinical matters to the outside. In this regard the executive administrative consultant played the role of "chair" of the collegium of consultants on the mandate of the hospital (and centre) management, which meant that decisions regarding clinical work were made primarily by the consultants. The group of nurses still possessed their traditional hierarchy with the head nurse at the top of the decision system and department nurses at the lower department levels. This meant that the traditional professional pillar decision system still was present. However, despite the head nurse's formal engagement in the joint management team, this position did not have

much say regarding clinical decision making and even administrative decisions were primarily made by the executive administrative consultant of the DC, albeit in close collaboration with the head nurse. Hence, despite the construction of a joint management team and the professional pillar decision structure, the medical professionals still dominated the overall decision system in 2006.

Despite the increasing blurring in the decision system, it still operated in a rather proactive way around 2006, as in the years before, because the medical professionals were still in a top position where they could make favourable decisions regarding the clinical issues, especially regarding their sub-specialties. However, in 2006 their decision power had become more limited to internal decision making in the DC as the joint management team had become the formal managers of the DC, representing the DC externally. This meant that the medical professionals increasingly had to communicate with the joint management team about clinical management information that could favour the DCs position in relation to other specialties they competed with for resource allocation at hospital level.

In summary, variations as to who possessed decision power over different kinds of management tasks did develop. This meant that in 2006 three decision forums existed (both formal and informal), despite formalized initiatives. Firstly, the joint management team consisting of the executive administrative consultant and the head nurse possessed a management forum – primarily taking care of administrative decisions in relation to internal and external responsibilities, but also holding the position of chair to the collegium of consultants. Secondly, the head nurse and the ward nurses provided a management forum where nursing matters were discussed and decided. Finally, the collegium of consultants, with a collective, collegial and consensus orientated approach, possessed, as mentioned, a position that qualified them to make legitimate decisions regarding clinical matters of the DC, especially about sub-specialties. Additionally every consultant was in a position to make management decisions regarding his or her own specialty based on their professional autonomy. These decision forums reflect the stratification among the medical professionals with the executive administrative consultant and the rest of the consultants. It reflects the traditional stratification among the nurses in the DC, and a blurriness regarding management responsibility for administrative and clinical work because the formal (joint management team) and informal (collegium of consultants) decision system worked across each other, pushing, negotiating and delegating these tasks up and down in their stratified system, making the decision system more differentiated regarding the type of responsibility. The formalization of the joint management team made the consultants' dominant collective consensus orientated decision system more blurry.

5.5.3. THE INTERPRETIVE SCHEME

This section presents different expressions of what was expected and believed of what the management organization of the DC should be doing, how the management should be appropriately organized and finally how performance evaluations should be judged, around 2006.

The majority of the doctors interviewed, including the consultants, expressed the belief that the management of the department should still be a matter of professional concern. As described above, it was a value and a belief of theirs that it should be those with seniority and expertise who run the DC. In this regard it was expressed by the majority of the doctors in the DC that the executive administrative consultant, who as mentioned in the section above did not possess the consultants' mandate as their representative but had got it from the centre management and hospital management, caused difficulties in managing the DC. In the quote below a consultant describes how the consultants' resistance towards the executive administrative consultant was based on a perception that the executive administrative consultant lacked sufficient medical expertise to be qualified to be their representative or chair:

> "Well I think that the executive administrative consultant (ed.) is an excellent manager. But he has resistance in the department because medically he does not quite reach the professional level you have to perform in a certain area." (Consultant G, 2010)

This quote illustrates a recurrent value that being manager (or chair) of the DC is dependent on one's professional expertise and colleagues' (consultants) acknowledgement of one's professional work. In this case, the executive administrative consultant seems not to be recognized as a highly skilled cardiology doctor since he did not receive a mandate from the collegium of consultants regarding his management position. Both consultants and junior doctors but also nurses commit to the value about being a skilled medical professional before handling management responsibilities, which was still present in the department around 2006, as in the late 80s, as a very solid value having a deep influence on the capacity to manage this particular department.

In other words, the most desired and valued ideal of an executive administrative consultant of the DC was a consultant who would possess both high medical expertise and professional acknowledgement, but also an interest in administrative management. Furthermore, there existed a conviction or idea that the most skilled managed themselves (medical self-management) and that there were limits to what a department manager can manage. This indicates that medical professionalism goes in front of administrative management, which is reflected in the belief that a

doctor should be a medical experts before he or she could be recognized as a professional manager/representative/ chairman.

This powerful and persistent value, which reflects the doctors' maintenance of their jurisdictional area regarding the management of the administrative tasks, was not consistent with the new hiring practices where the top management of the hospital (outside the collegium of consultants) appointed to the position, and that it was not a choice among equal colleagues.

This value underlines the informal decision system of the DC, where the most skilled consultants were involved in collective and collegial decision making, with the executive administrative consultant and the head nurse taking care of the more administrative work.

In summary, the above expressed values about the consultants' position of authority versus the position of the joint management team illustrates an increasing incoherence with the embedded values of the consultants' strong authority position and decision power and the power of the formalized management of the DC.

5.5.4. THE ARCHETYPE MANAGEMENT MODEL IN 2006

In this section I construct a picture of how the management archetype was expressed and perceived around 2006.

The authority structure, the decision system and the interpretive scheme described in the above sections represents an archetype model where the coherence between the formal authority structure, thedecision system and interpretive scheme of the DC seems to become disintegrated, primarily because of the further formalization of the top department management level – the joint management team and the continuing practice of an informal legitimate authority structure and decision system supported by values and beliefs that had been present in the DC from its establishment in the late 1980s.

Formally, the executive administrative manager and the head nurse as a joint management team possessed the overall top management position in the DC which meant that they were formally placed at the top of the authority structure. They were together responsible for the decision making of the DC. This meant that the collegium of consultants, who traditionally possessed authority collectively, did not formally possess this position around 2006. However, informally, the collegium of consultants still possessed a strong authority position in the DC in their daily work, especially regarding clinical work, and they chose to get involved to a lesser extent in the administrative work. This can be explained by the fact that they primarily emphasized their clinical work but also that the executive administrative consultant now had a stronger position regarding both internal and external administrative

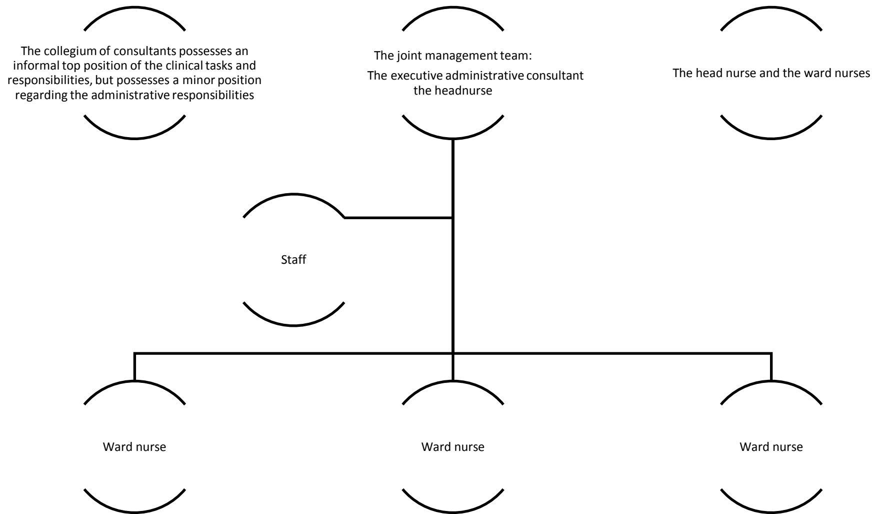
management tasks along with the role of chair and representative of the collegium. In practice the consultants possessed the power to make decisions both collectively and individually. This meant that the executive administrative consultant and the consultants were in some sort of mutual dependence because of the formal and informal management positions. In other words, the stratification among the medical professionals became more evident with the formalization of the "joint management team", influencing the consultants' collective authority position. However, overall was the authority structure and decision system was affected in an unimportant degree, which also included the consultants' everyday self-management. This also meant that the constellation with a "management team" in practice still was a close collaboration between the professions of medicine and nursing, which resulted in maintenance of the pillar structure in practice.

The argument about incoherence in the archetype management model around 2006 is based on the fact that the supported values reflected in the interpretive scheme did not support the formalized management authority structure and decision system that was formally introduced through the "joint management team" authority structure. These values, for example, did not support the head nurse as a legitimate manager of the consultants and their medical work as the head nurse did not possess the medical expertise and seniority that was valued for managing the DC. The executive administrative consultant did not fulfil the values about expertise and seniority in that kind of position either. This overall formalization of the management responsibility of the DC, which included both administrative clinical responsibilities, was not coherent with the traditional and also practised collective and consensual authority and decision-making structure of the medical professional which historically has characterized the department. This informally collective medical authority structure which was based on negotiations and collective consensus making was replaced by a more administrative hierarchical structure of authority and decision making.

Below I have constructed an organizational diagram of the how the management model was expressed around 2006. I incorporate both the formally expressed management organization and the informal management structures and decision systems. The diagram illustrates how the executive administrative consultant and the head nurse form the formalized "joint management team" which forms the top authority position. This means that, unlike before, the head nurse was more perceived as being a manager next to the executive administrative consultant regarding administrative issues, and not below him/her. However the head nurse was still not perceived as being the consultant's manager in practice, despite holding this top position. Below the head nurse are the managing nurses of each clinic or section and they refer to the head nurse in the nurses' hierarchy, but also formally to the joint management team. The head nurse also met with the ward nurses forming a management forum for issues regarding nursing. Regarding the collegium of consultants, I have placed the group beside the two levels of hierarchy

because the collegium of consultants did not possess a formal authority position, however, informally they still possessed and exercised a legitimate authority position and were also in the top of the decision system of the professionals in the DC.

Figure 9 The management archetype in 2006



5.6. THE INTENTION OF IMPLEMENTING "FUNCTIONAL PARTNERSHIPS"

In this section I describe and present the joint management team's intentions of re-organizing the management model in the DC starting in 2008.

The executive administrative consultant carried out an examination of the management issues then being experienced in the DC around 2006, interviewing almost every consultant in the DC and every nurse and bio analyst with management responsibilities. This resulted in a list of 30 management issues which was presented and discussed at strategic management meetings. The output of this examination was, according to the executive administrative consultant, knowledge about (1) lack of efficient management communication lines throughout the department, (2) lack of a formal management forum where junior doctors' opinions of the daily work may play a role as they were not involved in the collegium of consultants and their management meetings, (3) nurses' frustrations about the lack of consultants who were able to make larger and smaller decisions for a whole

section in the daily work regarding the operation. In 2008 the joint management team attempted more or less loosely to negotiate a management team constellation named “functional partnerships” or “functional friends” at lower levels in the DC than their department management level. A construction of informal management teams (functional partners) each consisting of one or more consultants depending on the sub-specialty or section and a ward nurse was created, who more or less willingly had engaged in the idea. The idea of the “functional partnerships” (FP) was primarily elaborated by the executive administrative consultant of the DC, and was primarily based on the results from the mentioned management examination in 2006 and management discussions with the head nurse during the following two years.

The purpose of the introduction of functional partnerships in 2008 was primarily to overcome the management issues mentioned above. For example, the joint management team intended to create more efficient management communication lines. They also sought to accommodate the nurses’ and junior doctors’ needs for medical management in their daily work.

For example, the head nurse expressed an awareness of the junior doctors’ lack of opportunity to discuss management decisions in the DC:

> “... the reason we do it now and do it this way, it is also a part of a generational change of the collegium of consultants, where we have been able to feel the openness for that the junior doctors partly are lacking a formal place where they can make decisions and get impact, so it is not only the ‘Brotherhood’ from 9 to 10 on Mondays. But then, where you have formal places where they can begin to position themselves as junior doctors who have some opinions that we particularly think the department could benefit of. So we also use it (the functional partnerships, ed.) for this right now.” (Head Nurse, 2010).

The joint management team also intended to create clear guidelines of economic decision making with the implementation of functional partners so the joint management team in the future would receive more appropriate details or information in relation to economic decision making. In other words, they expected that the functional partnerships could take care of a given amount of economic decision making, relieving the joint management team so they could take care of other management issues. The quote below by one of the joint management team exemplifies some experiences with the professionals’ confusion about economic decision making in their daily operations:

> “Speaking of the details you mentioned; it is also related to the FP, where we hope that the many details regarding… ‘Can I make a purchase of 1200dkr for a lamp?’ ‘We are doing budgets for…’, and so

> on and so forth. Distribute some responsibility and some power of decision and formalize it! Actually, it is the practice we have started. You won't believe the questions asked at the doorway of this office." (Head Nurse, 2010)

> "At the same time these (consultants, ed.) have just ordered something worth 4 million dkr without asking anybody for permission. So it has not been clear when to do one thing or another." (Executive Administrative Consultant 2010).

In relation to delegation of economic decision making and resource allocation the head nurse described that the department traditionally had an equitable apportionment negotiated by the collegium of consultants which was not prioritized or weighted between the specialties in terms of resource allocation. This policy for distribution was intended by the joint management team to change to an economic policy where resources were prioritized more, so that resources would be spread more as needed. They expected that it would be a challenge for the functional partnerships to negotiate with both their consultants in their specific section or specialty and with the joint management team in order to add resources to the specific section, putting them in a classical cross-pressure position as "middle managers" of the economy for each section:

> "I would say something about what I think we will be challenged by. In this department we have an equality principle and a justice principle, in which for example if (job, ed.) positions, key functions or resources are to be distributed then it is like: 'One for you and one for you...'. Well, we have had that kind of distribution. I think we will experience, because the FP will have differentiable capabilities, that new challenges with regard to the fact that some (colleagues, ed.) will be good at arguing their case to organize and get resources and be sharp on that part, while others will not get started with this. We've never discussed this, but I think we will be challenged, if we intend to preserve the equality that is given by the (principle of ,ed.) 'all will get the same and all will be happy'; well, we will be challenged here, EAC and I. Because there will be more levels (as a result of FP, ed.)" (Head Nurse, 2010)

> "I think it has already started, at least I have already verbalized it several times, that we treat all equally by treating them differently." (Executive Administrative Consultant, 2010).

Even though the joint management team believe that they need these functional partnerships to be able to make economic decisions at lower levels in the DC and also to negotiate some economic aspects for each section and take on some administrative responsibilities that were placed on the joint management before, in relation to relieving the joint management team of minor economic decisions, they

are rather ambiguous in relation to changing the whole resource allocation system, where the authority lies primarily with the joint management team and in some degree with the self-managing consultants and ward nurses. In other words, they are very ambiguous about actual delegation and decentralization of the resources and budgets to the functional partners at the lower levels in the department in practice. For example, a more vague or "long-term" description of the economic delegation appears when asking the joint management team what and how much economic decision-making power and responsibility should actually be delegated. As the quote illustrates, the joint management team had not delegated the budgets to functional partners, but they were assumed to be open to the idea in the long term.

> "…but it is clear that it is a slightly complicated matter, so to begin with we said: 'Just try to get used to the thought.' I think that it will end up with some of these decentralized budgets." (Executive Administrative Consultant, 2010).

> "I play with it when considering the ward nurses. Well, they handle their own salary budgets and follow them closely and we focus a lot on being responsible with respect to that. So in that way we are beginning to delegate things to see what happens." (Head Nurse, 2010).

They intended to get the functional partnerships to take on economic decision making responsibility. The intention was that each functional partner (FP) consultant (who did not possess more or less economic management power than his consultant colleagues) should negotiate with his colleagues in the clinic, making economic decisions for his section. But the joint management team was rather ambiguous about formally delegating economic and budget responsibility to the appointed negotiated consultants in the FP despite their suggestion. What is also interesting is that each FP possessed, as mentioned, a ward nurse and one or more consultants. The joint management expressed that these teams had shared management responsibility. This meant that the joint management, in practice, intended to give the ward nurse in the functional partnership team economic responsibility for the consultant's medical work (shared with the FP consultant). This responsibility was traditionally and historically held only by consultants with seniority and expertise.

In terms of dividing the department into fragmented specialized sections, when introducing the functional partnerships (management teams), this was not the joint management team's intention. The executive administrative consultant expressed that there was a great need for the doctors to be flexible and movable across the sections and clinics in order be able to cover the department medically across clinics but also with respect to use of resources:

> "… I would especially like to get the consultants out on the bed wards, meaning closer to the patients. The junior doctors would like that too (…) The senior consultants however think it is a waste of their time. I think that we are already very sub-specialized in cardiology, so that if a patient has diabetes then we say: 'Oh well then we will have to transfer the patient to the department of x', that am I afraid of. There we have a task ahead of us, we agree on that, but we must not let it develop in a way so that in the area of cardiology a consultant cannot take care of a x-patient or that the consultants cannot help a junior doctor. We are extremely flexible. Sometimes we will receive thirteen emergency cases in a given sub-specialty and none in another. Then, no matter what, we will have to be able to be flexible..." (Executive Administrative Consultant, 2010)

Regarding the naming of the "teams" with delegated responsibility, the joint management team considered the functional partnership at 2008 as a management teams, however they labelled them as "functional partners" as a strategy initiative in order not to scare the consultants by naming them managers in "management teams", with management concepts and terms. However, it is noteworthy that the joint management still expected that the FP would possess management responsibility and action:

> "It is not like we are going to give ranks to you; we are expecting you to engage in the FP and make it work functionally, so that we get some good solutions as close to the patients as possible." (Executive Administrative Consultant, 2010)

The intention of labelling the team as "functional friends" or "partnerships" was a strategic move from the joint management team in order to get the consultant to accept the teams as their own representatives or functional friends who should take care of managerial operational issues in the operation.

In summary, the idea of "functional partnerships" was primarily elaborated by the executive administrative consultant in close collaboration with the head nurse. The idea of these interdisciplinary teams at lower levels in the DC was to overcome issues such as lack of efficient management communication lines throughout the DC, lack of formalized management forums for junior doctors and nurses, and the nurses' frustrations about lack of consultants' presence regarding daily administrative and medical decision making. Furthermore the idea was also that the functional partnerships should deal with economic decision making. Finally, the joint management state that the idea of creating these interdisciplinary teams was not to sectionalize the department, because there was a great need for doctors to be movable and flexible across the DC in order to cover the DC medically.

5.7. SUMMARY

In this chapter, I have described the development of the management model of the DCs management organization, and the joint management team's intention of a re-organization of the management model in the DC in 2008.

The described *outset* for the intended management changes was an archetype template from the end of the 2000s, in which the executive administrative manager and the head nurse as a joint management team formally possessed the overall top management position in the DC, which meant that they were formally placed at the top of the authority structure and decision system. However, informally the collegium of consultants still possessed a strong and dominant position of authority over the DC, especially in the clinics and in the daily operation. In practice the consultants possessed power to make decisions both collectively and individually. This meant that the executive administrative consultant and the consultants were in some sort of mutual dependence because of the formal and informal management positions. In other words, internal stratification among the medical professionals became more evident with the stronger and formalized collaboration of the "joint management team", influencing the consultants' collective authority position. Furthermore the traditional pillar management structure between the medical profession and the profession of nurses was still present despite the "joint management" construction. This meant that the consultants were in practice still the dominating profession in the DC by the end of the 2000s. The increasing formalization of the top management in the DC and the internal medical stratification of the management responsibility of the DC, which included both administrative and clinical responsibilities, meant that the coherence between this authority structure and decision system and the practised values and beliefs about the collective and consensual authority structure and the decision system of the medical professionals which historically characterized the department, became increasingly disintegrated and incoherent. The joint management team's intention of a re-organization of the management model was based on managerial issues experienced in the DC. In collaboration with the head nurse, the executive administrative consultant elaborated the idea of interdisciplinary management teams called "functional partnerships" at lower levels in the DC. The purpose was, amongst other things, to overcome issues such as lack of efficient management communication lines throughout the DC, lack of formalized management forums for junior doctors and nurses, and lack of consultants' presence regarding daily administrative and medical decision making in the operation.

CHAPTER 6. REACTIONS TO MANAGEMENT CHANGE

In this chapter I describe and explain how the joint management team, the consultants and the ward nurses involved in the newly introduced management teams, and the consultants and nurses who were not involved in management, reacted to the management change in the DC from spring 2010 to spring 2013.

First I describe how the process of change of the management model with "functional partnerships" was more "formally"[18] implemented in 2010 in the DC compared with the joint management team's more loose approach to the functional partnerships in 2008. Then I describe how the recruitment process of the functional partnerships in the DC was perceived by the professionals. Then I describe how the joint management team, the consultants and ward nurses involved in the "functional partnerships" and the consultants and nurses who were not involved in these management teams have perceived the management idea and the initiation of the process.

Thereafter I describe and explain how the joint management team, the consultants and ward nurses involved in the section management teams, and the consultants and nurses who were not involved in section management teams, perceived and adapted the functional partnerships in 2010. In this regard I draw on the components of the precipitating and enabling dynamics (interest, value-commitment, power dependencies and capacity for action). Then I construct how the management archetype (structure, system and interpretive scheme) unfolded in 2010 after the consultants and ward nurses adapted and negotiated the functional partnerships.

In 2013 the functional partnerships had changed name to "section management teams", and decreased in number from eight functional partnerships to four section management teams. First, I describe how the process of change of the management model with "section management" teams was implemented in 2012 and 2013, including some of the professionals' perceptions of the management change process. Then I describe how the process of recruitment of the section management teams in the DC was perceived by the professionals.

I then describe and explain how the joint management team, the consultants and ward nurses involved in the section management teams, and the consultants and

[18] By formally, the FP as an additional management layer was not acknowledged by the hospital management, centre management or the Medical Association. However, it was articulated through the process as a formalization of the management model in the DC in line with the joint management team and the each consultant's management responsibilities.

nurses who were not involved in section management teams, perceived and adapted the section management teams in 2013. Again, I draw on the components of precipitating and enabling dynamics (interest, value-commitment, power dependencies and capacity for action). Then I construct how the management archetype (structure, system and interpretive scheme) unfolded in 2013 after the consultants and ward nurses adapted and negotiated the section management teams.

6.1. THE PROCESS

In this section I describe how the process of recruitment of the functional partnerships in the DC was perceived by the professionals. Then I describe the professionals' expressed views of a more formalized initiating management change process of the functional partnerships in the DC in 2010, including the process-related initiatives and activities the joint management team had performed from spring 2010.

The process of implementation of eight formalized functional partnerships began formally in April 2010. Both the hospital top management and the centre management level at AUH supported the initiative to re-organize the DC management and furthermore they supported the DC in conducting the management change process by itself. The implementation of the functional partnerships was characterized by no systematic or fixed meeting rhythm between the joint management team and the functional partnerships. Neither was there a scheduled meeting rhythm across the eight functional partnership teams. Two "roll-out" meetings were held, where all the professionals with different kinds of management responsibilities were invited. Those who attended were the newly constructed functional partnerships, the rest of the consultants, the ward nurses, the chief secretary and the managing senior laboratory technicians (and later, also the consultants and ward nurses from another cardiology department which was merged with the DC in 2011). Approximately 30–40 people attended these strategic meetings. The amount of invited professionals with management functions illustrates the developed spread of management positions in the DC, including the fact that the pillar structure was still functioning; the collegium of consultants, the joint management team, the newly appointed functional partnership management teams and the ward nurses. All the mentioned professionals had management positions, functions or responsibilities of various kinds. As noticed by a member of a functional partnership in the quote below the consultants attended the management meetings, despite the formal stratification of their management authority structure, which illustrates that the consultants in the DC still possessed a strong position of authority:

> "Actually it is such that all the consultants participate at the functional meetings. They are actually functional managers in one way or another

> even though they don't have a functional partnership with a nurse."(FP, Consultant B, 2010)

The functional partnership members acknowledge that the consultants in the DC still possessed a strong authority regarding management issues, as the joint management team legitimated the consultants' attendance at the management meetings in the DC. Because of the number of participating professionals with management functions, the meetings gained the character of being information meetings or briefings of the idea and intention of the eight functional partnerships. However, the joint management did express that their intention was in the long term to create forums where the managers were able to discuss management issues as they traditionally have been doing in the collegium of consultants. It was paradoxical to invite all these professionals with different management responsibilities and functions, since the intention of the functional partnerships was to reduce the amount of professionals who participated in the management decision making. The functional partnerships were intended to function like a "link" or "place" or team with whom the joint management team could corresponded and discuss issues and matters related to the daily operation, but also overall plans, without burdening the rest of the consultants and ward nurses. As I have explained in the section above, the consultants did still possess a legitimate authority position and decision power, as did the ward nurses in the daily operation of the DC. This may be an explanation for why the invited professionals participated in the "roll out" meetings. The joint management team did not seem to do without them in management decisions, including those regarding the functional partnerships' management work, despite the intention of making an upper level of management.

The joint management team furthermore wrote a strategic management paper[19] which described the basis of the strategic management in the DC and especially what management areas the functional partnerships should take care of and be a part of. Specifically, the stage was set for the functional partnerships to take the overall responsibility for the professional clinical management, strategic management, personnel and administrative management, and research management in each "unit" or "function" (Management Strategy of the Department of Cardiology, 2010). However, in practice the joint management team wished the functional partnerships to negotiate their management responsibilities with the other "managers", i.e. the consultants who possessed legitimate authority positions in each unit. This approach to the implementation process was also described in the strategic management paper.

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[19] Throughout that period (2010–2013), the management strategy paper was developed with point of departure in the AUH's vision and value formulations, in relation to the discussions that took place among the involved professionals about the department's management structure and responsibilities. In 2013 it had the character of an end-result of the process so far.

6.1.1. THE RECRUITMENT OF FUNCTIONAL PARTNERS

In this section I will describe how the process of recruitment of the functional partners in the DC was perceived by the professionals.

On the one side, the consultants in the functional partnership teams were "asked" or chosen by the joint management team (primarily the executive administrative consultant). On the other side, the consultant in each functional partnership was also "chosen" or "pointed out" through a collective consensus-orientated negotiation which took place in each sub-unit or specialty among the consultants associated with these units and specialties. In other words these consultants gave the consultants chosen to take part in the functional partnerships their mandate to manage, as the quote below illustrates:

> "Yes, indirectly I was assigned to it. We had to decide internally in our group who we would assign to it." (FP, Consultant F, 2010)

The next quote illustrates how it was also more or less voluntary for the consultant to take part in the functional partnership:

> "...people weren't elected in that sense, people spoke up if they were interested, and some chose it to avoid others having it assigned (to them, ed.). That is how it is sometimes, and in these places it might have complications." (Consultant G, 2010)

On the one side, there was a desire for the functional partnership position (a management position) to be held by a consultant with seniority and expertise, which is a strong value that traditionally has been desired in the leadership of the DC, see above. On the other side, the negotiations about the functional partnership positions reflect that it was difficult because the majority of the senior consultants were not interested in an additional layer of management and in this relation they did not intend to engage too much in the functional partnership work of the sub-units. This resulted in some of the younger consultants being "chosen" or pushed and "paradoxically" also given a mandate to manage by their colleagues. As a consultant in a functional partnership expressed:

> "If I could choose freely, I would have waited because I feel like the transition from being a junior doctor in the department to becoming a consultant in the department is a big task; finding my own legs and filling out that role is quite difficult I find. If in addition one has to shoulder the administrative responsibility – I think that is a big task, but that is how it is." (FP, Consultant F, 2010)

The joint management team in interviews described how the consultants in the different sub-units reacted differently in the process of recruitment of the functional

partnership consultant. The executive administrative consultant experienced how some of the units just looked for whoever wished to take on the FP position, while in other units there tough negotiations.

The selection process of the functional partnership consultants was overall characterized by negotiations among those with management capacity (decision power) in the DC, which were primarily the joint management team and the consultants. What is noteworthy is that this recruitment process was carried out in a very similar way to the recruitment of the former administrative consultants. The recruitment was characterized by negotiations and a collective consensus orientated process among the consultants. For example, the consultants negotiated at sub-unit-level and decided to give “the chosen” consultant their mandate as the sub-unit’s representative or spokesman in relation to the management work with the joint management team. Furthermore, it was expressed that it was easier to negotiate in some units because it was more unambiguous who should possess the functional partnership position than in other units, where among the consultants there was interest and positioning regarding the “management position” of the sub-unit. The selection of nurses to functional partnerships was performed through the traditional management hierarchy of the nursing profession. In other words the head nurse and partly the executive administrative consultant selected the nurses involved. The data material does not reflect that the nurses were involved in the recruitment process of either nurses or consultants’ to positions in functional partnerships.

In summary, the recruitment process of consultants to the eight functional partnerships was a mixed affair. On the one hand, the joint management team (especially the executive administrative consultant) of the DC selected and pointed out the consultants deemed “suitable”, and it was primarily younger consultants with less expertise and seniority but with an interest in management. Conversely, the consultants generally legitimized “their” “elected” functional partnership consultants as representatives of the various sub-units through collective negotiations in the sub-units. The process of recruitment of the nurses to functional partnership positions was much clearer since it was primarily the former ward nurses who were appointed by the head nurse. In other words, these positions were not negotiated as such among the nurses, which reflects a traditional recruitment process among nurses regarding management positions.

6.1.2. THE PROFESSIONALS’ PERSPECTIVES

In this section I will describe the professionals’ expressed perceptions and experiences regarding the process of change of the management organization and the functional partnerships in the DC in 2010.

6.1.2.1 The functional partners

In this section I will describe the functional partners' expressed perceptions and experiences regarding the process of change of the management organization and the functional partnerships in the DC in 2010.

As described above, the joint management team considered that the functional partnerships should try to sort out which kinds of management tasks and responsibilities the functional partnerships should be responsible for in collaboration with the joint management team and their colleagues. However, the nurses and consultants involved were very confused about what the functional partnerships position would entail and what the limits of the boundaries for their responsibility areas were in practice, as it was not clear to them what the joint management team had delegated and what the consultants delegated of their responsibilities. Is the management responsibility based on the clinical work or does it have a more administrative character? The quote below illustrates how a functional partner nurse is in doubt about where the boundaries or limits are for the management work in the functional partnerships:

> "I don't think we have come very far to have so many expectations. I certainly haven't, because we still need to figure out where we are all standing, and figure it out on a piece of paper – what do we think about it? We haven't been over and had a clarifying talk with the head nurse and the executive administrative consultant. What do they really mean with those really nice words (…). At any rate, I can feel it, because after all it has become a little more specific, but there are still some things up for discussion, and what that really is…." (FP, Nurse E, 2010).

The majority of the functional partners wanted the joint management to be more specific about the management responsibilities of the functional partnerships and their boundaries, as illustrated in the quote below:

> "… we have to ask the executive administrative consultant and the head nurse (ed.) to specify (…) about what they have formulated about the functional partnerships (…) because I, for example, can't decide anything about timetabling, or at least I can't imagine I can for the doctors." (FP, Consultant F, 2010).

They argue that it is unclear how they should "take charge" or in other words achieve their authoritative position when the joint management team seems vague in the definition thereof, as illustrated in the quote below:

> "… I believe I'm a bit more Stalinist in my head. Well I sometimes wish that the joint management would express some of their positions a little

> more clearly. I think it's so cliché that we have to… I wish that there was a sort of overall and more precise attitudes... that 'that's the way it has to be, and you just have to convey that within this and that frame in the single wards and units, but we do have a superior'. And there they say, they are definitely going to say that, it has been announced, but to me it's not very clear, and I could imagine that if I wanted more of an alpha elephant way of management, that 'this is the plan, this is what we want'. I'm not sure it is what I wanted, if that was the way it was." (FP, Consultant F, 2010).

The last line in the quote indicates that the management space between the consultants and the executive administrative consultant in relation to the management decisions is a "grey zone". There is an awareness that the functional partnerships should be developed in cooperation with the consultants of greater seniority and expertise. It is acknowledged by the consultants in the functional partnerships that the DC cannot implement the functional partnerships without the other consultants' views and perspectives about what kind of tasks the functional partnerships should be "allowed" to manage. The values of "colleagues as equals" and making decisions collectively and consensus orientated is then still reflected in the functional partnerships and their sub-units. This means that each consultant possesses legitimate power to decide and define management issues.

As long as the formal joint management team is predominantly considered as representative of the collegium of consultants and furthermore suffers from lack of professional recognition, it is unclear to the functional partnerships from which "top authority position" their mandate will or could be delegated. The functional partnerships' authority's position is not just "taken" by the individual consultants, but a "wall" of colleagues with the same decision-making powers and definition powers are still entitled to recognize and solve problems. It is a double-edged sword. This creates a desire for clearer communication of the delegation of the mandate to the functional partnerships:

> "A bit more like, good, like, the way I would like politicians to have a damn opinion and speak it out, you can't just tell us to respond, you have to say what it is, that we shouldn't do. Come with a qualified set of priorities already, it might be ugly, but you have to say it out loud. You can't just say, that we have to find some money, so you must have an attitude towards it, and for that I might like a bit more edge about it, but it's not sure it would last." (FP, Consultant, 2010).

The quote also illustrates that the decision power of the joint management team, especially the executive administrative consultant is perceived as diffuse by the consultants, despite their top authority position in the DC. An explanation could be that the values about the decision system still support the prevailing archetype

template where the decision system was characterized by collective and collegial negotiations, which means that the executive administrative consultant is dependent on consultant colleagues being involved and participating in the development process of the concept. In other words, the executive administrative consultant lacks the ability to set the overall agenda for the functional partnerships process due to the culture of collective decision making system.

Another area of ambiguity in the process is the difference in how much time the functional partners will have to take care of their management responsibilities. The nurses are fully employed in taking care of management tasks but the consultants are primarily employed to treat patients, as outlined by a functional partnership consultant in the quote below:

> "And you might say that it's something of a schism, that the ward nurse really is hired to lead, divide and organize and be an administrator. We aren't (consultants, ed.). We're hired based on (…) that we should treat patients, and then we have to do the rest on the side." (FP, Consultant F, 2010).

Some of the functional partnerships consultants express that it is not clear in the process who should delegate to the consultants the time to take care of the functional partnership responsibilities. It is primarily perceived by the functional partnership consultants to be their own "problem" to negotiate their management time and acceptance among their colleagues, as illustrated in the quote below:

> "Well yes I actually think, that my nearest colleagues are going to. Well, we're about seven or nine doctors, and our work organization is the way, that we have to our clinical work, and then there's really nobody keeping notes on how many we are. We just have to do the job, but we have a lot of moral extra activities, we do a lot outside; advise the national health service, teach students (…) We go and do presentations at conferences, so you really have to, in your own little group of colleagues, have some acceptance of, that this is a thing, which also takes time, so you kind of have to put it into our jigsaw, when we have to divide our time. (…). Fine, I invent a day more, a week?" (FP, Consultant F, 2010).

This indicates that it is the consultant colleagues in the sub-units who possess the ability to decide and negotiate with the functional partnership consultant about the time spent on the functional partnership management work versus the time spent on clinical work, which presses the involved consultant. When status and power are closely linked to clinical work, is it very hard for the functional partnerships to negotiate and justify time used on management task, even to themselves.

6.1.2.2 The consultants

In this section I will describe the consultants' expressed perceptions and experiences regarding the process of change of the management organization and the functional partnerships in the DC in 2010.

Consultants without functional partnership responsibilities express that they have been involved or informed in initiating the implementation process based on a strategic management paper and the strategic management meetings, as illustrated in the quote below:

> "I think I have to be fair and say that in relation to the consultant group it has been an open process. Nothing was concealed. No secret has been made of what the purpose of it was. It has actually not been concealed why it had to be done now. The size of the department made it necessary in some way. It was just not possible with one joint management team anymore because of the limits of what one or two persons can manage. Therefore, you have to delegate some things, that is what has happened, and I think it is fair enough. Whether or not it works is a matter of personal taste." (Consultant G, 2010)

However, there has not been a traditional collective and consensus agreement in the collegium of consultants in the DC about implementing "functional partnerships". All the interviewed consultants recalled that the idea of "functional partnerships" or "functional friends" was elaborated by the executive administrative consultant in cooperation with the head nurse, which indicates that the preparation of idea was a closed process. The quote below illustrates a consultant's perception of why the executive administrative consultant wanted to implement functional partnerships in the DC:

> "I think it came from the executive administrative consultant (ed). He also says that he invented 'it'. So that it is something he has introduced to the department. It is something he would like to have – the partnerships. I think they (the joint management team, ed.) would like it, so there is a 'place' you can turn to. So if there is a problem in a department/section/clinic – it might be a nursing thing or a medical thing, but then there is a place you can turn to and say 'You two!' (a consultant and a nurse ed.) – 'You must try to see if you can come up with solutions together.' Before, you could say that if there was a consultant assigned to a department, and if there was a medical problem, who could you then turn to? There are many specialties assigned to one part of the department. I think the idea is to get some consensus, and then there are some who can lead it into practice together. I think that is the idea of it." (FP, Consultant B, 2010).

The majority of the interviewed consultants had experienced this “declared” need or interest for a “specific” selected consultant who possessed the management responsibility to make decisions about medical problems in the daily operation, amongst the junior doctors and nurses.

6.1.2.3 The junior doctors and nurses

In this section I will describe the perceptions and experiences of junior doctors and nurses regarding the process of change of the management organization and the functional partnerships in the DC in 2010.

The majority of the junior doctors and nurses expressed that the implementation process was a completely closed process, as illustrated by a quote from a junior doctor below:

> “Well, for us junior doctors it has been a completely closed process. I do not believe we have got a share at any level. Well, we are not asked. In general the management on this department do not approach us about anything at all.” (Junior doctors I, 2010).

The knowledge of the junior doctors and nurses about the functional partnerships and the intended formalization of them was very limited. A few of the junior doctors and nurses had experienced an orientation about the process of management change at an *ad hoc* nurse meeting led by a ward nurse.

6.1.2.4 The joint management team

In this section I will describe the perceptions and experiences of the joint management team regarding the process of change of the management organization and the functional partnerships in the DC in 2010.

Regarding the ambiguity about who possessed the authority and management responsibility at different levels in the authority structure and the lack of clarity in the differentiation of management tasks, the head nurse acknowledged that the joint management team had a future challenge in defining what the intention of the functional partnerships is, what their mission is and where the management boundaries are in relation to both the joint management team and the consultants with management responsibility, as they are aware that the professionals are uncertain about the responsibilities and their boundaries:

> “That’s where I think, that we still have a job to do, defining what this is. Making it visible for our functional partners and, not least, the ones around them so we can put up some boundaries. I think they have an idea about it. I know I can feel it in the ward nurse group, that they are

> interested and curious, they want to take advantage of the benefits of it – but they are still insecure about, what kind of size this is (…) they are open and expectant.” (Head Nurse, 2010).

The quote below illustrates that the joint management team have realized in some degree that it is a challenge for them to be able to proceed with the development of the functional partnerships and that it is something that needs to be supported even more in order to avoid dysfunctions and alliances. Furthermore the head nurse also expressed uncertainty about how clear they have been in communicating the message of the functional partnerships in the DC.

> “… even though we have had a lot of dialogue with each other, and it’s clear in our minds (…) I can still have my reflections about how clear we managed to be in the bigger picture. I still think we have a job there.” (Head Nurse, 2010).

In terms of communicating clearly to the DC, the executive administrative consultant explained that the joint management team had formulated the strategy management paper about the intention of the functional partnerships in order to make it clear what the intention was in setting them up.

In summary, the joint management team are aware that they have chosen a strategic *ad hoc* approach to implementing the functional partnerships, however, they also acknowledge that they had a challenge in defining the concept and their intentions in 2010.

6.1.2.5 Summary

In summary, the majority of the functional partners, consultants, junior doctors and nurses found that initiating the implementation process was a relatively closed process, and only the professionals involved in management had been informed and partly involved. It made the process rather ambiguous regarding what kind of responsibilities the joint management team has delegated in practice, the boundaries of those responsibilities, who in practice should delegate those responsibilities, and how much time the functional partners should dedicate to the responsibilities, despite the formulation of the strategic management paper. The joint management team was aware of some of these issues in 2010.

6.1.3. SUMMARY

In summary, the idea of implementing an additional formal layer of management in the form of functional partnership teams was perceived as initiated, elaborated and decided in a closed process by the executive administrative consultant and head nurse. Hence this profound decision was made without the involvement of

consultants, which was an unusual move considering how decisions traditionally have been made by the consultants through collective negotiation and consensus making. Regarding the process of recruitment of the eight consultants to the functional partnerships, it was a mixed affair. On the one hand, the joint management team of the DC selected and appointed the consultants they found "suitable", who were primarily younger consultants with less expertise and seniority but with an interest in management. Conversely, the consultants in the DC generally legitimized "their" "elected" functional partnership consultants as the various sub-units' representatives through collective negotiations in the sub-units. The process of recruitment of the nurses to functional partnership positions was much clearer since it was primarily the former ward nurses who were appointed by the head nurse. The subsequent change process in 2010 was characterized by limited information about the purpose, content and further strategy of the functional partnerships. Af ew strategic meetings were held in 2010 for those involved in the management process, and the process and content was intended to be defined by those consultants and nurses who were involved in the functional partnership teams in collaboration with the joint management team but also other professionals with management responsibilities such as other ward nurses and consultants. The professionals found it rather ambiguous what kind of responsibilities they were delegated, the boundaries of the management responsibilities, who should delegate those responsibilities and how much time the functional partners should dedicate to the responsibilities, despite the formulated the strategic management paper. The process was intended to be more or less carried out *ad hoc*. The joint management team, moreover, removed its focus from the implementation process in 2011, even though the functional partnership teams continued to function (at least on the paper), as the DC became involved in a fusion process with another cardiology department due to a larger process of change to the AUH organization.

6.2. REACTIONS TO FUNCTIONAL PARTNERSHIPS

In this section I describe and explain how the professionals in the DC reacted to the management changes in 2010. More specifically, I describe and explain how the functional partners, consultants, junior doctors and nurses perceived their interest and value commitments in the functional partnerships in 2010. Then I describe and explain how the joint management team, the functional partners, the consultants, the junior doctors and the nurses perceived their capacity for action and how the power dependencies unfolded in relation to the functional partnerships in 2010.

6.2.1. INTEREST AND VALUE COMMITMENT

In this section I describe and explain how the functional partners, the consultants, the junior doctors and the nurses express their interest and value commitment to the management model with functional partnerships in 2010.

6.2.1.1 The consultants

In this section the views of the consultants are described and explained. The consultants' perceptions of and expressions about the functional partnerships are hesitant and cautious, as I will reveal below.

The majority of the consultants interviewed were not specifically interested in the idea or concept of functional partnerships in 2010, however, their attitudes towards the idea varied. Some rejected the idea and others were more understanding. For example, some of the consultants perceived the functional partners as a "necessary evil" on the grounds that it was necessary for the executive administrative consultant to initiate this process of management change because the consultants did not respect and acknowledge the formal authority of the executive administrative consultant. This was due to his apparent lack of sufficient medical expertise and seniority to manage the DC, as is illustrated in the quote below:

> "In my opinion, a weak executive administrative consultant is also a cause. A weak executive administrative consultant without a proper medical foundation. Therefore, he has to delegate, because he does not know what is going on and it is different from when the previous administrative consultants were around, with clinical expertise to cover all areas and their medical qualification were higher. In a way, he was forced to... We made him... bring someone to every meeting who had the right field of clinical expertise and in a way we clipped him. Consequently, it is natural therefore to decentralize the management when you cannot be responsible for the clinical content." (Consultant J, 2010).

The quote also illustrates how "clinical expertise and management go hand in hand" as a strong value and norm in the DC. Another dismissive perception from some of the consultants, especially some senior consultants, was that there is no point in delegating some of the management tasks to functional partnerships as it would damage the innovative clinical dynamics in the DC:

> "An additional management layer in a hierarchic structure… By this I mean if you go through with it as intended, that you have to have powerful FPs who have to have a strong hold on their consultant colleagues which they are FPs for, and that would be an extremely demotivating factor in a system which we perceive as a prima donna management system. Where people have to be innovative and be just a little bit anarchistic and not just stand in a single file, because if they stand in single file they stop working longer and being innovative and researching and being motivated." (Consultant J, 2010).

Instead those consultants expressed support and loyalty for the traditional prevailing template of management in the DC, characterized by collective and collegial consensus orientated decision making and consultants' individual authority position and where values such as "freedom with responsibilities" dominated the authority structure and decision system. The consultants regard their "freedom" as a driver for clinical innovation, which indicates that innovation and motivation are closely linked for them. The energy or motivation that drives the clinical innovation process originates from the consultants' own ability to take initiatives and be innovative, according to the senior consultants. This makes the consultants unwilling to lose their authority position and power to manage and be able take their own initiatives, as it is perceived that the initiatives that grow from the bottom of the department from motivated consultants make the DC the innovative department that it is:

> "Imagine if you chose to do so (FP ed.), that you said, that you had a professor and some consultants responsible for research (e.g. FP, red) in the separate units, who control and decide what's going on, that would kill any initiative in this unit. So it (the innovation, ed.) thrives when the grassroots are busy with activities. Often in cooperation with each other, and often in a way that the professor and others have a view over what's going on. The initiatives are very decentralized, and the research dies if there isn't continuing decentralized initiatives too." (Consultant J, 2010).

On this basis some of the consultants did not acknowledge the new formal management layer below the joint management team level. They framed their "management responsibilities" among each other as collective coordination and delegation between equals. They did not understand what they needed a functional partnership team for:

> "Well what do you want me to say? Organization of the daily work. Get things adjusted. Get them tuned. A lot of issues I see aren't problems management wise, in some way. I don't see it as management issues. It's a job we all have to find out and coordinate it with each other. And as such I'm not going to go on about it, I don't see it as a management issue, but it's clear, that if all of a sudden you find yourself in a situation where you can see that, despite the high amount of tuning you have done, a problem of quality or capacity or something else persists, then you would of course take it to the joint management team, or I might go to the medical chief of the hospital (ed.) with it." (Consultant J, 2010).

They believe that the prevailing management template or, in other words, the traditional collective and collegial authority structure among consultants, is an advantage for the DC because it creates cohesion and fighting spirit but also an understanding of each clinical sub-specialty. Their scepticism about the functional

partnership idea reflects a value commitment that the traditional collectively and consensus orientated organization of management in the DC should be the most appropriate way to organize the management structure in the DC in order to survive as a consistent and coherent department and thereby contribute to an innovative cardiology research department. as expressed by a consultant:

> "… it's all falling apart right now. Now there's an expressed balkanization, meaning you defend your own interests, and you don't care at all what the others do, and there's very little going across just to help. The junior doctors are getting thrown around the different groups, but the consultants who have some function described in the functional management system, they say that it's my responsibility, and the rest doesn't matter to me, others will have to take care of that. So I'm not a big fan of it." (Consultant J, 2010).

Furthermore, the functional partnership construction may make it easier to manage each unit, but it also encourages strategic thinking among the different units, threatening the holistic performance. It is not evident whether it is the increasing specialization in the DC that creates the perceived strategic sub-unit thinking or "balkanization", or whether it is the establishment of the functional partnerships in themselves. As expressed in the analysis below the functional partnerships still do not function as intended, which perhaps means that the strategic thinking is a trend that already characterized the DC in advance, but was enhanced by the structure of the functional partnerships, which however, intends to bringing the DC together through establishment of interdisciplinary sharing of knowledge.

The creation of a more stratified authority structure with two levels of "formal" management was not a strategy some of the senior consultants were interested in or supported, manifested by their hesitant value commitment to the functional partnerships. The quote below illustrates that the consultants possessed a strong value commitment to the traditional prevailing management template, or in other words they express loyalty to the norms and principles that support the collective collegial authority structure and collective consensus orientated decision system, where decisions are taken based on the value of "colleagues as equals", as described in the sections above:

> "I really think that there is a high amount of decentralization (…) in the decision (making, ed.). I actually think that, it's the really big advantage for maintaining motivation and job satisfaction. And there is no doubt about that, here in the department, (…) it has also been like this through the years, that there have been consultants here, who have worked an awful lot, well much of it has also been without getting paid for it, and that requires job satisfaction and motivation in order to do so. I think that there is a chance that it might be lost, if you're being rejected from

> most of the important decisions that are made. Well the downside to having a sort of anarchistic system, is of course, that it can be very hard to get control of things and keep an overview, report back and such." (Consultant K, 2010).

They perceive that they are included in an obligating collegial "community" where each consultant is their own manager. It is described by the consultants as a state of anarchy, which can be interpreted as an absence of a ruler or common manager – the executive administrative consultant. In other words, the consultants' self-perception is that each consultant should have the opportunity to develop self-organized, self-managed and mostly free clinics. However, despite this belief, the consultants express a concern for preserving the common overview and management communication in a department as the DC is characterized by growth. Furthermore, some of the consultants assess the construction of the functional partnership as a disadvantage, as they argue that the construction of the functional partnership makes one less able to gain insight into information about management issues and problems in the DC. Insight into what was happening had previously resulted in a closer commitment across the sub-specialties and colleagues, and if they are left out of this information some of the consultants fear that their job satisfaction and motivation will decrease. Motivation is what has strongly contributed to the success of the DC, according to the consultants.

In this regard, it is noticeable that some consultants perceive that the introduction of functional partnerships will hinder the way the collective understanding of decision making is performed in the DC and there is a concern that the construction of the functional partnerships (with responsibility for each sub-unit) will contribute to splitting up the department and thereby cause further lack of insight, perspective and understanding of each other's clinical but also managerial dilemmas, even across the organization and thereby triggering an inappropriate degree of strategic thinking, making the DC more fragile.

Despite these critical and unconvinced perceptions of the construction of the functional partnerships, however, there may also be traced a certain understanding of the need for the establishment of the functional partnerships among other consultants in the group. They perceive the potential in implementing the functional partnerships. Awareness of the DC's increasing growth has made more of them more open to an alternative template that it may be necessary to implement, as illustrated in the quote below:

> "So in a way the collegium of consultants performed a collective management of the department, and I think that was working really well, back when the department was five consultants, but now the ward is 25 consultants, and it might be hard to reach consensus in the management, so you might have to delegate a little." (FP, Consultant F, 2010).

Those consultants address the issue of the difficulties in collective decision making and connectedness in the collegium of consultants based on the increasing amount of specialties and consultants. It is argued that the collegium of consultants had become too big to perform the traditional purpose, namely, as a forum for collective negotiating and decision making, including delegation of responsibilities, as illustrated in the quotes below:

> "We grow a lot; we're a huge department, so it's happened over many years. For all the time I've been here, we have grown and grown and grown and grown. And the recognition that we are no longer able to make all the decisions as a collective might have been slow, but we have to accept that some have to be delegated, and I think it's a natural consequence, that's the way it has to be." (FP, Consultant F, 2010).

Re-negotiations of decisions already made collectively began over time to become an issue, which reflects the consultants' individual authority position in the negotiating process:

> "What I think was hard back then that could be to either get a decision about, what we are going to do, or what aren't we going to do, and then it could be hard to get what we agreed to sanction. Don't you come running on Monday and say that we're just going to change it because I have a different opinion. I think that was a problem." (FP, Consultant F, 2010).

Some of the consultants expressed that how the responsibilities in general are delegated was not so well defined anymore. Over time, lack of transparency and openness had begun to characterize the negotiations and delegations in the decision system compared with the earlier management organization. Lack of transparency and openness amongst the consultants, especially amongst younger colleagues, who did not have the historical knowledge of the department in the decision making process in the collegium, led some of the consultants to agree that it would be preferable to create more unambiguous management positions:

> "Yes I think it can be a benefit, that the organization might be more visible, that you know who is the manager. I think that was some of the things that the employees asked for, that it was sometimes a little hard to find out, who was actually in charge of the thing you were going to contact. I might be able to see that, because (…) if you followed the entire historical development, then you know who is in charge of the various things, but you might not know the same way, if you have only been here for a couple of years, and as a nurse, for example. So I think, that was what got me to see the benefit." (Consultant K, 2010).

In summary, the majority of the interviewed consultants were not specifically interested in the idea or concept of functional partnerships in 2010, however, their attitudes towards the idea varied. The most skilled and experienced consultants were more reluctant about functional partnerships, but some consultants were more understanding.

6.2.1.2 The junior doctors

In this section I describe and explain how the junior doctors expressed their interest and value commitment to the management model with functional partnerships in 2010.

The junior doctors expressed interest in the concept of a visible functional partner consultant in the daily operations who possessed specific management responsibilities for a specific unit, as illustrated in the quote below:

> "I have missed someone wanting to assume a management role in the units (ed.) so you had someone to keep an open dialogue with concerning present problems. I have missed it a lot." (Junior doctor, 2010)

The junior doctors expressed that they find it an advantage to get increasing medical management attention through the functional partnerships in the daily operation of, for example, the bed wards and in the out-patient clinic, because the medical presence is often represented by junior doctors in those sections. The junior doctors expressed that they were not consulted regarding their working processes (e.g. their routines, structures, principles, systematization, rationalization), despite the fact that it is primarily the junior doctors who are responsible for the daily work, as illustrated in the quote below:

> "... this department is very special compared with other departments because the attendance out in the 'field' (so to speak ed.) is relatively low (…) (for the, ed.) consultants. That means that, as a junior doctor, even though great efforts are made, you don't have a say in the work processes, contrary to the fact that the junior doctors are the ones getting their hands dirty. Well this kind of practice should probably have coordinating meetings with minutes of the planned work and how the department does the work in the daily operation, simply because the junior doctors are performing the daily routines in the patient bed wards. Therefore I would expect that the junior doctors would be more involved in the forum, where (…) the systematic tracking can be done (...) and it would bring a lot of satisfaction to have a small quarter of an hour or 20 minutes with the people who have their finger on in the soup, to get their feedback: 'What can we do better?', 'Okay let's adjust that', or 'We

> cannot do anything about it since this and this and that – so that is how it is.'" (Junior doctor, 2010).

The majority of the junior doctors experienced a total absence of medical management in the daily operations:

> "But in the daily operation we as the junior doctor group do not sense having an actual management." (Junior doctor I, 2010).

Some of the junior doctors expressed a perception that the medical management which had traditionally dominated the department was more transparent and straightforward. For example, some of the junior doctors expressed that their management communication with the consultants and the administrative consultants in the past was more simple and transparent, and they could often get clear answers to their problems :

> "… In the period when we had one chief, if there were problems they were somewhat taken care of. I believe it particularly happened in my time as a junior doctor. If you presented a problem and perhaps suggested a solution, you got a straightforward answer whether or not it was possible. Furthermore you got an explanation which was lucid and easy to relate to." (Junior doctor I, 2010).

This quote also illustrates important values expressed by the junior doctors; transparency in the management communication, clear and quick answers and solutions, but also acknowledgement of the junior doctors' presence and issues. In this regard, the junior doctors expressed that the prevailing management is a disadvantage regarding the management information and communication across the DC:

> "…the department has also gone through a huge expansion. The first meeting I attended here, we sat in a little conference room with eight consultants, today there's like 25, and the production has increased exponentially over the years, and there has been a sub-specialization and a huge development in the field. So from having a clinical working administrative consultant, who was in control of the separate doctors, and really also of the nurses, so it's physically impossible right, and now we have a full-time administrator who basically doesn't move around the clinic. So you need to have another construction, well it really couldn't go on if you do not have a clinical input for the management, which today is very administrative. But life was clear, and there was an administrative consultant, who was in pretty good control of the department regarding the infrastructure and took care of the problems there were, and they were solved." (Junior doctor I, 2010).

Based on these opinions, a new management model that features more management engagement and communication across the DC would be valued. The junior doctors argue that the prevailing template is not up to date in relation to dealing with the amount of “management communication” to be run through in this large department, with several sub-specialties, large production and many staff.

However, the introduction of the functional partnerships as a management initiative was not yet perceived to have affected the junior doctors’ clinical work on a daily basis. They did not see how the implementation of the functional partnerships should further solve or change anything in the management model in the DC in practice. Their assessment was that the junior doctors were so little involved in any management decisions in the DC that they did not notice a radical change in the management model as such:

> “…I don’t think that I see that there is a great difference in terms of management. As a junior doctor I think about management as a land covered in mist. You feel the most direct staff management about, when you have to go to work, is somebody keeping an eye on whether you’re here etcetera. We don’t have a lot to do with the economic issues...” (Junior doctor L, 2010).

In summary, the junior doctors were very interested and agreed with the necessity to introduce a new management model, as they stated that the management information flow was critically low, despite their sceptical view on the outcome in practice in 2010. They saw an opening for a “management forum” where they as younger, inexperienced doctors could be involved in the ongoing managerial decisions which have an impact on their daily operation practice. A place where they could turn regarding the problematic things they experienced in the daily work and consultations in relation to issues concerning cooperation. They expressed that what goes on at “the bottom” (junior doctors) of the DC does not reach the executive administrative consultant and, conversely, the management information and communication the other way around was very low.

6.2.1.3 The nurses

In this section I describe and explain how the nurses, including the functional partner nurses, expressed their interest and value commitment to the management model with functional partnerships in 2010.

In 2010 the interviewed nurses had very limited knowledge about the management change process to introduce functional partnerships and had not been involved or briefed about the process as such, which meant that they found it rather difficult to answer questions about their interest in the management process. The functional partner nurses had participated in the strategic meetings about the idea of the

functional partnerships, but also had limited information about the intentions and details of the idea. However, the majority of the interviewed nurses, including the functional partnership nurses, described how they were dependent on the consultants in their daily work and that they experienced a lot of ambiguity and randomness regarding medical decision making in the daily operation. As illustrated in the quote below, the decision making happened primarily by chance in the wards, whenever they met a consultant who was able to make medical decisions for the entire ward.

> “It was more in the wards – when we met the doctors and took something up there.” (Nurse, 2010).

The nurses expressed that if they could not find a consultant who would take a given decision, the nurses made use of their own traditional management hierarchy in order to reach a decision by a doctor. That is to say, they went through the head nurse to the executive administrative consultant, who then discussed the issue at the consultants’ collective consensus orientated Monday meetings. The quote below illustrates how the nurses used their management hierarchy to get through to a consultant:

> “…because we could go to the ward nurse and the executive administrative consultant. They were the ones we went to, so I went, at least, most to the ward nurse, and so she was the one who took it to either the executive administrative consultant or the head nurse.” (Nurse, 2010).

The decision process was then long and the nurses did not go to the head nurse unless it was about important issues in order not to activate this decision system unnecessarily. In order words, the daily medical management issues depended on a consultant’s professional assessment and decision making, which was arguably taken randomly and thereby caused a lot of frustration among the nurses. This meant that the majority of the nurses were very interested in getting a consultant associated with their wards, as the ward nurses would have better options for making decisions on daily operations in the wards that were robust and efficient.

6.2.1.4 Summary

In summary, different perceptions and expressions about the advantages and disadvantages of implementing functional partnerships in the DC were expressed in 2010. It is complex because the dominating profession was divided in its interest and perception of the functional partnerships, despite all the doctors being fully embedded in and committed to the values of possessing seniority and experience in order to be able to “manage”, which had been dominating the interpretive scheme in the DC since the 1980s. Some of the consultants, especially the most experienced,

found the FP a disadvantage as they believed that the management model should reflect a collegial and collective authority structure and a consensus orientated and collective decision system, which was broken by the medical management stratification with the formalization of the functional partnerships. However other consultants, especially those engaged in the functional partnerships, but also junior doctors and nurses, found it an advantage to implement. They found that the decision system embedded in the 1980s archetype management model had become more and more of an disadvantage as it was perceived to be less effective in making clear, apparent and evident collective decisions due to the large number of professionals with different areas of responsibility. They believed that the new construction could support them in their daily operations, but also create consistency in the DC. However, it was the dominating medical profession, particularly the most experienced consultants, who possessed the decision power and authority position (even though informal) to make an impact on the transformation of the management model, and furthermore they possessed the capacity for action to move the DC in the functional partnership model, which I will explain in the section below.

6.2.2. POWER DEPENDENCIES AND CAPACITY FOR ACTION

In this section I describe and explain how the joint management team, the functional partnerships, the consultants and the nurses perceived the power dependencies and capacity for action in the DC in 2010 in relation to the implementation of the functional partnerships.

6.2.2.1 The consultants in the functional partnerships

In this section I describe and explain how the consultants in the function partnerships perceived the power dependencies and capacity for action in the DC in 2010.

The consultants who were "accepted" or "selected" and involved in the functional partnership teams all expressed some degree of interest and commitment to develop their role in them, but they also expressed some confusion and a great concern about their impact. In other words, to what degree the functional partnerships indeed would be perceived as an authority position with the ability to make legitimate management decisions. In the quotes below it is illustrated how the consultants were very aware that fundamentally there was an interpretive scheme in the DC consisting of a belief of that you have to be the most skilled in your sub-specialty in order to "manage" it or have "impact" and be responsible for different tasks. In other words, the authority structure and decision system were strongly linked to values about expertise and seniority. The (younger) consultants in the functional partnerships recognized that if they were to manage anything they should be accepted by their colleagues as qualified to manage, which implied clinical

expertise at a high level.[20] However, what is essential is that most of the consultants recruited to the FP were not necessarily the most experienced experts in their sub-specialty but were on their way to it, which meant that they did not possess the legitimate authority and decision making power, which is acknowledge /embedded in the prevailing management template, to set the direction, or the power to take the necessary decisions through.[21] The quotes below illustrate this dilemma:

> "… there really hasn't been any doubt about, that if the consultant (ed.) and nurse has said, that it's going to be so, then that's how it's going to be, and then consultant X shouldn't come and doubt it, because the consultant (ed.) decided, and then you probably accepted it. What I might fear is, that some of them – now it might sound like I've been imposed to be a functional partner, and somehow I might be – but I do the job, otherwise I wouldn't have taken it. But I fear, that some might have taken it because they had to, and not voluntarily, and then I think we will have a really big problem, because then nobody will possess the responsibility, and then we will have a sort of shadow management, and then it's just going to be that some who will possess the responsibility anyway. And I think that there might also be the implicit danger of a system built in that way, that it's the one furthest ahead who achieves the possibility to decide the most. That's how it is among consultants, so the one who is the best contractor, who has been here for the longest time, is also him we have the most respect for, so it's him that gets to decide. And even though maybe he won't be a functional partner, can we make him not decide anything? Can the ones who have been given the role of decision makers (the FP, ed.), can they be allowed to make any decisions? Or are there those, walking around behind the scenes, really deciding?" (FP, Consultant F, 2010).

Some of the younger consultants involved express a concern for the recruitment process. They express that they are concerned that some of the consultants have taken on the functional partnership function because they were pushed or pointed out and not because they find the position meaningful. It worries them if the consultants in these FP position cannot take on the responsibility that is intended. According to younger consultants this might empty or hollow out the position.

[20] In the DC every consultant who was recruited (by the consultants) was at the very highest level of expertise, however, in the group of consultants, there nevertheless crystallized an internal hierarchy with more and less experienced consultants. Some were at the beginning of their careers and others advanced in their careers.

[21] Even though the decision-making process overall was expressed as collective negotiation and decision making amongst equals, the internal hierarchy had an impact on whose arguments weighed the most heavily in the negotiations based on their clinical expertise.

> "Well I have a hope, that making an unambiguous department management, it makes the management in the department more transparent and apparent, but I fear, that it will be in name and not in fact, because I think that, unfortunately, I see that some of those who have had the right of being a functional partner taken from them won't let it go, and that some of those given the right, and that is the fear you personally can have, will we be able to take power, can we get to decide, will you let us do it? And how much of a personal commitment is it going to take, and do you have the personal tools and education and understanding and income and strategies and things like that? But really I hope that it's going to work, but I think, that it's very person dependent unfortunately. I can see functional partnerships I think will be good, and then I think I'm going to see some, where I could fear, that it isn't going to be a whole lot different." (FP, Consultant F, 2010).

As described above, the quote above illustrates how consultants who had been selected and accepted to be a part of a functional partnership were concerned about whether the traditional, informal collective and collegiate decision system (where the consultants with the most expertise and seniority were the most valued), will give up some of their decision-making power to the newly established management teams, which might not possess expertise and seniority in the same degree. What we need to note here is that the values and beliefs linked to being able to manage in the DC (expertise and seniority) and to exercise/make legitimate decisions on their own peers' behalf, were very clear to the consultants who accepted the functional partnership role. Furthermore the quote illustrates that functional partnerships still had not establish their management space and functions, including which management tasks they could negotiate in relation to the joint management team and the most senior consultants.

Some of the consultants expressed a concern for the actual management impact but especially a concern for the senior consultants' loss of interest in allowing the functional partnerships to get managerial influence and impact due to their role as consultants with management responsibilities *per se*. Among the consultants there was no consensus about whether the functional partnerships were an advantage or not. This division of attitudes in the consultants' collegium influences the picture of the group of consultants' support or interest for the functional partnerships and it becomes much more dependent on individuals among the consultants in relation to getting the functional partnerships implemented as intended. The split in the interest or "agreement" of whether the functional partnership teams was a solution to experienced management issues affects the total power of the dominating medical group to move the prevailing management template towards a template with an additional layer of management. On the one hand, the transformation process is pushed forward by the doctors who express interest and value commitment thereto. Conversely, other consultants (primarily senior consultants) who desire the

prevailing management template are pulling the management model in that direction.

Another aspect in this dilemma is reflected in the quote below, which illustrates how a functional partnership consultant is aware that, despite being "a colleague (as equal)", he possesses a subordinate position in the consultants' internal authority structure because of his lack of experience compared with those of greater seniority status. The functional partnership consultant expressed that the functional partnership role is more like being a "sparring partner" and not a "manager" for the sub-specialty. Especially, regarding the professional management responsibility and task. The quote clearly illustrates that it was exceedingly difficult to take a management position, especially regarding clinical work (e.g. research and clinical strategy responsibility areas), since, as previously described, it requires a certain amount of skills, expertise and experience to be able to negotiate:

> "That is for certain. I might be the youngest in the group. I don't believe that they think of me as a manager in that way, I rather think that they see me as a sparring partner. I think it could be really hard if I was to come and say… to the older ones what they should do professionally, because they know that for themselves." (FP, Consultant B, 2010).

The functional partnership consultants perceived the functional partnership position more as a "spokesman" or "coordinator" position, as explained below:

> "You see four of those… there is something called staff/personnel management, there is something called research, there is something called daily management and then there's some strategy. It is a giant mouthful to give a person, and there are many from my group who contribute on everything… I see it as if I have to coordinate the visions of strategy of my group to the joint management team. I have to be the one they communicate with, and if some area is slacking, I have to be there. But I can't sit down by the desk, because it would be more than a full-time job to run all those circles." (FP, Consultant B, 2010).

In summary, the functional partnership consultants perceived that the stratification in the consultants' authority structure and decision-making system was a break with the collective collegiate pattern and created a new challenge which is "managing one's colleagues" – professionals who are at the same academic level as themselves and even higher clinical levels. Those consultants possess autonomy and a top position in the authority structure that is inherent in their professional expertise, which made the position as functional partners, for the younger consultants with management ambitions difficult to possess, as they did not possess the necessary professional legitimacy, respect and legitimate decision power, because they did not possess the same amount of expertise and seniority and

thereby a knowledge based authority. This lack of acknowledgement from their colleagues, meant that the functional partnership position did not possess the ability to drive the management change process forward towards an alternative template without their colleagues' mandate.

6.2.2.2 The consultants

In this section I describe and explain how the consultants perceived the power dependencies and capacity for action in the DC in 2010.

The more experienced consultants were split in the sense of whether they perceived it as an advantage or disadvantage to introduce the functional partnership. Some of the consultants felt that it was an advantage, since it had been difficult to decentralize and delegate administrative/management tasks collectively in the collegium of consultants, as the number of consultants in the DC increased. Others did not acknowledge the advantage of the model, as I will explain below.

The consultants who were not involved in the functional partnerships were very aware that the functional partnership positions wre primarily filled by consultants with less expertise and seniority than other (more experienced) consultants in the collegium of consultants. This was problematic for the consultants, as the quotes below illustrate:

> "You have to consider that the ones who have become functional partners aren't those, who on the highest levels are drawing the sub-specialty. They are the administrative managers, people who you have been able to force into doing it, or who might have wanted to. However, there are still some old geezers, who think they should have a major influence on the professional evolution in their area of expertise, making the other one a lackey, who is sent out to make a sub-specialty thrive."(Consultant J, 2010).

It is stated that most of those who had become functional partners had been educated by those consultants for whom they now acted as functional partners, as noted in the quote below:

> "It's implied that the person sitting there, he's trained, or she's trained, by one of the others sitting there, and maybe hired by another one sitting there. It is pretty strange…" (Consultant K, 2010).

The majority of the more experienced consultants in the collegium I interviewed could not imagine that the functional partnerships would be in a position to manage a sub-specialty (or sub-unit) because they were not the most skilled or experienced consultants, which as described before, is a precondition for achieving the

opportunity, respect and acknowledgement from one's colleagues to manage. It was absolutely unthinkable, according to the senior consultants, to be managed medically by a less skilled and experienced colleague:

> "Now, I'm not under a real functional partner, but if I had to be, and he came to me and told me how I should treat (…), I would never accept it." (Consultant J, 2010).

The consultants involved in the functional partnerships were indeed considered as some of the least research-intensive, and thus the least skilled and experienced, and therefore the most unsuitable for the management position:

> "If anything you might say, that the functional partners are some of those, who are least active in terms of research."(Consultant J, 2010).

The more experienced consultants expressed that the consultants in the functional partnerships neither had years of experience nor were particularly active in research, and were thus not experts in their sub-specialty. There was thus a perception amongst the consultants that in order to manage the DC and possess an equally authoritative position, legitimacy depends on the values that are linked to the position: expertise and experience.

The quote below illustrates the belief held by some of the experienced consultants that the functional partnerships and an additional layer of management would not turn out successfully. Basically, it would not be a success as academically functional partnership consultants would find it very difficult to get their professional decisions respected by their colleagues, as they, according to the experienced consultants, do not possess experience or expertise enough to draw on, which can qualify them to get their colleagues' mandate to be their professional "manager" or functional partnership. Furthermore, the functional partnerships would experience difficulties in their decision making process, since the decision system in the DC is believed to be based on collectivity. In other words, "individual" functional partnership decisions would not be acknowledged since they were not based on consensus orientated, negotiated and collective decision making:

> "Well, there are some sweet and nice people, but it is not those who possess the greatest professional skills. And if there is any action towards that they will begin to be disciplinary, so it ends up completely wrong ..." (Consultant J, 2010).

Some of the consultants who expressed less interest in the functional partnerships around 2010 also expressed that they had not paid attention to who possessed the new positions as such, which may indicate that the functional partnerships had not

yet begun to negotiate and mark their management space in relation to experienced consultants as such:

> "…it's not because we haven't been told about it, but they (they FP, ed.) haven't been so visible that we would remember it." (Consultant J, 2010).

This quote also illustrates that the decisions about functional partnerships and who should be recruited to the positions had not been made collectively amongst the consultants.

Some of the consultants who believed that the new template with the additional level of management was an advantage expressed that the functional partnership attitudes towards decision making in the sub-units was very important. In other words, the way the younger consultants access the functional partnership role was very important according to these more experienced consultants. The quote below illustrates how a consultant perceived how a functional partnership consultant behaves and communicates when performing as such:

> "He comes over and says: 'Can't we agree upon that we have to refer in the centre this and that way, so we have a consistent way of doing it?' Well, that's how it takes place; which is also smart of him. Generally that is how it is, if you have some good people undertake a certain function, of course it's going to work out reasonably well. It can also, I can see that, it can be an advantage that there are some "caps". As the consultant puts it, in the old days you delegated the jobs, and that's just right, because that's how it was when I became a consultant. When you sat around the table, you were told what you were going to handle. Then you said yes, because you really had no right to decline, it was a part of the deal. But I gradually felt, as more and more people joined (the collegium of consultants ed.), that why should it be me? Why shouldn't it be him? It's a bit tiring; I'd rather be doing another thing. I think that's how it started coming on gradually." (Consultant K, 2010).

It is perceived by the consultants that the functional partnership consultants seek to create collective decisions with their inquiring, consensus orientated approach, which is in line with the prevailing template for decision making. This behaviour reflects that the functional partnership does not possess a superior position in the sub-units *per se*, but acts more as a representative amongst colleagues, like the executive administrative consultant in the collegium of consultants, but at sub-unit level. The issue of the functional partnership role is that the joint management team gave the functional partnerships their (administrative) mandate to make different kinds of decisions regarding clinical, strategy, research and personnel areas of management. However, it was difficult to attain an authority position and get

decision power/a mandate from the collegium of consultants – who possessed the top authority positions. The authoritative structure was still rooted in the collegium of consultants. This structure was however being undermined, since this structure made it difficult to provide a solid decision system (the consensus approach no longer worked in relation to discussing the management issues and broader academic coordination) as the number of consultants increased. Therefore, some consultants acknowledged that it was necessary to stratify the authoritative positions and responsibilities in order to make it possible to take more rapid and more local decisions, which embraces the consultants' traditional management authority and decision powers. But could those more experienced consultants let go of their legitimate authority position if it is about medical clinical decisions and research decisions? Had the functional partnerships in practice received a mandate to make real professional decisions in the sub-units about these areas or must they negotiate this managerial space with their colleagues in the traditional collegiate consensual style, before attending the joint management team? This was still undecided in the material from 2010.

Overall, the consultants still perceived themselves as having a legitimate dominating authority position and decision power to influence the transformation process and the outcome of the initial implementation process of the functional partnerships. However, the consultants were internally split on their views on the additional layer of management in the DC. This internal power struggle regarding the functional partnership position and management responsibilities affected all the consultants' behaviour regarding the legitimacy of the process of constructing the functional partnerships, which I characterize as progressing from a prevailing template to being hesitant to the alternative model in the form of functional partnerships as the interest differed in the collegium of consultants and the medical group in general.

6.2.2.3 The junior doctors

In this section I describe and explain how the junior doctors perceived the power dependencies and capacity for action in the DC in 2010.

The majority of the junior doctors felt that by 2010 the division of responsibilities between the management of the joint clinical management team and the consultants reflected a model of management within the DC that lacked transparency . When interviewed, most of the junior doctors are not aware of who was selected or had accepted a functional partnership position in the different units or if it was one or two or three consultants who shared the management responsibilities within the units:

> "Anyway, it requires…, that it is clearly defined which areas of responsibility… who it even is? I really think that among the junior

> doctors, I think most of us who not know down deep who we should address, if there are questions about practical work-related work sharing (…) Is it the executive administrative consultant (ed.), or is it one of the other consultants? Or who is it? And the answers are usually the same." (Junior Doctor H, 2010)

Some of the junior doctors even felt that the amount of shared responsibility diluted the sense of responsibility of administrative management among the consultants:

> "It is interesting to talk about, where the responsibility really is in this organization. A lot of the responsibility is shared, and maybe there aren't any, who feel that they have the responsibility. Sometimes, I have a hard time seeing, who has the responsibility, and how it actually is placed." (Junior Doctor I, 2010).

Regarding power dependencies, the quotes above reflect that the junior doctors do not possess any authority position or power that qualifies them to be involved in both clinical and management decisions, and they are not "listened to" either regarding management decisions in the DC, which leaves them with a small degree of capacity to form or drive the management change process towards the management template they are interested in.

6.2.2.4 The nurses

In this section I describe and explain how the nurses perceived the power dependencies and capacity for action in the DC in 2010 in relation to the functional partnerships.

Regarding power-dependencies, the group of nurses acknowledged that it is the doctors and especially the consultants with expertise and seniority who are listened to most keenly regarding clinical and management decisions in the DC. In this regard they also perceive themselves as subordinate to the medical group. However in the daily operation the nurses focus on their relation to the nearest ranked ward nurses and their decision power, as they traditionally have been doing. The nurses had not been involved in the process of establishing the functional partnerships, and they perceived the process of implementation of the functional partnership as quite closed. Maybe because they express that they do not possess any legitimate medical skills or competencies to manage any management activities regarding the functional partnerships.

6.2.3. SUMMARY

In summary, the collegium of consultants possess the informal but dominating authority position and thereby are the ones who are listened to more keenly than the

other professionals. They thereby possess the power to define who should be responsible for different kinds of management tasks. However, what complicates the process of management change is that the consultants who theoretically could be drivers for the management change are split in their interest and commitment to the idea, which makes the direction of the process more unpredictable. Even though the joint management team also possess a formal authority position to drive the process, and the fact that they have initiated the process, they are conspicuous by their absence in defining and delegating the management responsibility more accurately and thus cause the professionals uncertainty and ambiguity. Due to the collegium of consultants' collective and consensus orientated domination they do not possess the ability to embrace and define the functional partnership management space in detail. In other words, they lack capacity for action in the decision process of who should be responsible for what in the DC, including the revitalization of the consultants' management space.

6.3. THE MANAGEMENT MODEL IN 2010

In this section I describe how the management archetype of the DC in 2010 was expressed by the professionals. This section is based on the interviewed consultants' and nurses' expressions and perceptions about the management organization in the DC.

6.3.1. THE AUTHORITY STRUCTURE

In this section I will describe and present the how the authority structure was perceived in 2010 after the functional partnerships had been formally initiated in April 2010.

In 2010 about 26 consultants were affiliated to the DC. This illustrates the fact that the number of consultants has increased even further as a result of growth and development in the specializing of cardiology.

In 2010 the executive administrative consultant and the head nurse in the joint management team still possessed the formal top authority position in the DC. It was expressed that the internal interdisciplinary collaboration between the executive administrative consultant and the head nurse was getting stronger, but they did also maintain the traditional (pillar) positions in their team, as the head nurse managed the nursing group and the executive administrative consultant was perceived as the representative or chairman of the collegium of consultants. Furthermore, the head nurse was still formally acknowledged as a part of the overall management of the DC. However, the position of the joint management team was even more removed from the clinical operation, towards a more administrative position, when implementing functional partnerships. The eight functional partnership teams

constructed a new formal authority structure in the DC. They formed a mid-level formal management layer, which meant that the DC management structure formally consisted of two formal management levels with medical professional representatives.

However, the concept of the "formalization" was blurred since the formalization of the eight functional partnership positions were not a "validated" form the medical agreement, association and medical community have approved like the formal position of the joint management teams and consultants in the medical agreement, which made the "formalization" and the "formal" delegation of management positions and tasks rather questionable. Moreover the nurses in the functional partnership teams possessed a stronger authority position formally, as they possessed an equivalent position to the consultant in the functional partnership. This meant that the functional partnership nurses formally possessed a higher authority position in the overall management hierarchy than did consultants in the DC, as the nurse in collaboration with a consultant in each functional partnership was intended to manage each sub-unit. This meant that the collegium of consultants who traditionally possessed the authority collectively, were formally pushed a layer down the authority ladder by the medical management above the collective authority level of the collegium of consultants; the EAC and the functional partnerships.

However, this new formal stratification of the medical management authority structure was very ambiguous in practice around 2010 as the consultants and ward nurses involved in the functional partnerships, but also the joint management team and the collegium of consultants had just started constituting the "partnership form" and the different responsibility areas in practice. In other words, the professionals with formal and informal management responsibility positions were in a position where they were negotiating about who should possess the legitimate authority positions and areas of responsibility.

In practice the executive administrative consultant was still perceived as a colleague among equals by the consultants, however, representing the collegium of consultants regarding overall administrative issues. Informally the collegium of consultants still possessed a strong authority position in the DC, especially regarding clinical and research management areas. In practice, the head nurse did not possess any overall management position over the consultants in the DC, especially not regarding clinical strategy and research strategy, as they were primarily self-managing *per se* based on their expertise and seniority. Similarly the ward nurses in the functional partnerships did not possess any management positions over the consultants in their specific units, despite their formal mid-level management position.

In summary, the collegium of consultants dominated the authority structure through their traditional collegial authority structure in 2010, despite the formalization of the interdisciplinary functional partnerships and the derived formal stratification of the consultant's authority structure. This meant that in practice the head nurse and ward nurses in the functional partnership teams were still subordinate to the consultants of the DC in many aspects regarding clinical management responsibilities and partly regarding the overall administrative work, because the consultants still in practice possessed the full jurisdiction over the administrative management work. This left the head nurse as traditional top manager for the group of nurses, and the group of nurses had gained yet another administrative management level in their professional hierarchy with the functional partnership teams. The more formalized and stratified structure with the functional partnerships also resulted in an enhancement of the cross-pressure position around the functional partners.

6.3.2. THE DECISION SYSTEM

In this section I describe how the decision system was perceived in 2010 after the functional partnerships had been formally initiated in April 2010. The expressed rationale of the system and how the professionals perceived the decision system is described. Lastly a focus on how the decision system unfolds in a rather proactive or reactive way to gain competitive advantage is described.

Regarding the rationale of the decision system in 2010, it was still perceived to be strongly dominated by the professionals and primarily by the medical profession who possessed the overall legitimate power of the decision system.

It was expressed by the majority of the professionals interviewed that the overall decision making was done collectively in the collegium of consultants and that the executive administrative consultant possessed the top position as its representative in the stratified medical decision system. Around 2010, the introduction of the functional partnerships had not yet had an impact on the consultants' overall power position in the decision system. However, internally in the medical group, the functional partnership consultants were negotiating a position as their units' representatives. These negotiations touched the traditional collective and consensus orientated decision making structure across the DC, as the functional partnership could break the consultants' collective decision structure in the collegium but also their self-management positions in their units. The group of nurses still possessed their traditional decision system, with the head nurse at the top. The functional partnership nurses gained a position further up in the nurses' decision system, as they became managers for more nurses and units. However, despite their position in the functional partner team, they did not possess any decision power over the consultants in their units, especially not regarding clinical strategy and research management. Finally, I would argue that the decision system operated in a rather

proactive way, as the joint management team and the majority of the consultants were interested and committed to construct a management model with functional partnerships that would be able to take decisions that could facilitate the increasing complexity and managerial issues experienced due to the growth of the DC. It was believed that the established stratified decision system could support the DC's internal clinical coherence and thereby strengthen the DC's competitiveness.

In summary, variations developed in who possessed formal decision power over different kinds of management tasks. This meant that in 2010 eleven decision forums existed (both formal and informally). Firstly, the joint management team with the executive administrative consultant and the head nurse primarily took care of administrative decisions in relation to internal and external responsibilities, but also holding a chairman or representative position in the collegium of consultants. Secondly, the head nurse and her functional partner nurses and ward nurses provided a management forum where nursing matters were discussed and decided. Then eight functional partnerships existed. The intention was that they should possess the power to take decisions about professional management, research management, strategic management and personnel management in their units. Finally, the collegium of consultants with a collective, collegial and consensus orientated approach was still present and possessed a position that qualified it to make legitimate decisions regarding clinical matters of the DC, especially about sub-specialties. Additionally every consultant possessed a position to make management decisions regarding his or her own specialty based on professional autonomy. These eleven decision forums reflect the stratification among the medical professionals with the executive administrative consultant and the rest of the consultants. They reflect the traditional stratification among the nurses in the DC, with a blurriness regarding the management responsibility of the administrative and clinical work because the formal (joint management team and the functional partners) and informal (collegium of consultants) decision system worked at cross purposes, pushing, negotiating and delegating these tasks up and down in their stratified system, making the decision system more differentiated regarding the type of responsibility. Finally, the decision system operated in a proactive way, according to the majority of the professionals.

6.3.3. THE INTERPRETIVE SCHEME

This section presents different expressions of what was expected and believed of what the management organization of the DC should be doing, how the management should be appropriately organized and finally how performance evaluations should be judged around 2010.

The majority of the professionals expressed a belief that the management of the DC should be a matter of professional concern in 2010, which is in line with previous expressions thereon.

Regarding appropriate management organization, it was still an overall value and belief that it should be those with seniority and expertise who should manage the DC. Both consultants and junior doctors committed very strongly to the value about being a skilled medical professional before handling any management responsibilities. This powerful and persistent value reflects the doctors' attempt to maintain their jurisdictional area regarding the management of both clinical and administrative tasks. This value also had an impact on the implementation of the functional partnerships. The functional partnership roles were primarily possessed by younger consultants with less expertise and skills than their colleagues with seniority and expertise in the units and specialties. This meant that the functional partnership consultants had a difficult starting point in relation to any challenge to their position by their more experienced colleagues. The nurses in the functional partnerships were not deemed to have sufficient medical expertise or skills to engage negotiations with consultants about medical responsibilities. However, it was not expressed by the functional partnership nurses that they actually sought to gain any management responsibilities from the consultants in their units. Furthermore, the value about being colleagues as equals was still present, which also made the stratification of the medical group difficult, as the opinion of the functional partner consultant was just one voice in the decision system. This belief made it difficult for the functional partnerships to "manage" the different management areas the joint management team had suggested. Moreover, the value about being self-managing as a consultant was a challenge for the functional partnerships, as they had to negotiate with the joint management but in particular with their more skilled colleagues about different management responsibilities they *per se* considered as their traditional management area.

However, the majority of the consultants did not reject the idea of functional partnerships and the necessity for more medical involvement in the operation and administrative management issues at sub-unit level for various reasons, which helps to explain why some of the consultants actually got recruited to the functional partnership roles, despite the consultants' overall collective authority position. This must also mean that the values and beliefs about being colleagues as equals, taking collective, consensus orientated decisions as a collegium of consultants, and being self-managing regarding one's specialty, had moved towards some sort of acceptance of a stratification of the medical decision making, at least compared with some types of management responsibilities, as e.g. the more administrative tasks, which also had been managed by the nurses traditionally. The clinical and research management responsibilities were properly further away regarding acceptance from the consultants, however the data cannot inform us accordingly.

In summary, the interpretive scheme in 2010 reflects that such values and beliefs as that it must the medical professionals who possess the authority power to manage the DC, colleagues as equals, being self-managing and making collective and consensus orientated decisions, was still strong and permeated the organization of

the DC management. With the implementation of the functional partnerships, those values and beliefs were threatened.

6.3.4. THE MANAGEMENT ARCHETYPE MODEL IN 2010

In this section I construct a picture of how the management archetype was perceived around 2010.

Formally, the executive administrative manager and the head nurse as a joint management team possessed the overall top management position in the DC, which meant that they were formally placed at the top of the authority structure. They were also together formally responsible for the decision making of the DC. However, informally the collegium of consultants still possessed a strong authority position in the daily work. In practice the consultants possessed power to make decisions both collectively and individually. This meant that the executive administrative consultant and the consultants were in some sort of mutual dependence because of the formal and informal management positions. With the formalization of the functional partnerships in 2010 the stratification among the medical professional became more evident, as the professionals' negotiations about these positions began to influence the consultants' collective but also individual top authority position and decision making power. However, overall the authority structure and decision system was affected in an unimportant degree, which also included the consultants' everyday self-management.

The authority structure, the decision system and the interpretive scheme in the above sections reflect an archetype model where the coherence between the formal authority structure and decision system and the interpretive scheme of the DC seems to become more disintegrated and incoherent, primarily because of the strengthened position of the joint management team and the further formalization of the functional partnerships.

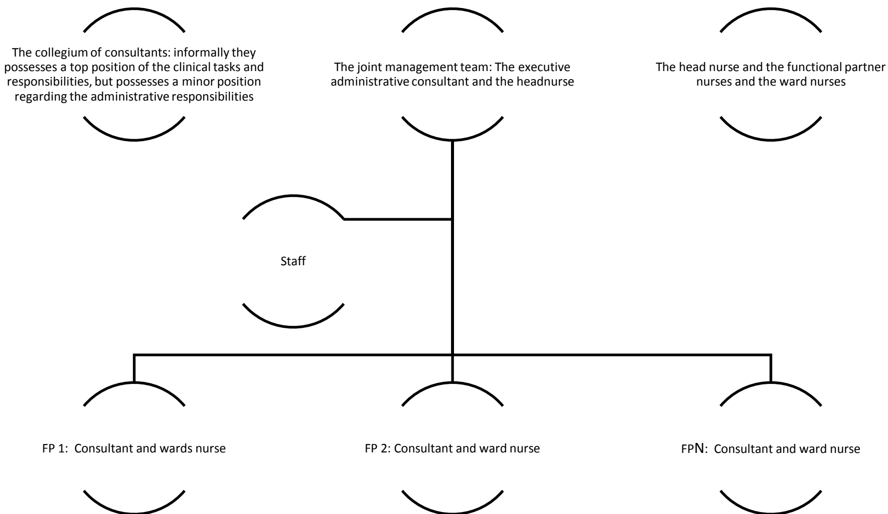
The incoherence in the archetype management model in 2010 is based on the fact that the supported values in the interpretive scheme did not support the formalized management authority structure and decision system with a joint management team and eight functional partnership teams forming the authority structure. The interpretive scheme did not support the head nurse as a legitimate manager of the consultants and their medical work as she did not possess the medical expertise and seniority which was a strong value regarding management in the DC. The executive administration consultant did not fulfil the values about expertise and seniority in the degree required by the collegium of consultants to have a legitimate management position in the daily work. Furthermore, the values embedded in the interpretive scheme did not support the consultants selected for the functional partnerships as they were primarily younger consultants with a lack of expertise and seniority. Finally, the values embedded in the interpretive scheme around 2010 did

not support the authority position of the nurses in the functional partnerships, as they did not possess the medical seniority and experience which was an imperative to manage the consultants' and junior doctors' clinical work.

In summary, the overall formalization and stratification of the medical management responsibility of the DC, which included both the administrative and the clinical responsibilities, was not coherent with the traditional prevailing template and the practised collective and consensual authority and decision-making structure of the medical professionals around 2010. The informal collective medical authority structure and decision system which was based on negotiation and collective consensus making was challenged in 2010 in favour of a more administrative hierarchical structure of authority and decision making.

Below (Figure 9) I have constructed an organizational diagram of how the management model was expressed in 2010. It is based on both the formally expressed management organization but the informal management structures and decision systems are also incorporated. The figure shows how the executive administrative consultant and the head nurse form the formalized "joint management team" which holds the top authority position. Below them are the eight managing functional partnership teams, where each team consists of a consultant and one or more nurses. The functional partnership refers to the joint management team in the hierarchy. What is not visible in the diagram is that the even though the joint management team and functional partnerships are "teams", the traditional professional pillar structure is still present in the daily work and collaboration in the teams, where the functional partnership consultants are connected to the executive administrative consultant and the functional partnership nurses refer to the head nurse primarily. The head nurse still met with the functional partnership nurses and other nurses with management responsibilities regarding managerial issues in relation the nursing profession. Regarding the collegium of consultants, I have placed the group beside the two layers of the medical management hierarchy because the collegium of consultants did not possess a formal authority position, but informally it still posseseds and practised a strong legitimate authority position and was also at the top of the decision system of the professionals in the DC.

Figure 10 The management archetype in 2010



6.4. THE PROCESS

In 2012, the eight functional partnership teams were reduced to four interdisciplinary teams which were named "section management teams". In section 6.4.1 I describe the professionals' perceptions of the management change process regarding the section management teams in the DC in 2011, 2012 and 2013, including the process-related initiatives and activities the joint management team performed during this period. In 6.4.2 I describe how the process of recruitment for the section management teams was perceived by the professionals.

6.4.1. PROFESSIONALS' PERSPECTIVES

In this section I describe some of the professionals' perceptions of the management change process regarding the section management teams in the DC in 2011, 2012 and 2013, including the process-related initiatives and activities the joint management team performed during this period

In April 2011 the DC initiated a fusion (or merger) process with a similar department located at another hospital in the same region, due to a larger re-organization of the hospitals in the region and the development of a new major hospital centralization and construction (The New University Hospital in Aarhus, DNU). This meant that the joint management team decided to suspend the process

of implementation and facilitation of the functional partnerships until the fusion process was completed. This meant that it was expected by the joint management team that the functional partnerships should still fill the intended position and role, but there would not be held any transverse meetings with the FP and other professionals with management responsibilities as anticipated in the autumn 2010. First, in the spring of 2012 the joint management team initiated management workshops for the functional partnership to facilitate the process. The joint management team put management organization, administration, priorities and economics on the agenda at these workshops, but the overall intention was to create a feeling of a management community or fellowship. Most of the professionals involved in the process perceived the management strategy process with an additional layer for the first time seriously starting up at this point in time. It should be noticed that the joint management team had hired a management consulting firm to facilitate this change process through workshops. The workshop meetings were primarily held outside the DC in Aarhus and the professionals expressed that it was very valuable for them to be invited to a location outside their workplace as they were not interrupted by the daily operations but could stay focused on the management subject and each other. In relation to their participation in the workshops, the majority of the professionals expressed satisfaction with this process, as illustrated in the quote below:

> "And it's completely obvious, that this is the place in the process, that they have given a lot. When you think of our first camp and the last, it's very obvious, that we talked ourselves into each other, for good and for worse. That's for certain. It can't just be done with a single one, if you want to go through such a process. We did have some really great consultants, that's for sure. Especially the consultants from the consulting firm (ed.) were really good at when we say something, he couples it with half a minute of theory, he's super at that. So we get a lot more, than we immediately realize, I think." (SM, Nurse F, 2013).

In 2012 the eight functional partnership teams were reduced to four interdisciplinary professional teams: constituted by a consultant and a ward nurse in three of the teams and a consultant and three ward nurses in the fourth team. The name of the teams was also changed to "section management" teams. It was not evident in the data material who took the initiative to decide this reduction of teams, but overall it was the joint management team who formally decided that the eight functional partnership teams were not functioning optimally and that it was time to reduce them to four teams. There was no open dialogue about the reduction, but I would argue that a few consultants, with top authority position, and who were already involved in the functional partnership teams, were involved in generating this idea of reducing the number of teams. Furthermore, the professionals expressed that there was no communication in the DC about this change, only to those who possessed the new section management positions. Not even those ward nurses who

had "lost" a functional partnership consultant in the reduction process were consulted, which led to confusion and vexation amongst those ward nurses and consultants who would no longer be involved in the additional layer of management. The joint management team expressed that they perceived that the number of four sections was a "natural transition" from a professional point of view and they perceived that with four section management teams the joint management team could better establish an overview of the cooperation with eight functional partnerships, as expressed in the quote below:

> "… that's an important point I think, that there was partly some natural (order, ed.) in the way the department professionally is divided, but also that it went very well in that we, as the joint management, had a reasonable amount of section managers to spar with." (Executive Administrative Consultant, 2013).

The professionals involved recalled that they held two management workshops with all the teams.

In summary, the change process developed only sporadically in the years 2011 and 2012 due to the merger of the cardiology departments. However in 2012 the process seems to have taken off with the change from eight functional partnerships to four section management teams which was expressed as very closed process by the professionals involved. The argument from the joint management team was that four management teams was more manageable than eight. However, the closed process and sparse communication about the reduction left the former functional partnership teams hanging in the air. The rest of the professionals in the DC were still very decoupled from the process.

6.4.2. RECRUITMENT OF THE SECTION MANAGERS

In this section I describe how the recruitment of the section managers was perceived by the involved professionals, because the joint management in the spring of 2012 formally changed the number of management teams and created a new name for the teams. This meant that some of the functional partners "lost" their position, while others "gained" the position of section manager. However, overall it was in general the same professionals who were involved in the functional partnerships in the beginning of the process in 2010 who became section managers in 2013.

The quote below illustrates a section manager consultant's view of how the position was negotiated with the consultant's section colleagues, which was characteristic of the general recruitment process of section managers:

> "Yes, I've handled it all backwards. And sometimes I directly asked my colleagues, they have to know too, that when I take upon the role as section manager, I am also going to be putting a lot of work into it. And besides that, I still possess a full clinical function. I don't receive a single penny, not one. So I'm doing this purely of interest, really. And then I told them, that if I have to this shitty work, as a lot of it is, then I also want the right to be able to make some decisions sometimes. Even if the group isn't in agreement, I have to make the decision that I think is best for the group." (SM, Consultant D, 2013).

More consultants point at the fact that even though the section management consultants have accepted to be a "section manager" and have negotiated the position with their own colleagues, are they also "chosen", "spotted" or "asked" by the joint management team. In other words the chosen section managers were acknowledged by their own colleagues as their representatives but also acknowledged by the joint management team to be a manager with an administrative authority position, which is illustrated in the quote below by a consultant:

> "Maybe they took the consultants, they thought were more defining or who would pull the biggest load, or who could make both things happen and still have support among their peers." (Consultant S, 2013).

What was interesting was that the recruitment of the consultants as managers was not defined from their base of management skills and competences, but by their clinical skills and experience, their interest in administration and management and their capacity to manage. This is in line with how the recruitment of professional managers in the DC traditionally has been conducted (the most experienced and skilled but also interested in management was elected by his own colleagues). Through a negotiated collective decision process the consultants gave a mandate to the section manager (SM) consultant to represent them (the sub-unit). In other words, it was not necessarily the most qualified consultant with a base of management knowledge or education (which practically does not exist in the DC) but the most clinically skilled and also interested (in management) consultant who met the various requirements of the administrative hierarchy and the collegium of consultants all together. It was those who fit this compromise best as illustrated in the quote below:

> "I think that the ones who are sitting as section managers now, at least on the side of the doctors, and really also on the side of the nurses, but on the side of the doctors, the ones I know the best, I actually think they have a high amount of professional competences. They're not the best in the department, I'm not the best in the department at what I do, my colleagues are better than I am. But I know everything they do, and I

> have full insight into it, and I can also do it. But I'm not the best. But I might be the one who has shown the most interest in organization and management and pushing papers around on the table. I like making things work, and of course you're going to send that impression, and in that way you might raise your hand without making it completely official. And I also think that the others who are section managers have shown the same, definitely. So in a way you might say that they are somewhat the natural choice. I see myself as a kind of natural choice, and don't think there are any of my colleagues who could do it all the way round. There might be some who can do it better, but I think, I can do a bit of everything." (SM, Consultant D, 2013).

The recruitment process was performed as it traditionally has been done in the DC. The process was closed and the consultants negotiated internally a skilled and respected consultant, but at the same time one interested and engaged in management, to each of the management positions. This meant that it was not the most foremost research-intensive consultants who was pointed at, but "the best compromise". Both the joint management team and the other consultants had confidence in them. However, it was the joint management team who formally decided who should hold the positions. It is perceived that the joint management team was more involved and took the initiative of who should hold the positions unlike the more traditional recruitment process characterized by consensus orientated decisions about recruited personnel. A small break with the traditional recruitment model was then present.

Despite some of the consultants showing greater interest and engagement in the mid-level management positions in 2013 compared with 2010, the quote above illustrates another "value" or belief, which can be traced back in the DC's history. The "management" position was not referred to in positive terms but had a bad status and was referred to as "a necessary evil", "the shitty work", "the monkey work" by most of the consultants. The recruitment process was very similar to the process of recruiting for the functional partnerships, which was characterized by the consultants' own internal collective negotiations and judgements (in the sub-units) about the appointed representative, which gave the chosen SM consultant some legitimacy in the position. However, despite the low status of the position, based on the consultant's derogatory remark quoted above, the consultants seemed more committed and interested in the concept of section management than they had been in the functional partnerships in 2010, which I will explain in the sections below. The low status can probably be explained through the culture of the DC as it has always been characterized by a strong grounding in clinical research and education and a low degree of focus on (administrative) management. Management in the DC was believed to be tasks you did for a period of time and then you returned to your clinical work in order to keep up the high professional ideals.

The section management nurses were not included in the negotiations in the recruitment process. They expressed that they were not knowledgeable about how the process had proceeded. However, some of them were consulted about the appointment of the respective consultants by the joint management team. The section management nurses expressed that they were recruited by the joint management team, as they traditionally have been to management positions.

In summary, the recruitment process of the four section management teams was perceived as a closed process but also a more straightforward process than the recruitment process for the functional partners, as the consultants who became section managers had already agreed to being in functional partnerships and had thus accepted this starting point with an intermediate layer of management. However, the consultants this time had more serious negotiations internally in their sections regarding which of the functional partnership consultants should possess the section management positions. It is expressed that the consultants chose skilled and respected consultants, but those who were also interested and engaged in management, to the section management positions. This meant that it was not the most research-intensive consultants who were appointed but "the best compromise" candidates. Both the joint management team and the other consultants had confidence in them. The process of recruitment of the nurses to section management positions was dominated by the head nurse (in collaboration with the executive administrative consultant), who assessed and selected them herself. In other words, these positions were not negotiated as such among the nurses, which reflects the traditional recruitment process among the nurses regarding management positions.

6.4.3. SUMMARY

In summary, the change process developed only sporadically in the years 2011 and 2012 due to the merger of the cardiology departments. However in 2012 the eight functional partnerships were reduced to four section management teams. The change process was still perceived as very closed and with sparse communication to the professionals in the DC who were not involved in the management process.

6.5. REACTIONS TO SECTION MANAGEMENT TEAMS

In this section I describe and explain how the professionals in the DC reacted to the management changes in 2013. More specifically I describe and explain how the joint management team, the section management teams, the consultants, the junior doctors and the nurses perceived their interests, their value commitments, their capacity for action and the power dependencies in relation to the introduction of section management in 2013.

6.5.1. INTEREST AND VALUE COMMITMENT

In this section I will describe and explain how the joint management team, the section managers, the consultants and the nurses expressed their interest and value commitment to the management model with section management teams introduced in 2013.

6.5.1.1 The joint management team

In this section I describe and explain how the joint management team expressed their intention, interest and value commitment to the management model whereby they introduced section management teams in 2013.

In spring 2013 the joint management team's perception of what they expected from the section management teams was much more evident and clear compared to the changes in 2010, when the understanding of the management responsibility of the functional partnerships was much more loosely defined and barely negotiated. However, in 2013 it is still a task for the section management teams to discuss and define their tasks internally in collaboration with their colleagues in each section and sub-unit. The head nurse expressed in the quote below how the different management tasks in 2013 were still very traditionally distributed and delegated, which made it increasingly relevant to get the consultants to be more involved in the overall management:

> "The intention with the section management actually was to bring interdisciplinarity into the agenda (…) to a higher degree. Traditionally (…), it has been very hard to involve specialties - our group of doctors into many of the areas of management. The ward nurses and myself have typically taken on many of the operational tasks, where it has been… where staff management, compliance of payment budgets, compliance of conference budgets, all those sorts of things, have traditionally been with the nurses group (…) booking of patients etcetera, traditionally. And the doctors have focused on their field of expertise. And in recognition of partly the growth of our department in height and breadth, and there are more and more interests in the game. So to make the managers (the consultants, ed.) get involved with the whole management pallet with the executive administrative consultant and I in this big management puzzle, we made the section managements." (Head Nurse, 2013).

The overall intention in 2013 was to create a more interdisciplinary management environment. As reflected in the quote above, the head nurse perceived that there was a need to get consultants more engaged in the management of other issues than just in the medical clinical field. The section management teams were an attempt to

foster this involvement. After the four section management teams had been created, the executive administrative consultant said that the collaboration and managerial overview with the four teams had turned out to be closer than before with the eight functional partnerships.

> "We are a lot more in on – we're a lot more distinct on who's running with this ball, and who's running with the other ball. It creates the fast decision power that has been asked for so much (…) It's probably still going too slow, but I think it has gathered a lot more speed. I think we're a lot better at saying either we aren't going to worry about that, or we are going to worry about this." (Executive Administrative Consultant, 2013).

The executive administrative consultant also perceived that it had become more legitimate amongst the consultants to work with "management" after the section management teams were created, as the quote below illustrates:

> "Well the daily contact with the various section managements across mails and verbally etcetera, it has a tremendous value, because 'management'' has a completely different legitimacy…" (Executive Administrative Consultant, 2013).

The executive administrative consultant indicated that the expressed belief about management as "a necessary evil", "shitty work" or "monkey work" has moved on to a more "moderate" approach to management, at least among those consultants involved in it:

> "Well the nurses have always done it but, especially from where I'm sitting, there are now five doctors in the ward who have a legitimate recognized right to drive and manage, and there isn't anyone complaining about it. They've almost stopped giving them nicknames, the way they used to. And to me that means that it has become completely legitimate, that there are some people in on making the decisions management wise. So it has put management completely differently on the agenda, and it has become accepted in a completely different way." (Executive Administrative Consultant, 2013).

The executive administrative consultant also explained how management discussions and dialogues amongst the SM teams were more fruitful and "rewarding" than in recent experience in the DC. The executive administrative consultant also found that conflicts could be solved more easily through discussions:

> "… you can really turn to each other, but you do it out of respect, because you believe that it brings the debate, the dialogue and the

> managerial decisions further, and the very cooperation ahead. And then the meetings we have once a month have especially given me one thing; the section disputes there can be between the different sections (…)We can really shout and curse, and then all agree on…, that we're going to get it out, now we've discussed, we've got it out into the open, we know where we stand, but we can also agree on what is to be the official position. These are some of the activities which I believe are going to mean a whole lot." (Executive Administrative Consultant, 2013).

Also, according to the executive administrative consultant, it had become more legitimate and natural for the consultants in the section management teams to say to their colleagues in sub-units that they have to discuss different management matters with the executive administrative consultant as a legitimate work responsibility.

According to the head nurse, the SM model breaks or impacts on three understandings or values of management in the DC: (1) it makes the values about the medical domination in management stronger, by giving the medical group a stronger and more close position to the joint management team, (2) it challenges the interdisciplinary clinical work, because the nurses are formally placed as equal managers beside the section manager consultants, and (3) it breaks with values about having a single administrative representative (the executive administrative consultant). In other words the stratification of the medical management group breaks with the belief in collective and consensus orientated management decision making:

> "I will say that the strong medical professional domination, I think we're strengthening it with this. So in that way it doesn't break with that value. It supports a value, that might have been weak for many years, and created a lot of frustrations. So it's a trait which helps in bringing back the value, one might say. On the other hand we're going to have a period now, because we want an interdisciplinary management, and the executive administrative consultant and I agree, and it is that which we practise, but I think to myself, that the value is going to be a challenge to get through, because you want to focus on your own management space and the struggles, that are between the professional groups, I fear. Otherwise, if it really breaks with some values, it still does in the way that the complete top-down management, which has often been in the paternalistic administrative consultant, is going to be challenged too." (Head Nurse, 2013).

The process by which the joint management team has involved the consultants and got them to participate formally in management workshops outside the overall consultant group also breaks with the prevailing values of open and transparent

decision making and collective negotiations dominated by all the consultants in the DC:

> "I will say, that there were some consultants earlier on, who were spokesmen for other consultants. So in that way it doesn't break definitely. It definitely breaks, because they get stars on their shoulders too, and are invited to formal meetings and connections and decision forums. So it definitely breaks there." (Head Nurse, 2013).

Defining the management responsibility areas as overall strategy, personnel and administrative management and research management also breaks with the managerial responsibilities consultants have traditionally focused on:

> "This also breaks significantly (…); the notion of taking care of management in different areas. The fact that management in a unit is no longer only about making schedules and plans in a certain manner but is also about taking care of the nursing group if you are a consultant in a given section. (The consultant ed.) will have to take interest in the routines; take interest in all sorts of things consultants traditionally shouldn't care much about. Thus essential, yes. I also hope that the interdisciplinary (cooperation ed.) will come through and make essential changes."(Head Nurse, 2013)

In summary, the joint management team reported that they had experienced a more positive, willing and interested approach to management at section level from the consultants, including a stronger focus on management responsibilities other than their specific clinical management responsibilities. Especially those involved perceived the model as an advantage. This development breaks with different prevailing values and interest. Primarily it is perceived that it has become more legitimate to be interested in and to work with section management in the DC, which breaks with the more sceptical beliefs held hitherto. Moreover it is perceived that the prevailing values and beliefs about collective and collegial authority structure and a decision system dominated by the most skilled clinicians are broken in favour of a more stratified medical management approach. More precisely, it breaks with the previously open and transparent (at least to the consultants in the collegium) decision making system where collective negotiations were dominated by consultants in the collegium. The value about being colleagues as equals in the authority structure and decision system was then being "sabotaged" through the stratification process. Finally, the formal position of the SM nurses in the interdisciplinary team broke with the value about the overall medical management domination and nurses' subordinate position. But in 2013 the development of the section management position and tasks was still perceived to be in its infancy.

6.5.1.2 The consultants

In this section I describe and explain how the consultants expressed their interest and value commitment to the management model with section management teams introduced in 2013.

The majority of the consultants interviewed in 2013 experienced and expressed a growing understanding of the increasing number of specialties and employees as well as the increase in complexity in the DC. They recognized that these factors have an impact on their daily work, which made the majority of the consultants recognize that there was a need for more solid management of the various sections and units – the idea of an additional layer of management matures. They expressed a growing interest and commitment to implement an additional layer of management in the DC compared with 2010. In this connection they found the idea of implementing the four section management teams a “natural” part of the process of implementing an additional layer of management in the DC, and consider it as a continuation of the process of implementing the functional partnerships. In other words, the implementation of the section management teams was perceived by the majority of the consultants as a necessary measure for handling the increasing number of employees and specialties in the DC, especially after the fusion of two departments in 2012 and 2013 which boosted the number of professionals. The majority of the consultants said that they found it an advantage to have a model with an additional layer of management, as illustrated in the quotes below:

> “I think that through the years, there has been an increasing understanding that the department grows bigger and bigger, becomes more complicated and especially just now where we also have been going through a fusion (…) And that is gradually how it is in our everyday life and work, at least as doctors, we actually worked in some completely defined areas, and in the last ten to fifteen years, it has been a increasing evolution. And then you might say, that there might have been resistance; there are some who have been afraid that sectioning would nearly start a war, a rivalry, between the different groups. I myself might have, far down the road, been sad about how it may come to sectioned. On the other hand, I can both see and acknowledge that with the amount of complexity there is in the ward now, you just need to have a firmer management in certain areas. So that’s why I think the right thing is working towards sectioning. I also think in consideration towards management in the department, because it is becoming increasingly difficult to be a manager in all these areas. You have to somehow recognize that when the organization reaches a certain size and complexity, it can be hard to manage it all, so you might need to make some sections. So in that way I think that the place we are now, has been a process over some years.” (Consultant L, 2010).

It is acknowledged by the consultants that it is difficult to manage a department of the size and complexity the DC has become. The traditional decision system with collective consensus orientated negotiating amongst the consultants seemed to be outdated when you have to listen to 30 to 40 consultants' opinions and reach a consensus orientated agreement. This is perceived as almost impossible in 2013 and often results in re-match regarding the decision making process:

> "Formerly it might have been distinctive, at least at consultant level, that everyone got heard, and that you sought for a consensus management in the way, that the consultants agreed mutually about what you thought, and then that was what you thought. And then again, that was what the department thought. You can't do that anymore, and you haven't been able to for several years. There might be those who made themselves believe that you could still get consensus, but in my opinion you haven't been able to in years. And that meant that there has been a lot of decisions that have been fought over and over and over, because when you're thirty consultants, and only fifteen are at work, there are some who haven't been heard, and then they think that the discussion should be brought up again. So in that way it might break with the notion of how the ward was before, because now it isn't a consensus management. Now we sort of have to delegate responsibility to some, and ask them to make a decision. So yes, there might be breaks in how the department was earlier on. But it is also a consequence of how big we have become, compared to back when the department started." (Consultant S, 2013).

The prevailing management template dominated by the informal collegial, collective and consensus orientated decision system which was dominated by the collegium of consultants created a sluggishness and slowness in the decision-making processes. Because of the increasing number (30–40) of consultants in the DC the system lacked decisiveness and was perceived as stiff and rigid by the majority of the consultants, who were directly dissatisfied with the prevailing decision system as it was practised. They recognized that their ability to take decisions and have an impact on the decision-making process in the DC was impeded by this model, making it disadvantageous. On this basis the majority of the consultants perceived and believed in 2013 that the DC had to create a more favourable management decision system and preferably in the form of an additional layer of management in order to create a contemporary system that could accommodate effective and constructive decision-making in a large department like the DC with an eye for each section.

However, a smaller part of the consultants perceived that the creation of the section management teams was still an excuse for a weak executive administrative consultant to strengthen his own authority position in the DC:

> "I think that it's a way of a weak management to strengthen its mandate by selecting some, who attaches more easily, and use it as a shield against the rest of the dangerous world." (Consultant O, 2013).

Furthermore, the model was perceived as being "protection" for the executive administrative consultant:

> "… it's protection. I see it as a guard, so they're isolating themselves behind a palisade… And then they let them run the business, and then as management you can settle for giving directives to those section managers. And in that way you aren't bothered with much more than the daily practical business of making the company run. You're able to focus more on nursing your interests towards the top of the system." (Consultant O, 2013).

There was thus a smaller part of the consultants who were not interested in or committed to the idea of an additional layer of management, similar to the reactions in 2010. They perceived the joint management team to disclaim their responsibility of the DC.[22] As described in 2010, they perceived that the implementation of an additional layer of management would restrict their management space and "freedom of movement", which fundamentally was what motivated them to become experts in their specialties, as described by a consultant in the quote below:

> "I think we're still going to experience that, and you might say it doesn't matter, but you have to consider that some of that which drives those employees is a special sort of motivation, it's a special feeling that they are a part of the decision making and having influence." (Consultant L, 2013).

Even though the majority of the consultants found the model with an additional layer of management an advantage, some consultants also expressed that they expected the model to be time-consuming, producing more cold hands than warm hands.

> "Well the downside is clearly, that we're going to get more cold hands. There are a lot more people who are going to be occupied with management, communicating and ensuring communication across and up and downwards. And it takes a hell of a time, and if you think that it's something you can just do without dedicating time for it, then you're wrong. And the resources are taken from the daily research or care for

[22] I would argue that the untenable decision system in itself also intensified the consultants' dissatisfaction with the EAC because they considered him paralyzed (more than perhaps was fair) because their system itself primarily blocked efficient and deep management decisions.

> the patients, and I think it is a huge problem. The benefit is that the organization is so big that I think it is necessary to have some form of structure where you, as I said in the beginning, first of all suit our executive administrative consultant better professionally, but also ensure communication. But the problem is, that there isn't resources set aside for it, and that resources have to be found within the existing frames." (Consultant S, 2013).

However, as expressed in the quote, it was perceived as an overall advantage to construct the section management teams despite the disadvantages. Notably, the ability to communicate across specialties had always been valued in the DC. It was perceived to give positive synergistic effects always to be able to draw on colleagues to resolve given problems.

Naming the section management team as "managers" formalized the teams even further in the DC. The functional partnerships were perceived more as "friends" or "partners" and seemed undefined compared with the SM constellation in 2013:

> "No, I kind of think that you might think that what's going on is that the section managers have in some way delegated some tasks into the groups, and there the functional partners basically have, what should we say, the positions they had before. They just don't have any kind of formalized responsibility, if they ever did. I am in doubt about that because I actually don't know how well defined it was and I don't really know how much was written down regarding the functional partners. For me to see it was, there are also some who call it functional buddies, because it is like that in a way. There is something in partnership… well section manager is somewhat a different word." (Consultant L, 2013).

Regarding the specific management responsibilities in the sections, the consultants expressed an interest in the section management teams becoming teams who are able to ensure coherence, integration and communication across the sections and units:

> "The most important to me is that the section management – or our section managers – is capable of integrating what we believe in our group and taking care of our interests the best way in the overall game and in the overall frame, and then… Well, it's really to secure that there is a connection across the organization, and that the single sections are integrated, and that you kind of make sure that everyone is heard, but also that there are actually some decisions made, and things are communicated from one end to another." (Consultant S, 2013).

In summary, the majority of the consultants found the model with the section management teams an advantage in 2013, as they perceived the model with an

additional layer as a solution to major difficulties in carrying out the prevailing decision system and authority structure. This indicates that the consultants increasingly acknowledged alternative values and beliefs regarding the authority structure and decision system as they found the values and beliefs about collective and collegial decision making almost impossible to put into practice across every sub-specialty. Therefore they welcomed a certain degree of medical management stratification regarding specific management responsibilities, which will be explained in the sections below.

6.5.1.3 The section manager consultants

In this section I describe and explain how the section manager consultants expressed their interest and value commitment to the management model with section management teams introduced in 2013.

Very similar to the majority of the consultants' perception of the section management teams, the consultants involved in the section management teams expressed a clear dissatisfaction with the prevailing collective, collegial and consensus-orientated decision system, as they express that they find it outright ineffective:

> "… 10 years ago or something like that, there was maybe ten consultants in the department, now there's thirty or something like that. Formerly it was like this, I can remember from when I was hired out here as a junior doctor, that the consultants had a meeting every Monday, and they would make decisions and discuss things and argue loudly, but they kept it inside those four walls. They were so few, relatively, that they could actually handle things without anything formal, and go out and get the various decisions implemented. That is, of course, first and foremost regarding the medical professional issues, and the management of the department and such, and then you did what was said for the most of the time. Now there are so many. And there was also some really strong personalities, I will say that, very charismatic people, men all of them, by the way. But definitely some who managed to create respect around themselves, by what they said and did, in a way where things weren't discussed very much. And now there is such a big consultant group, that you can't agree on anything on those meetings, and the meetings always change character. Their character is more of orientation and more about operational economy. Deep down, it really doesn't interest us, it has to be the executive administrative consultant's troubles. That's what he's getting paid for, to come up with solutions for those problems." (SM, Consultant D, 2013)

All the consultants in the section management teams considered that the decision system had outlived its usefulness since it was almost impossible to come to an agreement as every consultant possessed a legitimate position to postpone the decision with a veto as they, by definition, are equals:

> "Because I think there has been a tendency for too much talking and too little action. And we are in a situation now, where we can't keep talking. I can just feel the frustration spreading, and it has done so for a long time. There just isn't any 'go' on anything. And the whole idea was, so to speak, that if every section management (team, ed.) could sit around the oval table and know that you represent the interests of your section, both medical professionally and nursing, you would be able to get a go-ahead for some decisions. Knowing full well that everyone can't have their way, but it is in that board that you try to make a prioritization of the effort. Because to send it all out into voting and big meetings and stuff like that, I don't believe in that, when we operate in this kind of field, where the surroundings change so rapidly. (…) But I just think that it has been like this for a long time in the department, and I also brought it to the notice of the joint management team, that you simply sit too long with your hands in your lap, and wait too long for some parts to fall into place, before you act on it. So it is basically the same as having written a play, then wait for the set to be built, and then you rewrite the play, so that when the set has been built, the play and the setting don't match. There is far too much waiting on outer things, and that simply makes us paralyzed in my opinion. So that was why I advocated it." (SM, Consultant D, 2013).

The SM consultants express an interest in the process of delegating the management responsibilities to the section levels and in this regard they have also been involved in the process of defining the section manager teams' position instead of the functional partnerships. The quote below illustrates how a consultant felt he/she been involved in an open process of constructing the section manager positions:

> "I actually think that we've become very implicated in that. I myself actually think that we helped create it. I think that it has occurred, what do you say?, through brainstorming at those management meetings." (SM, Consultant E, 2013).

Another consultant expressed interest in the section manager position because he believed that one in this position could gain influence and impact on important clinical medical decisions:

> "I do want the influence, because if I don't have the influence, then I can't make the impact I actually believe is important from a professional assessment." (SM, Consultant G, 2013).

Another section manager consultant explained in more detail that if consultants take on organizational and managerial responsibility they can really use their medical work to create better treatment for the patients and better patient flow which provides a sense of professional achievement:

> "… if you really want to put your doctor's calling to the best possible use as fast as possible for the most sick people, you can't do it just by being a doctor, you have to undertake management and organizational responsibilities. And in an organization that doesn't want that and knows it, it is hard. So my argument is, of course, that I have taken a management job to solve that, which I think, gives professional meaning." (SM, Consultant G, 2013).

Furthermore it was expressed that the executive administrative consultant cannot possess the highest clinical level while also taking care of the top administrative position, because there are so many management tasks in this position due to the size of the DC. Thus it is also recognized that the resistance to the executive administrative consultant should not necessarily be justified in "lack of professionalism" as such, but also in the recognition that it is impossible to maintain clinical professionalism and exercise leadership and management for the entire DC due to its size. Therefore, the consultants are very interested and satisfied with the position of section manager as they perceive that they do not have to compromise their clinical professionalism:

> "I don't want to be the executive administrative consultant because, with such a big department that we have today, it isn't completely consistent with a high level of clinical work. So I am really happy about our section management idea, because it means that you can take advantage of the highest clinical competences in some management functions, without the need for compromising your clinical work." (SM, Consultant G, 2013).

Furthermore, they believed that the joint management team had strengthened the management decision system through this kind of decision system. The section management teams will act as spokesperson, and it will not be necessary for the joint management team themselves in the same degree to reach the outer corners of the organization then, which the consultants in the SM also believe will be impossible, as illustrated in the quote below by a consultant involved in the section management:

> "Firstly, it is completely obvious that the department size has become too big, and I think that the management, as it was, the joint management team, had a hard time keeping the overview and feeling of what was going on. Both clinically, production wise and the staff wise, they don't have any insight in that, and they can't have an overview of it, they can't have any detailed knowledge. So in no way would they be able to handle that. So if it was, it would be complete overall and economic management which they would end up with. Of course there would be contact with the consultants, but the collegium of consultants in itself will also be very large, and it will also be difficult for the medical part of the joint management to even get an overview and insight into what's going on between the consultants alone. Besides that, there is a giant group of junior doctors, which he was also responsible for. And it also includes the nursing group of the joint management, that they in a similar way will have more contacts with the ward nurses, if they were to be put in everywhere. And then it might have been a bit in the time, of the criticism, there has been of the joint management, that their feeling of what's going on in the department and development isn't cared for well enough. So I also think it was to strengthen the management and development of the department." (SM, Consultant B, 2013).

The consultants in the section management teams express a greater understanding and interest in implementing an additional layer of management, based on the perception that the executive administrative consultant will not be able to provide a managerial overview and get a sense of what is going on in the DC in relation to expertise in clinical issues, production, or staffing, nor detailed knowledge. They therefore recognized that the DC had become too big a department to be managed by the constellation of a joint management team and a collegium of consultants grown too large for consensual decision making among colleagues. The acknowledgement means that they move away from beliefs that it can only be the executive administrative consultant in cooperation with the collegium of consultants who possess decision power. Instead, they found the additional layer of management an advantage as they believed that it would strengthen the management and development of the department, which would create better conditions for clinical work, which the DC values the most. In other words, the implementation of the section management teams was a solution to preserve and maintain the department's high level of expertise.

During the workshops, some of the consultants in the section management teams elaborated an additional idea to the section management teams in general. They invented a medical "board". "The board" consisted of the executive administrative consultant, the consultants from each section management team and the clinical

professor and would meet once a month. The head nurse and the section manager nurses would not attend these board meetings:

> "… then we had that idea of having a 'board', a kind of board of the department, where the ward management sits at the end of the table with the clinical professors, and then the representatives of the sections would be sitting there to. And then it is there you make the big decisions." (Consultant D, 2013).

What is interesting here is that the consultants who possess a legitimate mandate from their colleagues in each sub-unit create their own medical forum of section management consultants. I will argue that the forum is a substitute for the collegium of consultants, or their "extended arm", as it is possible for the consultants to have deep discussions without the nurses in this small forum, which is what the collegium of consultants did traditionally. By creating this formalized forum of consultants close to the executive administrative consultant, they are seriously breaking with the DCs decision system, which as mentioned before has been characterized by collective, collegial consensus orientated negotiation culture, by stratifying the decision making to another level. On the other hand, it would continue a tradition where the consultants in the DC have appointed their representative, their administrative manager, to take on the broader management and administrative tasks both internally and externally. In this case I will argue that the consultants in each section appointed their representative in a collective manner, but at sub-unit level, which means that the output is four "administrative consultants" in a conventional manner, and the executive administrative consultant. We then have the four consultants who are the medical professional representatives for each "section" and then the executive administrative consultant as the more administrative representative as such. The board construction then moves the executive administrative consultant's position away from being the clinical medical representative as such, but more possessing the overall coordinating administrative work. On this basis I will argue that the joint management position would be strengthened through the expansion of its section management consultants who want to be part of the administrative management work of the DC.

What is interesting is that this establishment of "the board" is constructed, despite the existence of the other different management forums: the joint management team, each section management team, the forum of the traditional collegium of consultants (the Monday meetings), the forum where all the professionals in the section management teams and the joint management attend (once a month) and finally the meetings where the head nurse and ward nurses attend.

What is also interesting is that the consultants in the section management teams find it difficult to explain why they need this board along with the interdisciplinary management forum with all the professionals in the section management teams

attending. What kind of discussions, dilemmas and issues can only be solved in the "board" and not in the expanded forum with section management nurses and the joint management? The section management consultants express that they need a forum where they can discuss medical matters and issues by themselves (at their high level of expertise), like they did previously in the collegium. In 2013 they believe that they are without a genuine useful medical management forum, which means that they do not feel equipped to meet the nurses in the section management forum. In their view, they are not properly prepared in the collegium of consultants, to discuss cross-organizational problems with the nurses in the section management forum, as illustrated below:

> Especially for the professional, medical management and research, I think that it is important that we review this internally in the consultant group, because we are educated with medical science, and to be here is to be on the highest level. It can be quite specific. And to make the decisions clearer, and you can expect all these things, then I actually think, that when it is on this high professional level, that if the nurses wanted to participate, it would be a bit of a waste of time. And it makes it more efficient, and I also think it is important purely professionally that we have the opportunity to discuss colleagues' and junior doctors' efforts and perspectives and future and such (…). But I think that the place where the ideas and the structure has to be formed, and there are some things that need discussion and to be brought forward and crystallized, made ready to be presented, and I don't think it is a forum, where you should be sitting interdisciplinarily. I think it would be a waste of time." (SM, Consultant B, 2013).

The constructing of this board of section management consultants helps to constitute the medical professionals'authority position and dominance in the decision system, by constantly eliminating the nursing profession from their meetings, as they did in the Monday meetings of the collegium of consultants. The board is considered as a solution to the need for an unambiguous medical decision system which clearly arose after having "talked themselves into each other" through the workshops. What is noteworthy in this regard is that the collegium of consultants has not been negotiating about the construction of this important board structure, which breaks with the traditional values about collective and consensus orientated decision making.

Through the construction of the board the section management consultants became more aware of their presence as section management consultants in the collegium of consultants. They expressed how they (the consultants in the board) have become more interested in appearing as a united entity when participating in the ordinary consultants' meetings. This breaks with the characteristic individual understanding of the consultants and their focus on their own abilities and attempts to positioning

themselves in the collegium. Their focus has shifted to what they can do as a united board as illustrated below:

> "It is also to agree, I was just about to say. We had some difficult battles here in the beginning, where we weren't in agreement, and where we took some of the battles a bit out in the open. The medical section managers in between at least, I will say. And we have talked a lot about that, that the tone, the rhetoric, we have to be careful with that, that we don't, when there is fifty other people located around in the organization, that they don't sit with the feeling that we come out as disagreeing too much. Where maybe we have to concentrate our discussions and fights to when we have joint (board ed.) meetings." (SM, Consultant E, 2013).

Furthermore the quote below illustrates how the section management consultants perceived how their position in 2013 put them "above" the rest of the rank and file consultants. This attitude breaks with the traditional collegial principles of being colleagues as equals, which underlines the stratification of the medical professionals' management positions as illustrated below:

> "I think, that the biggest advantage is regarding the strategic work, and if we can make that work along with making some deals and listening to each other and respecting each other, that we make a joint plan, then I think, we would be able to exceed a section war. The biggest disadvantage might be that we have to be careful, that we have the others with us. That there isn't too much distance between the section management and the rest of the organization. The thing is about getting them informed about what's going on, and make them understand it, so that they don't just see us as drones, or foremen. And also (they need to, ed.) feel that they aren't disconnected, that they as such don't feel, that well, now they're gone, now they don't have any chance of uttering a word, that we forget to inform them. The communication between section management, and I was just about to say the rank and file collegium of consultants – but you don't have to relate that I said that – but the rest of the collegium of consultants, that we aren't going to be removed from them and aren't a part of them, but still have a connection to them, I think that is the greatest danger." (SM, Consultant E, 2013).

However, the section management consultants are very aware that their position breaks with the value about equality amongst consultants in the decision-making process in the decision system, but also the more close interdisciplinary decision making process:

> "It breaks with that equality in the decision processes within the consultant group. It also breaks with the values, that it hasn't been a tradition to work as closely with the nurses' group." (SM, Consultant G, 2013).

Also the consensus-orientated approach which has been closely linked to the collective decision system has been broken, as expressed by a SM consultant:

> "Well that thing with consensus management, where we already broke a bit with that, when we had the functional partnerships. But if you go back longer, it's that consensus culture about, that we would all sit over there and discuss until we agreed. And you just won't do that. So I think that's where it definitely breaks with it. And then I do think that the thing about being at the top, where you define the strategy and have influence on it, I think that is a defining point too." (SM, Consultant E, 2013).

The consultants express in general that they find the section management construction makes the communication lines more regimented, which makes it possible to take more qualified clinical decisions, and also much faster:

> "The biggest advantage is that the lines of communication are more one-way, it was that, which was the whole idea of it in my opinion. (…). Then you can take off on some professional decisions and do it a lot faster." (SM, Consultant D, 2013).

Despite the section management consultants' expressions about their interest and value commitment to a management model with a section management level, the majority of the section management consultants perceived that the implementation process of the section management teams was still in its infancy. The section management consultants expressed that they are "orangutans" who are beating their chests and want to possess decision power (which they have been fighting for), but at the same time they find their management responsibilities diffuse and some of them demand management principles from the joint management team in order to progress in the position:

> "… I think it's a process. Because you have to consider our department as being in the stone age of organization. It is completely nonexistent. It has been a collection of anarchists, who have been controlled by some scumbag at the top." (SM, Consultant G, 2013).

In summary, all the section management consultants find the section management teams an advantage for the DC. They express that the prevailing model with the collective and consensus orientated decision system cannot function in the same valuable form anymore. According to them, the collegium of consultants is an

outdated forum because there are too many consultants involved in the consensus orientated decisions, which makes it almost impossible for the consultants to make any decisions as each consultant possesses the right to go against any given decision. Values about collective and collegial decision making do still dominate the decision and authority structure, however, according to the section management consultants, the collective and consensus orientated decisions are taken more locally in each section or sub-unit. This means that they are willing to reduce or re-organize the collective consensual decision system, because they perceive that the whole DC will get stronger, faster and more qualified clinical management decisions by constructing the section management teams. This belief is also in line with the values about being the best (most skilled) DC nationally and internationally.

6.5.1.4 The section management nurses

In this section I describe and explain how the section manager nurses expressed their interest and value commitment in the management model with section management teams introduced in 2013.

The growth of employees and specialties of the DC created a situation where the ward nurses found it difficult to consult a consultant about medical and administrative issues in their daily operations. Previously, when the DC had fewer employees and specialties, the ward nurses experienced that the joint management team had time and space to discuss various managerial issues *ad hoc* in the daily operations. There was time for *ad hoc* meetings in the units (in addition to the regular joint meetings). The increasing growth of the DC had made it almost impossible to have these meetings on *ad hoc* basis, according to the nurses:

> "They came into the offices now and then and chatted a bit, and then you would have an opportunity, if something crossed your mind. They came and had coffee and asked about some things that they wanted to know about. But that's ancient history; they can't handle that at all. Back when we started with the functional partnerships, that was more to make a layer that could pass on some information in the systems and handle those things." (SM, Nurse F, 2013).

In 2013 the majority of the nurses engaged in section management teams were fairly interested and satisfied with the new model, because a given consultant was formally associated to each unit. They found the process very natural:

> "I really think, that it's a good development, and it's very natural, also because, as I say, the department has got so big. So somehow, I think that it makes really good sense." (SM, Nurse A, 2013).

In other words, all the nurses involved in the section management teams found the section management construction an advantage. The biggest advantage was expressed to be shorter “lines of command”.

> “The biggest advantage is that the lines of command are shortened. For example, everything about the clinical part is a hundred times easier to me now than it was ten years ago because now I have a place. These kinds of things have got a lot easier, those are some big advantages. And as big as the department is now, it wouldn’t be possible, it’s impossible. You have to schedule a meeting with the head nurse and the executive administrative consultant practically two months ahead. And it’s just no good, if you find yourself with a problem, then you have to be able to find someone. And that is where the SM consultant and I have to kick in, when they have a problem out there.” (SM, Nurse F, 2013).

However, the majority of the nurses in the section management teams found their position as section managers and their mutual position and responsibilities undecided and ambiguous in 2013. Their internal management tasks still lacked clarification and were ambiguous in the spring of 2013, which made them feel more “section manager” by name than by fact. This may reflect a constellation where the consultant and ward nurse still practised their traditional work and day to day routines despite the intention of interdisciplinary team work in the sections. However, some of the nurses involved in the section management teams expressed that they had established a closer relationship and cooperation with “their” consultants, and perceived they were behaving more like team mates than representatives from two different professions. This indicates that the establishment of management teams has led to a decrease of the “pillar” behaviour, where each professional consulted their own medical colleagues or nurses consulted the head nurse. In other words, the team constellations have broken down the traditional management structure and behaviour somewhat with the nurses and consultants in teams cooperating about daily management issues before consulting their own group of professionals.

Regarding the specific changes in management responsibility and the clarification and definition of the section management teams’ areas of responsibility, however, the quote below illustrates how the section manager nurses did not perceive a major change in their task portfolio compared with the period before the additional layer of management was introduced:

> “It is about involving the expertise on the floor, I think. But I also think that it’s something with the process about the consultants who have management responsibility but aren’t necessarily the best managers. They follow their own dreams in their own specialties and think that it is the most important. So maybe I do think, that the transition is bigger for

> the consultants and the medical group than for the nurses' group. And the consultant you just interviewed also said, 'For how long have you actually been a section manager?'. I said, that I don't care much for that. My jobs have become different, because it has become a bigger department, and I might feel a bit more powerful than I did before, since we are just four section managers now. Basically I still think that I move around in the tasks, I always have done." (SM, Nurse A, 2013).

According to the section management nurses, the teams are consolidated but the "cooperation surfaces" and the management tasks are still being discussed and defined. This is also reflected in the staff knowledge about the section management teams:

> "…there isn't anyone at all in the X unit who is in doubt that the consultant and I are a team. But what it really means, what it is that we decide, and what it is that we don't decide, and what we do besides the things we practice, I really don't think they have much feeling about it." (SM, Nurse F, 2013).

However, the nurses are not so concerned about titles such as "section manager". It is the tasks in the daily operations that drive, them as illustrated below:

> "Whether I'm called section manager, we aren't very focused on titles, I think. It is our jobs that drive us, and which makes sense." (SM, Nurse A, 2013).

I will argue that it is perceived as a "smaller thing" or less of a cultural rupture when a nurse through his or her career achieves a "management title", than for the doctors, because the nurses have a history for being administrative managers at different levels in the DC, which the doctors do not have.

Despite the perceived minor changes in their position as managers and their responsibilities in practice, the SM nurses express that the joint management team demand more of the section management nurses than in the time before the additional layer of management. The responsibilities have become more complicated and the time to handle the tasks has been increasingly limited. They still have to manage "their" unit and the operational work as before, however, they must also participate in more meetings about section management.

In summary, the section management nurses are very interested in the model with section management teams, and especially the cooperation with the consultant in their team. However, the development of their section management team position and relations, both internally and externally, is perceived to be in its infancy as it still reflects traditional professional execution of tasks and limited awareness of cross-sectional tasks.

6.5.1.5 The junior doctors

In this section I describe and explain how the junior doctors expressed their interest in and value commitment to the management model with section management teams introduced in 2013.

Some of the junior doctors express that the development and implementation of the section management teams has made some of the organizational issues easier to solve in their sub-units, especially for those doctors who possess higher levels of expertise and seniority. However, the junior doctors at the “bottom” of the authority hierarchy have not felt the benefit from the established constellation, as expressed in the quote below:

> “I will say that, for junior doctors (ed.), no. But for the doctors in the department it has meant that they have a section manager to relate to (…) So for the doctors in the department, I think, it must have meant something.” (Junior Doctor K, 2013).

In general, the junior doctors were not involved in the process of developing the additional layer of management in the DC. They were more or less uninformed about the process, which they perceived as very unclear. Furthermore, they did not perceive that the SM teams in the daily operation had an impact on the junior doctors’ work and working environment. Whether they are interested in and committed to the idea of the deployment of the model is unclear in the data from 2013, despite their expressed commitment to reform in 2010. Overall they still seemed interested but were questioning whether the different section management teams had any influence on the younger doctors’ working day in 2013.

6.5.1.6 The nurses

In this section I describe and explain how the nurses expressed their interest and value commitment to the management model with section management teams introduced in 2013.

The majority of the nurses did not notice, in their daily operations, that the functional partnerships were reduced to four even more “formalized” section management teams in 2012. Moreover they were not informed in a large degree of what was happening in the DC regarding the overall changes in the management structure and the attempt to implement an additional layer of professional management below the joint management team. Several of the nurses interviewed said that the process was perceived as being initiated at the centre management level or the regional level, but also department level, which illustrates that they had not informed much by the joint management, the section management teams or the ward nurses, despite the process continuing for several years. In fairness it must be

said that a few individual nurses expressed that their section managers had arranged meetings about the implementation of the section management teams. The above described picture is however still the strongest impression. The quote below indicates that the intentions about making the medical presence visible and creating the ability to have a particular consultant associated with each section and in the daily operations, initiated in 2010, was still not particularly visible to the majority of the nurses in 2013.

> "For us out on the floor, I don't feel a big difference." (Nurse Q, 2013).

However, despite the lack of insight, a minor part of the interviewed nurses expressed that they perceived that the section manager consultants in general were more present in the daily operations, but it was also more apparent to those nurses that the section managers were working more closely together about the daily operation which, according to the interviewed nurses, created the basis for greater consistency and better patient care, because in the daily work they adjusted things in a more clever and appropriate manner with the focus of both section managers. The felt that it created more continuity in patient treatment. As the quote below underlines, some of the nurses had noticed the consultants in the section management team, and have felt their interest and value commitment to the collaboration:

> "But it's my experience that they also, the section managers, think it's a fine way for them to gather some things (…) So I really think, that they express that they are interested in it." (Nurse, 2013).

What is also interesting is that the nurse quoted above perceived the consultant as "the section manager", leaving out the ward nurse position. This could indicate that the traditional pillar structure with the consultant in a top authority position was still practised in the teams, which does not indicate equal authority positions in teams as intended by the joint management team.

After the implementation of the functional partnerships and then the section management teams, according to the nurses interviewed, only the *ad hoc* presence of the consultants in the units had decreased and it was perceived that the framework for the associated consultants' presence had become more solid. It was perceived that there was more continuity in the daily operations because of the section management teams.

> "… but it's a lot more in fixed boundaries, than it has ever been (…). But if I have to assess it, as I see it today, things are far more controlled." (Nurse P, 2013).

Despite the construction of a more involved and present section management consultant, the nurses in general still made use of and referred to the ward nurses in

their units, which indicates that the traditional hierarchy was still functioning as usual in the traditional manner within the units.

In summary, the nurses expressed an interest and commitment to the construction and implementation of section management teams, but they were not involved in the development or implementation process. The majority of the nurses experienced more continuity due to the consultant's presence in the daily operation after the section management teams were created, however, they had not experienced a larger impact of the section management teams.

6.5.1.7 Summary

In summary, the majority of the professionals' expressions and perceptions about their value commitment and interest in the section management teams in 2013 reflect an overall positive interest and commitment in them. The joint management team is (of course) engaged in the idea and implementation of it. However, on the one hand, it seems like they perceive the degree of implementation more positively than do the professionals. The majority of the consultants express an interest in and commitment to the new model, but a minor part of the consultants resist the model for various reasons. Primarily those consultants express that the break with the collective, collegial and consensus orientated decision structure threatens the motivation and innovation culture in the DC. They also express that the idea of creating the model is a weak manager's work. The consultants in the section management teams are more interested in the model and find it overall a better solution because in their opinion creates a stronger medical decision system, which in their opinion had been weakened for a number of years. They express a value commitment to it in that it will make the position of the medical consultants in the DC stronger. All the section management nurses express a strong interest in and commitment to the additional layer of management. They express that it creates a better communication flow and sharper decision making. The majority of the junior doctors are more hesitant in their interest and commitment to an additional layer of management. They have not yet experienced the intended outcome in closer cooperation and management communication with the junior doctors. Finally, the majority of the nurses are interested in and committed to the idea of the section management teams despite their lack of insight into the re-organization process. Like the junior doctors, however, they have not experienced any significant outcome of the implementation of the section management teams in 2013. The nurses have not received a lot of communication about or involvement in the intentions and outcome of the process either, which resulted in information about the changes not having reached into every corner of the organization. The management change process around 2013 was still characterized by the fact that the individual section management teams were trying to understand and define who they were and should be and the tasks they should undertake in relation to each

other in the team, in relation to the joint management team, in relation to the other teams, but also in relation to their colleagues in the DC.

6.5.2. POWER DEPENDENCIES AND CAPACITY FOR ACTION

In this section I describe and explain how the joint management team, the section managers, the consultants and the nurses perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

6.5.2.1 The joint management team

In this section I describe and explain how the joint management team perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

Regardless of the joint management team's intentions, it proved quite difficult to effectuate the management changes, as the head nurse describes in the quote below:

> "There it is again, the part about intentions. Have you ever visited Lauritz.com? That's a sidetrack. When you read about the products in there, right. Yay!! You have to bid on them. Then when you get them into your home, it's something else. And that is of course how it is, that idealism, which revolves around, that we have made it clear to ourselves, that we want this. It has also been a process for the executive administrative consultant and me as a joint pair to find a management profile, which is joint. There, the management strategy is just as much an expression of that. Not that we don't mean it, but it's ideally a piece of paper, that we of course run some things with, but…." (Head Nurse, 2013).

The overall strategy process has been characterized by an *ad hoc* meeting culture and spontaneous meetings or talks:

> "Then I'm going to say, a strategy for the process – it might be enough said. Well, we might have formulated the strategy a little, while we walked the patch, I would say. Again because it isn't something we can go out and look up in some books about, that you have done this and that in ward x and y, and experience this and that. It has been really difficult. It has been about feeling our way forward and feeling what the organization can withstand, what works theoretically, when we merge it. So in that way it really has been a gamble I'll say…." (Head Nurse, 2013).

The joint management team kept track of the process, and have expressed that it feels “artificial” to construct more formalized meetings, as they meet those involved in their day-to-day interactions and routines. This is perceived less formally, which is rated highly amongst the joint management team, but paradoxically those involved demand more concrete expression and action, as I will explain in the sections below. In the quote below the head nurse underlines how the strategy for changing the management model in the DC has had a “feel and touch” approach:

> ”Well, it’s a bit ‘feel and touch’, I almost said. Well, we don’t have any milestone things or defined goals. We go and feel. It’s much about that through what is said, what’s required, it’s much like everyday life, that defines, that we take some sort of temperature. But heck, it’s going rather fine, so you might say about it, that it’s not very academic, but it… those are some very good, also because we work so closely together somehow, so it’s some really good parameters, where you can quickly sense how it’s going in that section and between the sections, or…. But of course we formalize some areas, where we then produce these statements or…. Well, we have implemented some other meetings. Where we have close contact, where we constantly have the possibility to follow, how is every single one about this. It’s on as a notion on meetings, how is it going with both the bookwork, section management etc., yes.” (Head Nurse, 2013).

Regarding the implementation of the additional layer of management in the DC, the executive administrative consultant expressed an optimistic view about the overall change in the management model. He felt that the joint management team has achieved their goal compared with their intentions in the first place:

> “Well I will say, that we’re home safe. It’s damn working. I think so. Well, it’s a management model, a management organizing. It constantly has to be perfected and adjusted etc. But there aren’t questions asked about it anymore. They undertake the responsibilities, some of them extremely well, and some of them to the limit of their abilities. (…) we still have some unfinished business here and there…” (Executive Administrative Consultant, 2013).

The head nurse is more restrained in her formulation about how the implementation of section managements has progressed. She describes that there is acceptance and recognition of it in the organization, but also fumbling:

> “But there is no doubt that there is a clear recognition in the organization and also an acceptance of that’s how it is. But therefore it is still hesitancy.” (Head Nurse, 2013).

However, the head nurse found that the section management teams were more and more becoming a “buffer” for some of the more practical questions and tasks regarding daily operations, which was also the intention with the additional layer of management:

> “The section managers themselves meet and solve things, that you earlier on would have involved us in. You don’t do that anymore. Well, you can have two section managers in-between, where you sit down (…) then they handle it. Or something internally in a section, where earlier on I would have been contacted by a unit, because they had problems with something. Now they go to their section management, and then I hear about it, when it’s solved. There are lots of practical examples now.” (Head Nurse, 2013).

Compared with the management strategy paper which has been developed during the process, it is highlighted that the section management teams are responsible for professional clinical management, strategy management, personnel/HR management and research management. According the executive administrative consultant, the section management teams are well aware of their specific responsibilities regarding those mentioned management areas:

> “Yes, I would actually say so. We asked them to come up with a strategy yesterday. It might have been the consultants who were asked to do it, but of course it will just be even wider and perfected, and there they do have, there they have all the ‘bubbles’ (the drawn management areas in the strategy paper, red) in. There might be some of them who will say that they don’t think they do a lot of administrative and personnel management, because they don’t have any medical resources, but then you do it on joint management level or ward nurse level. Research management I think they all have. I can give you examples from all of them trying to do it. Production management, yes. So basically I think they make it all the way round. There might be some who want more, and therefore don’t think that they do it very much, but that is just, you might say, really an example that they do it, but they aren’t satisfied that they can’t do more. So there might be some who will say, that they aren’t doing very much, but that might just be out from the wish, that they want to do more than they are doing now.” (Executive Administrative Consultant, 2013).

The head nurse described clearly how she perceived what the section management teams focus on in daily operations:

> “Well in the everyday life it’s a mix of – well the operation fills a lot, resource consumption, priority between staff, competence development

> of staff, hiring of staff they handle. But there are also strategic tasks. It is some of what we are focusing on right now, that we try to let them work as section managers with strategic areas in their own section. So it is a kind of a mix, if I might say so, operation and strategic areas." (Head Nurse, 2013).

The executive administrative consultant was aware that section manager consultants demand more delegated power, even though he perceived it is delegated regarding the four management responsibility areas. Especially regarding the management of the more administrative operational tasks the executive administrative consultant expresses that many of the more operational questions are "moving" away from his desk, which is perceived as positive, but his are concerned about the joint management team becoming even more invisible and blurred in their work, since the section managements began to take off. He also points out that open cooperation therefore becomes even more important in relation to making good decisions. The joint management team have put themselves in a position where they are becoming dependent on the managerial work of section management teams:

> "And we have many examples now that there are many operational tasks, that we were involved in earlier, at some time, sometimes too early, sometimes at the right time, but often too late and that gave you a feeling that we were very sluggish at making decisions. There are many of the decisions, we never hear of them again, they are just set into motion. So it's a huge advantage, well some of the things we had as an ambition – we can see it works too. The disadvantage, the biggest disadvantage to me, and personnel management, is that we are pushed even more back into our offices and distance ourselves more and more from our employees. But it was in reality something we wanted to do, but it's a disadvantage because we become more and more dependent on… that the cooperation we have with the section managements is so hugely open and giving, because otherwise we really don't know what is going on." (Executive Administrative Consultant, 2013).

The executive administrative consultant explained that when they move away from issues regarding the DC's operation they paradoxically lose touch with the daily operations, and it is actually difficult to take tactical and strategic decisions, despite the fact that it was indeed the intention of implementing the section management. This makes the joint management team even more dependent on the cooperation with the section managers and their clinical knowledge about the operation according to the EAC.

In this regard the executive administrative consultant expressed that it is a concern of the joint management team that they will lose power to the section management teams as they fear their position will become more blurred and maybe even

interpreted as unnecessary to the consultants, which may cause legitimacy problems:

> "… it is also a dangerous position the joint management team suddenly is positioned in, because we in reality can be leftover in the background because the day-to-day operations and the daily visibility gradually fades. It could be a problem to our authority and legitimacy. That is at least, I think, how I sometimes notice how they take so much authority and legitimacy without them having problems with it, that they weaken my authority and legitimacy." (Executive Administrative Consultant, 2013).

As an example, the joint management have not delegated responsibilities for budgets or finance to the section management teams. However, in the daily operations, the section management teams agree upon resources and create different allocation systems in order to achieve production targets, especially regarding who should work in each section or unit. In this regard the joint management team consider that the section management teams need management education despite their medical expertise. A lot of them possess more or less management experience from the functional partnerships, and a few of the section management nurses are involved in master programmes about leadership. However, in general, the professionals involved do not possess management education or experience in more administrative tasks.

> "Of course they lack tools. Each of them is hugely gifted, and they are experts in their field etc., no matter which professional background you have, it is a culture of experts we have. So in that way there are some parts of the management that they naturally turn to. But when it comes to being aware of management and being able to reason about management, and why I choose management-wise to do some things instead of others. They definitely lack tools there. And the variety, which I also think, management requires, when you are many in a big department, because management too is actually a balance of considerations, if I may say so. And they lack tools for handling exactly that, most of them. They are tunnel visioned, for better and worse." (Head Nurse, 2013).

The joint management team are also concerned about the development of sectioning and that the sub-sections' one-sided focus or tunnel vision will mean that they are not able to handle a financial responsibility that meets all the department's welfare.

Furthermore, the head nurse expressed that taking the responsibilities on their shoulders unfolds differently among the doctors and nurses in section management teams. The section management nurses are more aware of and dedicated to the daily

operational tasks, as they traditionally have been and it has been difficult to involve them in the more strategic work and research. The consultants have traditionally possessed the political-strategic and research work and find those tasks closely attached to their profile. These traditional work areas are very difficult to break in interdisciplinary team work, according to the head nurse:

> "Well it depends on which section management team you look into, because they have a lot of different profiles, you might say. For my part, well the section management nurses – and that term still isn't quite precise yet, I don't know if we're going to speak more of it, because it actually matters – I have a hard time getting my ward nurses to commit to section management and, for example, to take interest in research management. It is very much up to me and the research responsible nurse, whom I hired. And the thing to take part in the research development field as a natural part of the management job, that is a challenge. They are still very production oriented and very schooled in being narrowed in on it, so it takes up very much. I will also have a challenge in the strategic planning, if I have to speak of them as a group, because we have typically made strategies in the nursing group together. We have made strategies in, for example, research and development, in the field of basic education, the number of staff, and in documentation. Well, we have all sorts of different fields, where we make joint professional strategies. And whereas, what do you say, the more political and tactical part of the strategic work, we are going to be challenged there, because the doctors have a longer nose for it, they demonstrated that as recently as yesterday, so we are really going to have to be steady there, and find out where we can contribute to the political-strategic field there." (Head Nurse, 2013).

This perception makes the head nurse focus on the cultural management boundaries. She considered that the SM nurses would need to be supported even more in their more "inexperienced" management responsibility areas as e.g. strategy and research:

> "… but that is where I think, that for me to get my nursing group of managers into this work, plant the confidence it takes, well the independency they can bring into it, I have to challenge them there, and I still have to support them a lot in that work. I hope that at some point in time we get some profiles, that naturally and equally kick into it, but I can feel, that right now – if you have to keep up with – because it is still a very expert and medically dominated environment, we have, so if we have to have some equality in the strategic work, we are going to have to invent and reinvent some independencies." (Head Nurse, 2013).

Furthermore, the head nurse describes how it is difficult for the joint management team to delegate an authority position and power of decision making to the section managers:

> "… we still try to gather and agree on some joint decisions, that we may go out and announce something identical. It is absolutely a process we're training and need to get going. But there are still challenges in relation to who is primarily responsible for what. Well, how much decision competence has really been delegated?" (Head Nurse, 2013).

The head nurse expressed that, despite the joint management teams' intentions, they are in doubt how much power they in reality would like to delegate to the section management teams:

> "… I don't really think either that we are completely clear about how much power we want to delegate, and what the consequences of it will be…." (Head Nurse, 2013).

The head nurse expressed that the delegation process is actually a process of negotiation of managerial responsibilities. The joint management team are a bit tentative in relation to delegating the specific management responsibilities because they perceive that colleagues with very different management profiles possess the section management team positions, which makes it difficult to make clear delegation of tasks, as individuals will react differently:

> "Well, I will say, it's still so new, so the thing about seeking out management competences and management space, it's kind of a thing we still fumble around. And it regards both letting go of and tightening the reins, both with the background of, that you have to find out, which consequences it has, when you do either, because we are such a tangled organization, so if you let go of the reins in one place, it has consequences for some of the things happening elsewhere. So it's the thing about finding balance in how much you want to put into certain profiles, because it is also very different profiles we have on our posts. It's an exercise right now. It's not sure that we will ever reach some result, we can put a mark under. I actually think that we as joint management team have an extremely big management job keeping these things in check." (Head Nurse, 2013).

The executive administrative consultant, independently from the head nurse, also reported that the professionals involved possess different competences regarding the managerial responsibilities, which has made them being a little tentative in relation to the delegation of the different responsibilities:

> "We let it evolve on purpose. And therefore it also evolves differently. Well, there are some who take a lot of management and there are some who take management moderately. There are some who are drowning in regular operational tasks or at least tactical decisions. But it isn't clearly defined and we have actually not held any bilateral meetings with the section managers, which we had imagined that we should." (Executive Administrative Consultant, 2013).

Regarding the lack of "formal" delegation of management responsibilities, the head nurse explained how despite her formal top authority position she finds it difficult to be involved in the constructed management forums in practice as the traditional parallel "pillar" structure with separate professional management groups was still practised in 2013. The dominant medical profession still possessed their authority position and took management decisions in the (traditionally) "closed" management forums – the collegium of consultants and the board of consultants, where the head nurse is not invited. Conversely, the head nurse is aware that the nursing group also held management meetings without the doctors' presence:

> "And the thing we are talking about is that this management space, where the executive administrative consultant and I, where we have an equal amount of speech time, say, opposite a consultant forum and having equal management space – I don't have that. Well, as such it still isn't defined. I don't attend consultant meetings. There is no access, so to speak. Well, it's a closed circle, right? And I must say, that it isn't giving me real management space on an equal footing. In the same way I have separate meetings with a circle of ward nurses, where we clear a lot of stuff that we think only concerns us. And there, the executive administrative consultant is only in *ad hoc*, so to speak. So we do have some parallel systems, which we are still challenged by. And it brings some divergence in the information, some breakdowns in communication, and it also creates some unrest in the section management circle in relation to the joint management. Definitely." (Head Nurse, 2013).

The quote illustrates that despite the head nurse's formal authority position, it is difficult to delegate management power and responsibilities formally, when the head nurse is not even acknowledged as possessing a position that enables her to attend the important strategic decision making meetings with the consultants. In other words, as before described, the head nurse's position is roughly speaking not as acknowledged or as legitimate as a management position of the consultants, but only for the nurses. This blurry management construction makes it difficult to delegate management tasks and responsibilities and furthermore it strongly influences the communication and spread of management information.

The executive administrative consultant also referred to difficulties due to the amount of different management forums, and the difference in authority positions and decision making power. However, he perceived that the management tasks the joint management team and the section management teams should be in charge of is still a matter of negotiation:

> "Because now the head nurse, she has meetings twice a month with her ward nurses, I have a meeting once a month with my section management consultants, and there, at any rate, we are clearing lots and lots of things. What you do and what you don't do, and what your section manager has done that the other one wants or thinks we should have a talk about that because they actually still want me to be in charge of that. So in that way it might become clearer and clearer to the separate section managers as it catches on…." (Executive Administrative Consultant, 2013).

The joint management team perceived that in practice the section management teams developed their own management "approach" differently. Some of the teams focused more on one of the four described responsibility areas. Others were able to focus on some of the other areas. The executive administrative consultant explained that in practice much of the "clearing" and communication was done through the meetings with the head nurse, the section management nurses and ward nurses. In my view, the decision system and communication routines maintain the traditional pillar authority structure. The consultants are making medical decisions in their "own" collegium and board, and the nurses are making decisions about the nursing areas as they traditionally have been doing with the head nurse. According to the executive administrative consultant, this construction with the board was necessary in order to prevent the consultants from the section management teams negotiating and fighting against each other instead of cooperating and finding common ground.

In summary, the joint management team's expressions and perceptions of who possessed top authority and of power in the decision system has changed from 2010. The creation of the four section management teams had an impact on the prevailing archetype structure, system and interpretive scheme. According to the joint management team, the collegium of consultants still possessed a strong top authority position in collaboration with the joint management team. However, their informal top authority position has been called into questioned as most of the professionals felt that the section management teams should take a higher position as acknowledged "representatives" for each section. This position has been acknowledged by both the joint management team (of course) but also the consultants in collegium in general, despite a few sceptical consultants, according to the joint management team. Thereby the collegium of consultants are not necessarily the ones who are listened to most keenly in the decision system anymore, compared with 2010. But it depends who you ask and what responsibility

areas are being discussed. Overall, the collegium of consultants and the most experienced consultants do still dominate the strategy and research management areas, where the section management teams and the joint management team strive to take on the management of all the intended areas, but are in practice mostly involved in the daily operations. Regarding the joint management team's position, they perceive that they still possess the top authority position, but they worry about their position becoming less necessary or legitimate in the authority structure, if the board structure and section teams become more powerful and respected by their colleagues, as they possess a stronger clinical knowledge, respect and overview of the clinical work in the DC. Despite the stratification of the medical consultants' management positions regarding the more administrative and operational overall tasks, it is still the values about being a skilled expert and possessing seniority that dominate the interpretive scheme, according the joint management team. This dominant interpretive scheme challenges the nurses' possibilities to enhance their management positions in the section teams to an equal level, especially according to the head nurse.

Regarding the joint management team's perception of their capacity for action in order to implement the changes, the joint management team shapes the construction of the management model through different "activities", a "touch and feel" approach to how they can delegate different kind of responsibilities and how the involved professionals are aware of and take action on different kinds of management tasks and areas. So the joint management team adjusts the organizational formalized changes through daily negotiations with the involved section management teams. However, it also seems clear that the consultants' overall authority position and the traditional collegial decision making structure makes it difficult to effectuate top-down processes, if the joint management team wished to do that. However, I assess they are aware of their limits in this regard, which is very important in order to understand their hesitancy but also "activity shaping management model approach". Many of the professionals perceive that the joint management team, and especially the executive administrative consultant, are conspicuous by their absence when it comes to defining and delegating the management responsibility more accurately and thus meeting the uncertainty and ambiguity thereof in 2013, which I will explain in the sections below. This process approach forms the construction of the concept of the section management teams. However, it is also clear that the joint management team does not possess the ability to embrace and define the section management team space specifically due to the dominance of the collegium of consultants. In other words, it lacks capacity for action in the decision process of who should be responsible for what in the DC, including the revitalization of the consultants' management space.

6.5.2.2 The section management consultants

In this section I describe and explain how the section management consultants perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

Some of the consultants in the section management teams said that they were listened to and respected by their colleagues and the other professionals (primarily nurses), when they managing in their sections:

> "They accept me as a manager, most of them. And it is also because we have good teamwork, and they feel comfortable, they work with those things too and have got it structured the way they want it. And also the junior doctors, I also feel that they are satisfied. There are always small things we go around adjusting, but the view of the management I actually feel, that those who feel good, they respect it. So I think it has something to do with the fact that, if you feel comfortable, then you respect it and recognize it and want to work with it. But if there are any hurdles, that aren't working for you in your own performance, then you will be critical towards it, so you won't be part of it. So I think that the point of departure is a little important." (SM, Consultant B, 2013).

Another section management consultant expressed that they have to earn that respect among their colleagues through their work with management tasks. In this context, it is perceived that they establish respect for their position through this process. But this consultant also commented that there is an awareness that some will not endure the stratification of the management model and should be dealt with by means of"shielded" management:

> "It's something self-perpetuating, that you get some stars on your shoulders. That you are used to something doesn't give you absolute respect. I think, that you need to show too that it works, that you are making an effort, and then I also think, that the respect will come by itself. So I actually feel that even though there are some who can't understand it, and who just run their own race and don't care, but they are out of psychological range, it doesn't matter what you do, there will be some who are of that type. It's all right, they just need some shielded management, as it's called, then we can make it work. Well, it's clear that if you huff and you puff, and you run it into the extreme and don't respect what the others say, then it won't last." (SM, Consultant E, 2013).

They also express that even though they feel that they overall possess the authority to practise section management, it is a position they have “taken” and not received from anyone with an authority position:

> “I didn’t feel it as much in the start, but I think, that it is increasing, I feel, that I decide some more. And it’s not like that I feel, that it is something someone has given me, it is something I have taken. It is not something, I feel is agreed. So I have actually by myself taken management in the areas, where I could clearly see, that I could it. So I did it.” (SM, Consultant B, 2013).

This indicates that some of the consultants in the section management teams possess the authority position and power to make legitimate decisions in their sub-unit. However, other consultants in the section teams find it rather difficult to be listened to and respected by their colleagues and other professionals associated with their units. The quote below illustrates how a section manager consultant describes different reactions of colleagues:

> “Some accept it, I think, and others will say, that it is only the executive administrative consultant who can manage them. You can’t have a colleague who manages you. So there are those, who will confess to it and accept it and also say, that it is good, that we undertake it. The others are free to do the clinical work, they haven’t any interest in it and trust in us and stuff like that. But there are also some who have a sort of a reactionary, conservative, old-school attitude towards it, and it shouldn’t be like that, we are all managers when you are a consultant.” (SM, Consultant E, 2013).

However, despite some of the consultants expressing that they themselves took on this position, all the section management consultants ask for a clearer statement from the joint management team about their legitimate authority position and power to make decisions, especially for the colleagues who are more hesitant and uninterested in the additional layer of management:

> “So you haven’t got everyone in, and it’s not sure that you can. But if they are in the department, then I think that you have to push through and say that this is actually the way we work, so they have to adjust to that. And there I think, that the whole function has to be clearer. It’s not sure, it should come from me, it might be, that it could come from higher management levels. And it’s a very weak spot. You don’t want to touch that, but you have to. I point out that the section management has to take more management. And if people don’t want to join in, they have to anyway. Then they have to be pushed into being in, or we can’t use

> them. It is necessary to manage things a bit more, it is too messy in my eyes." (SM, Consultant B, 2013).

In this quote it is also clear that the consultant is aware that the "joint management team" and their implementation strategy was perceived as a weak point when stating the overall power of the section teams. It is expressed that the SM consultants are very much interested in being informed about what who should be "in charge" and what they will be "in charge" of:

> "There I think that the joint management team should have been much clearer from the start and said that now we have chosen to make these section management teams. They should have said that there lies a lot of decision power in the section managements, and that the joint management actually go out and dictate or announce, 'This is how we want it to work', and then we expect, of course, that the employees are loyal to their section management." (SM, Consultant E, 2013).

Some of the consultants feel that they do not possess enough power to "take action" on the different issues related to their section manager function. They describe their "power" to manage as a whole and that they are not "met with" or listened to by the joint management:

> "I feel a lot like, that I of course have some management competences, but it's hollow. Well, whatever I am going to say, is going to sound hollow. That when I try to raise some problems that we face daily a level up, when I say that now we have a problem, we have to try and find a solution here and now on this professional, operational problem etc. Then I come with the solution, along with my SM nurse, and with full support from my colleagues, we raise it up a notch, and then it dies. And I know that the executive administrative consultant and the head nurse have a whole lot to do, but it's just not an excuse." (SM, Consultant D, 2013).

On the other hand, some of the consultants are clear about the limits to how much authority and power over their colleagues they could possess as a section manager. For example, they do not possess a right to sanction as they are still regarded as equal to their colleagues:

> "And there I actually spoke to the executive administrative consultant about it, saying that if there are any such problems of a more fundamental kind, that people can't behave properly, then he has to face them. Because I can't be a sergeant to my equals, because I work side by side (with them, ed.)." (SM, Consultant D, 2013).

In relation to this quote it seems that the section management consultants overlook or ignores the medical stratification that is going on internally in the collegium of consultants. They moreover perceive themselves as their colleagues' representative. This perception reflects values and beliefs that are still rooted in the traditional prevailing values and perceptions of the authority structure and decision system. In this regard the section management consultants are very aware that it is a challenge to be listened to and to represent the section by which they have been chosen as the representative. They must obtain their colleagues' trust, acceptance and mandate for practising the role and maintain their position of power:

> "But again, it's a process. Section management is involved in the consultant culture too. So with me becoming a section manager, I will also be spokesman for a large group of consultants who won't let anyone lead them, and who think that we have a flat management model, and that they get to decide as much as me. Which deep down they do, both in the matter of their settlement and our terms of employment and the lack of mandate in the section management. So that I can only take on the management, if I can fill that role myself. Well, that I myself can legitimize, that I have management. It might be that the joint management say that I have it, but it isn't real, until the others accept, that I have it." (SM, Consultant G, 2013).

The section management consultants express that the mandate to perform management and the definition of their responsibilities is not only given by the joint management team's decision thereon. The biggest challenge is to get their colleagues to accept their position as a loyal, legitimate representative:

> "In reality, the biggest challenge is for the people who end up in these roles. They obtain legitimacy and an understanding and an eligibility in their units, otherwise it isn't going to work out. It's difficult, it takes time." (SM, Consultant, 2013).

In this way the values and beliefs about the prevailing management organization, where a selected negotiated representative could become an administrative manager within the DC, dominates the position of the section managers and their abilities, as the quote below illustrates:

> "It is the culture, well, that some doctors have to put up with, that there are others, who represent them. And that you believe in, that the others represent you loyally. It has a lot to do with personal trust. To know that you have faith in (him/her, ed.), that the one you send out as a representative will speak your case and do it really, really well and not sell something only very reluctantly. Well, it has something to do with trust." (SM, Consultant D, 2013).

In relation to obtaining their colleagues' trust and confidence as their representative, most of the section management consultants expressed how they had to negotiate even more in the board,[23] putting their own section arguments forward. But they were also aware that instead of taking the "fights" outside the closed forum they should reconcile their visions and strategies internally in the board and not take the discussions into the open air amongst the other consultants. This is because they believed that this strategy would make the section management teams seem stronger when facing the collegium of consultants, as illustrated below. If they do not face their other colleagues from an agreed position, then they would not differ from the prevailing decision system where everybody claimed their right to decide:

> "There are some challenges. It's very much about if we get our visions and strategies internally aligned. We already experience that now, that some have gone out with their strategies, before it has been negotiated by the board, if you can say so. And I think that has been a problem, because then they have taken it further out, they have gone out into the organization with it, they have taken it out to the entire staff group (…) And then you think, that now we made this organization, and we have the four sections. If we aren't going to negotiate things first and make them match, but have to continue the fight afterwards, we are putting ourselves in a stupid position. We are going to stand out as some who aren't working together, and then we stand and argue, and then people will think, 'What is this now? They should have that 'directors' board', and then they haven't negotiated it, and they stand there and disagree and argue.' Then it's going to be much about, that it is us four section managers who stand and argue at meetings, and there has been a tendency towards that, and I think that it's really important that we slow that down and negotiate things. Then we can have our fights, when we have our internal meetings, and then support each other on the outside." (SM, Consultant E, 2013).

In terms of gaining the other consultants' acceptance as their representative, there also occurs a dilemma when the joint management team use the "activity shaping" or "touch and feel" approach, but not specific on paper about the details of the section management consultants' management tasks and the boundaries of the other consultants' responsibilities. The other consultants, namely, ask for some documentation in order to accept that their "colleague" has also become their manager, besides the joint management team. In other words, they would like to have it in black-and-white even though they know that it is difficult for the joint management team, as it has traditionally been negotiated verbally and collectively

[23] It is worth noting that it is "the board" that is referred to here and not the cross-sectional management forum with all SM management teams and the joint management attending.

among colleagues. It makes the section management consultants struggle over who possessed a position to decide amongst their colleagues:

> "Then she says, 'Can I see your management mission?'. Then I say, 'You don't have that, but you have me.' Then I walk up to the executive administrative consultant and say that I can't lead a consultant, because I haven't got a management mission. Then he says that I don't have that, but I have him (the Executive Administrative Consultant, ed.). Then I say that I don't have him." (SM, Consultant G, 2013).

Traditionally the self-management of the consultants – "the anarchistic behaviour" and power to be able to define their jurisdictional area – has been closely linked to their motivation and drive for medical innovation. However, in 2013 some of the section management consultants express that demands for structural and economic consistency and for productivity and efficiency have squeezed the "anarchy". However, the section management consultants do not consider that clinical innovation can only be done from a self-management point of view:

> "Yes, but there might be some who will say that if the department has been known for being anarchistic in that way, and also very innovative, then you might say that if that is the trademark then it might have gone into the background. And you can say something good and bad about it, but I don't think that being innovative is the same as being anarchistic. You can be innovative and in a structured unit. But there are some who might believe, that both parts are important to the department. And there have also been persons who have taken up a considerable amount of space with the help of it, but in the meantime there has come a development from the outside, that has affected the department, that there are now higher demands of structure and economical coherence, demands of productivity, efficiency and so on. So those anarchists have been pushed all the way out. It actually can't be done anymore, and if you do it, it creates a world of trouble. That might be what I am hinting at, that we have one or two who are a bit like that. And it makes a lot of trouble for the rest of us because, here's the thing, it concerns the rest of us. If there has to be structure and some justice and some visibility for people, you just can't do it. The innovation shouldn't be anarchistic, it should be put in a structure. The space should be made for the innovation, but it's a defined space." (SM, Consultant B, 2013).

The quote above also concerns a change in how the department is run professionally. Motivation and innovation have traditionally been closely linked to "anarchistic" behaviour and self-management. However, all the consultants in the section management teams advocate that the former view of what drives clinical innovation in the DC is not necessarily the best way in 2013. The consultants' self-

management perspective endures while new values and beliefs are put forward by the section management consultants. They are trying to transform the DC into a more structured and stratified organization, but this compromises the values of being colleagues as equals and of collective decision making. They do not see it as a contradiction to clinical innovation, while some of the consultants with greater expertise and seniority argue that there is no positive alternative to the prevailing management template. Those who push for breaking with the tradition of anarchistic behaviour must basically gain their mandate to become a representative from those consultants who find the section management team concept useless. The section management consultants then find themselves in a paradox, as they are embedded in a traditional archetype template where the consultants who are opposed to their position are the ones who are listened to most keenly (i.e., the dominating consultants internally in the medical group), but they believe that another alternative should be negotiated in order to create and maintain the respect about the clinical work.

The boundaries between each consultant's jurisdictional self-management area and the section management jurisdictional area, but also, as before mentioned, the boundaries between responsibilities of the section management and the joint management teams, were not specifically defined and in 2013 were still open for discussion. Below, I will explain this blurriness in details based on the section management consultants' perceptions. This is done in order to examine who possessed the authority and power to define and to decide who is responsible for the different kind of management areas.

In general, the section management consultants are aware that they have to learn to broaden their view of different interests and to compromise when they take on a management position:

> "… if you have to be on the board at this level, then I think, then it can't help that you wear too tiny glasses. (…) You simply have to wear some wider glasses to be able to see some bigger solutions, and be considerate towards the others. So the danger is, that if we all walk around wearing our own sector's glasses, then it isn't going to work. If you have to have management on that level, where it has to be so broad, then I think that you also need to carry some different, a bit more wide-angled glasses." (SM, Consultant E, 2013).

The same consultant expressed a perception that "parallel section dreams" is not going to benefit the whole DC:

> "I think it is something new. I think that you have to have your glasses changed. Because it is clear, that you can shout, when you are just representing your six colleagues, then you can shout all that you like,

> ‘And now we have to do that, and this is also important, and you should also listen to us, it’s simply too bad!’, and all of that. But well, if we just sit there and have four parallel dreams, which aren’t compatible in the least, it won’t work at all. So I think that you have to be more versatile, it’s something of a challenge for all of us.” (SM, Consultant E, 2013).

The same consultant perceived that the intention and construction of the section management teams is not about “strengthening” the joint management team, and especially the executive administrative consultant position, as described, but to delegate power in order to get a more functional department:

> “… there are some who really haven’t seen the light of it, and they don’t want to be in on the process. And I can understand that, it of course takes an effort to inform them about it. But there are some, I think, who have misunderstood it, so that they believe that this was a way for the executive administrative consultant to pacify people and hoard more power for himself. That’s not how I see it. I see it as a surrender, a delegation, of some of the management responsibility and power. And completely deliberate, I think, to make it work. That’s how I see it.” (Consultant E, 2013).

The same consultant perceived that the section management teams were also constructed as a buffer for the joint management team ,and especially the executive administrative consultant, in the decision-making process:

> “It does something else too, because before the administrative management were sitting alone and had to make decisions, and it is clear that if people are unsatisfied with the administrative management or the decisions that were made, it would be like the fun fair, there would be free shots on them. Now we’re put in, in a some way, I don’t know if it is what they intended, the joint management, but we somehow become a buffer. I would say, given the fact that we are in on some of the decisions, that the executive administrative consultant and the management have created a buffer around itself, and are able to say that it (a decision, ed.) is something, that we talked about in the section management. Then he will be a bit more protected, he has someone who is in on making the decisions. So it might also be easier for him to get an acceptance of it out in the organization, I think.” (SM, Consultant E, 2013).

Furthermore, it is expressed that there was an intention to construct the medical forum (the board) as a counterpart to the nurses’ forums, not as a counterpart to section management teams as such. The reason is that the consultants wanted to regain power and influence over the more organizational and operational management issues:

> "You can say that there might have been a period of time where the doctors out of laziness or unwillingness or something like that haven't taken an interest in management, and then a big part of the decisions have actually been taken by the nurses. And I don't want to risk that again, we want back-and-fill something professional into it again." (SM, Consultant D, 2013).

Despite the fact that the consultants and the medical group are the ones who are listened to most keenly, and thereby dominate the overall medical decision making, is it striking that they perceive that they have lost strategic decision power in the department. The section management consultants then highlight that the board construction also is a way to regain practical management decision making power.

However, internally in "the board" and in the section management team forum the section management consultants found that it was important for the joint management team sometimes to set the framework, and mark the outlines and priorities in their cooperation:

> "… it is so important that they at some point, and you can discuss when it is in the process, that they (…) say, 'Okay, now we have heard what you have said. Now I think we put down these frames. That will say that the outer frames for section X, there we think, that the superior purpose with this is, that it should be this and this way.' I think there is a need for (that, ed.) at some time, otherwise it's going to keep on sticking out in all directions. So the challenge for them is that they should sometimes stop, look at the process, where we are now, and put down a corner flag and say, 'That is how it is.' So there I think there are some challenges." (SM, Consultant E, 2013).

Furthermore, it is interesting that the management strategy paper, which was formulated and developed during the process, and especially at the workshops, set the stage for interdisciplinary management. However, despite the "interdisciplinary" intention, the consultants have elaborated the management forum (the board), because they perceive that they needed it, despite the fact that their management task in the section management teams was intended to be interdisciplinary. Most of the consultants agreed that they need a management forum as a counterweight to the nurses' management forum, in order to be able to set the strategic agenda in the DC. In other words, they did not perceive the collegium of consultants as a powerful and legitimate forum to take decisions as it traditionally had been:

> "… I also think, that the nurses are a bit puzzled about it. I just think, that you have to say that they have done it for long time, they have their ward nurses meetings. I just think that it's a counterpart to that. What we

> could be missing might be that we held some joint meetings. I think that's missing, and we have to be careful that we don't run our own race, because it is of course important that we are interdisciplinary. Because I could feel that when we on the meeting presented some strategy for each of the sections there, some of the nurses got a little offended, because they hadn't been in on it. But I also think that it is important that we sort of start, I wouldn't say to take the fight, but in the least to make clear, that there are some medical strategies, where we require… well I think it's legitimate, that we also have a mono professional forum, where we address the medical issues. And it might be that we haven't been good enough at informing and telling them, why we do it, but I believe there is a need for it. But it might also be that it is important that we have a mono professional forum, but we should also remember that we section managers should be meeting." (SM, Consultant E, 2013).

Some of the section management consultants felt that it was legitimate to create a mono-disciplinary forum to be able to discuss medical professional related issues in order to set the strategic agenda in relation to the nurses' elaborated agenda. In other words, some of the section management consultants indicated that the collegium of consultants and the collective collegial consensus orientated decision making amongst more than 40 consultants had failed in the struggle between the professions to dominate the agenda of the DC. This newly devised mono-professional forum and actions around it (the board) seemed to thwart the interdisciplinary perspective inherent in section management, according to the section management consultants. However, they still perceived that they should focus on the interdisciplinary tasks in order to prevent fragmentation in the DC. However, their focus in 2013 was primarily on the board and the construction of it.

Moreover, the majority of SM consultants perceived that they had a real opportunity (a mandate) to exercise the different types of responsibilities and tasks that formally lie with section management, even though they were perceived as loosely defined. It is interesting, however, that the responsibility areas of, for example, clinical management and research were primarily dominated and taken care of by all the consultants, and the decision making was still performed collectively in the sections, where the section management consultants would act as representative or "draftsman", as expressed below:

> "Some of them I do (have to negotiate with, ed.), well, the professionals, them of course. I constantly have to negotiate with my colleagues because I am not the professional manager in the unit. We are kind of horizontally…. So I manage very horizontally in my sub-speciality group. I of course manage the junior doctors, because I have a higher charge than them, but my consultant colleagues I don't manage. I share an office with x, who is a professor, and I don't manage over a colleague

> who is almost twenty years older than me. We don't… we don't manage over each other in that way. But I am the one who is spokesman, and I am also the one who people complain to, if the others aren't behaving well." (SM, Consultant D, 2013).

I will argue that the values of the prevailing traditional interpretive scheme such as seniority, expertise and skills still dominated the decision system within the group of consultants in each section. The consultants in the section management teams drew the clinical profiles of the sections. Regarding the types of responsibilities other than professional clinical management and research management, the consultants express that personnel management and operational management were more something the section management nurse did:

> "Well personnel management and such, for example, I don't have a lot to do with that, if I have to compare myself to the section manager nurse, for example, who spends a lot of her time on personnel management. I basically only have to keep an eye on, that my colleagues behave properly, and if they don't, I am told through the nurses and the section manager nurse." (SM, Consultant D, 2013).

A section management consultant explained how a nurse never could make or take any management decisions or influence the management of research, since the nursing profession is subject to the medical profession's power and domination:

> "Well the problem is the level of influence, because you can equate the management responsibility. The SM nurses have it for the economy and the organization, but the research related management responsibility is hard to place. Because you've got to either have your own research field, and the nurses group does that really well, but that research field isn't recognized by those they want to be equal to in research, point one. Point two, if they make that research field, if we suppose that they reached the same level in another field that they have chosen, then they still won't be equals because the nurses group is still, no matter how much you twist and turn it, subjected to the development, dictated by the doctors' group. The nursing group, on the other hand, are much better organized, so they want influence on the level, they think they should have. But they haven't genuinely thought through the possibility of getting it." (SM, Consultant G, 2013).

Regarding finance and accounting responsibilities, the consultants found that they were taking on more responsibility:

> "It is clear, that we have got far more assignments, and I think we have taken on more responsibility. Some things, like that with distribution of resources, that it runs, and the thing is there, who are hired, what do we

> need, and how should we distribute it. I actually think that we handle that far down the road from the executive administrative consultant too. Well unless we need it. Of course he is informed, but it isn't necessarily something he has to be involved in. He is in on finding out, how many we hire, who is hired, and how many we are overall. But the distribution of it, we handle that a bit on our own." (SM, Consultant E, 2013).

Regarding responsibilities and the cooperation internally the section management consultants experienced that there was not yet so much action behind the (few) discussions among section managers in the board. Some of the section management consultants were more impatient about this than others. Most felt that one of the challenges in relation to clarifying the cooperation was full transparency and honesty in what strategies the individual sections are working with:

> "First and foremost I simply think it is full transparency and full honesty and full frankness about what your plans are. And if you make any agreements, you keep them. And it should be that way, that you are allowed to say: 'That it might be that you say this and that, but I don't believe what you are saying' (…) and inform each other mutually of what it is you are planning. (…) and sit down and find out, where we want to go with our share of the cake, our part of the business. And then discuss it with the other section managers and say what there is room for, and what there isn't room for. Well, where we need to sacrifice some places. And there I think, it is really important to go into these discussions honestly and without prejudice." (SM, Consultant D, 2013).

It is also stressed in the above quote that the section management consultants perceive should listen to each other and respect each other in terms of developing an overall strategy. This indicates that they perceive that they have to create an overview of their sections' strategies and thereby create cross-sectional knowledge about the DCs strategy work.

In this connection it was also discussed whether to hold these discussions in the section management forum or the board, and in this regard the consultants argued that the overall medical strategy should be negotiated in the board. The consultants in the board rejected participation by nurses on the grounds that the medical arguments were still decisive, hence nurses' presence and arguments would be meaningless in the negotiations and discussions:

> "Yes, I have also discussed that with the SM nurse, if she should be in on our strategy meetings, and it should be said, that it is only us five consultants, who sit there and discuss. But I really don't think that she should in the next wave, when we speak of implementation. She is being sent the summary. It's not that there is anything secret to it in any way.

> But you can say that nurses could be in it, but it would only be to listen. Because the doctors, we decide that, that's just how it is. And there, where you might say it has run a bit off track, as a doctor, is that the nurses have been creative at inventing some functions that we really don't agree that you necessarily need to have. Well, inventing functions, that we, from a medical point of view, think are completely surplus. It doesn't have to be something that goes on in this department, their own doctor might as well deal with it, for example. And the reason that you have got a bit of focus on it, is now we can suddenly see that the more resources we spend there, less there are for us. And vice versa, of course." (SM, Consultant D, 2013).

A section management consultant expressed the logic about professional decision making and power hitherto in the DC, which explains their perception of their power to make decisions:

> "Well there are the medical things, which you have to discuss, about colleagues and staff and treatment strategy, but especially research, and where the department is developing. There we think that it is us doctors who should come in and show in which direction our treatments should develop. Because it is treatment that drives treatment. The nursing is a part of it, but if there weren't diagnoses and treatment, then there would be no nursing and no patients. And the nurses might have a bit of a hard time understanding that. Or they might understand it, but respect the volume of, what it is that comes first and what follows after. It is not because that what follows isn't as important. They feel that, because it doesn't come first. But it is implied in the job, if you can't diagnose, have proper treatments, then you can't nurse in any way, that makes sense." (SM, Consultant B, 2013).

The quote also reflects that the consultants dominate the structure design according to what makes sense to them and puts them in a dominant authority position. The section management nurses' professional assessments and focus are only appreciated in the further implementation of decisions, which reflects their subordinate position.

In summary, the majority of the section management consultants perceived that they and the medical group in the DC possess the authority and legitimate power to define who should be listened to and who should possess power. In their perspective the nursing group is a subordinate profession. This is reflected in their perceptions and expressions about the SM teams and their behaviour and construction of the board, with only consultants participating in it. Internally, the authority in the medical group was more blurry and undefined regarding the different formalized responsibility areas. They felt they were at the beginning of the

process of implementing the section management teams and the medical board, and the definition and the boundaries of their work still had to be clarified and narrowed down. As point of departure, power had been stratified. The section management consultants possess, in cooperation with the joint management team, especially the executive administrative consultant, a position of authority, especially regarding the more administrative and operational tasks. But their authority relied on their colleagues acceptance and mandate to possess this position. Furthermore, the consultants also behaved as if they still possessed a dominant self-management position regarding their research and clinical responsibilities, according to the section management consultants.

Regarding capacity for action, the section management consultants perceived that they were calibrated as an intermediate layer between the joint management team and the collegium of consultants, which would have to take responsibility when things went wrong but not have many opportunities to act, and they expressed dissatisfaction with this. Regarding these experienced cross-pressures, they believed that they lacked a framework, and that it is not clear how the joint management team sets the scene. Some perceived that they were doing fire drills and acting as foreman most of the time. They undertook operations management. This means that the section management teams' work moved into the departmental nurses' operational work, especially on recruitment, occupational health and prescriptions. They thus experienced the capacity to carry out some types of management tasks, especially those tasks that the nurses traditionally had been doing, but not capacity for action regarding strategy in each sub-specialty's discipline and research. They believed in this context that a small part of their colleagues did not recognize section management and their position to make decisions. The section managers agreed it was the consultants with seniority and expertise who set the medical professional direction, but that at the same time there was a need to have a spokesperson or representative at the sectional level. The argument is that the consultant were committed to involvement in the management tasks that might affect their professionalism. The change was driven by the need to regain their dominance at the level of their professionalism and clinical work at the strategic level. The section management consultants were also aware that the role of section management was not to nurture a "production department" but a department that provides space and opportunity for new thinking and new development and a level of "anarchy" as the department develops professionally.

6.5.2.3 The section management nurses

In this section I describe and explain how the section management nurses perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

The majority of the section management nurses perceived that they were at the beginning of the process of implementing an additional layer of management as they perceived that the joint management team had not delegated any of their management areas and responsibilities to the section management teams in practice, despite the process being initiated in 2010. Neither, internally in the section management teams, did they experience equal cooperation with the SM consultants regarding the different section management responsibilities. They perceived that in 2013 the construction of the section management teams was formalized, but it had not changed who possessed the power in the DC as such. The majority of the SM nurses perceived that the consultants who not were involved in the section management still possessed the top authority in the DC, in cooperation with the joint management team. This also means that the nursing group and even the section management nurses still found themselves in a subordinate position as a profession in the DC. Regarding the internal stratification in the medical group, the nurses perceived that it is very difficult for the section management consultants to be accepted and to take on legitimate authority position as the value of being "colleagues as equal" was still dominant. They experienced that the consultants who were not involved in the management at section level found it very difficult to let go of their management position and power to decide in which direction the section should develop, and in this regard to let another colleague be a representative for the sub-unit, as expressed in the quote below:

> "They haven't decided in what direction the department has to go. The consultants have. It has simply been professionally managed. It has clearly been far more professionally managed than I have experienced anywhere else. And I think they have a hard time letting that go. That they are the ones who decide which way we are going. That there are some superiors who actually… that it can be an overall issue. Who decides? What should we go for? Should we go for x or go for y or how should we position ourselves? And what should we prioritize with the resources we have available? There you have been used to, well we just did as we wanted to because we wanted to, and the resources just came in a steady flow from the region or others. I think Skejby had that in some way, especially in the cardiac field. We just used to spend because we just received. It's not like that any longer, and the whole political scene is different compared to what kind of management mechanics are being used." (SM, Nurse C, 2013).

The nurses observed that the section management consultants were challenged because the section management teams break with the prevailing decision system values where colleagues are equal and decisions are taken collectively.

> "Because the consultants have always been used to being 'king carrots', every one of them, and it is also that, which sometimes has given some

> trouble. That someone has to go in and coordinate something, they aren't very fond of that. So that really breaks a lot. Also the fact that now we have a management group who make the overall decisions, where earlier on it happened among the consultants at their meetings, where they decided it all in one hour every Monday. So it breaks a lot with the culture there has been. And we are going to fight with that for many years, there is no doubt at all about that." (SM, Nurse F, 2013).

In relation to consultants being appointed at as section managers the nurses perceived that the joint management team did not possess the authority alone to point at a given consultant to perform as a section manager. Like the consultants, the nurses perceived that the positions among the consultants were negotiated and the section managers had to be professionally recognized and respected among their own colleagues:

> "… they (the joint management team, ed.) know who they shouldn't place on those positions, who aren't respected. Because it's really about, that the consultant in such a place, he is professionally respected by the other consultants. Because if he isn't he might as well not sit there – simple as that." (SM, Nurse F, 2013).

The values about being skilled and experienced to become a representative for other consultants was also reflected upon by the nurses. This also means that it must be assumed that the section management nurses in practice do not come into consideration in the same way as the section management consultants, despite their formal title, as they do not possess the relevant medical qualifications. The section management nurses possessed authority within the nursing group, but do not possess the authority to make overall medical decisions without involving "their" section management consultant, as expressed below:

> "… it's definitely not like that, that the doctors haven't been responsive and understood our argumentation and such, it's not that. But, well, I haven't got the authority to say that now I want it to be this way, and then it's going to be that way. I don't." (SM, Nurse F, 2013).

Furthermore, the nurses perceived that the cross-organizational perspective on the sections was absent from the activity, behaviour and focus of the section management consultants and the joint management team. They found that the focus in the daily operations was on the operation in each section, and not on the overall operation of the DC. The section management nurses were mostly engaged in having the right professionals to do the right tasks and the proper number of professionals in the right place. In other words, the nurses focus on the daily operations and not to any great extent on, for example, research and strategy management areas, which means that they take care of their traditional tasks and

jurisdictional area of management. Moreover, they tried to cooperate in the tasks they have in common, but so far they had not succeeded in doing this.

Despite the section management nurses' perception that the consultant and the nurse in the section management team still performed traditional professional tasks, the formalization of the team had however contributed to the general internal cooperation and knowledge of each other in the teams. The nurses perceived that in the team they experience that the consultants is more present and takes responsibility for their section more than in 2010 and before, even regarding the more nursing-related tasks, as expressed in the quote below:

> "So far I don't really think that our jobs have changed so much, at least not for me. Where it has changed for me is where he takes more responsibility for the parts that aren't necessarily medically oriented." (SM, Nurse F, 2013).

In relation to constructing the team as a common management team the section management nurses expressed how they experienced that the other professionals did not relate to them as a team consisting of "equivalent managers" with a similar authority position, as explained below:

> "Well I think, for example, that if the section management consultant and I completely agreed on how we run our operation, then it shouldn't matter if it was the section management consult or me who was here. Then the nurses should get in line with what the section management consultant puts out, and the doctors should get in line with what I put out, if that is how the section management consultant and I agree that is how it should be run, then it shouldn't matter. But that isn't how it is today. The nurses do as the section management consultant says, if they know that it is in harmony with what I say. If they know it doesn't harmonize with what I have said or now think that he runs out on the deal, he might do that in the spirit of good intention, then they won't do as he says or if they do, at least they will ask questions. And in the same way I can't manoeuvre the doctors. If a consultant (ed.) and another consultant (ed.) decided that they should go home at three o'clock and they don't want to do any more, or a consultant (ed.) decides he will stay till five o'clock, then they do that. But ideally speaking it shouldn't matter which of us is here." (SM, Nurse C, 2013).

The quote stresses that the traditional management pillar structure is still functioning completely into the core of the section management team despite the intended interdisciplinary management approach for more equal positions between the consultant and the ward nurse. I will argue that when the specific interdisciplinary work across the sections has not eventuated, it might be difficult to

be equal regarding the daily operation tasks as such, which means that those involved perform/take on their traditional tasks, albeit with the team spirit more in mind. The section management nurses and consultants lack reciprocal authority amongst each others' groups. But if they look at the "respect" throughout the organization, then they perceive that they have possess it. But generally throughout the organization it is paradoxical that it is also perceived by the nurses that the decentralization and delegation of the management tasks needs some kind of full acceptance from a part of the consultants in the DC.

The SM nurses perceived how the consultants not involved in section management still struggled to accept and thereby legitimize the additional layer of management, as illustrated below:

> "I have actually experienced that there have been some consultants who have had a hard time, that a person like the SM consultant gets to have more stars on his shoulders than them. They are all consultants and all have management responsibility. It's not how most consultants think, but there are some who sort of run their own race, and it's a bit exhausting." (SM, Nurse A, 2013).

Despite the expressed struggle for acceptance amongst consultant colleagues, the section management nurses also expressed that they experienced consultants in the section management teams trying to get more management responsibility. But there were also limits for how much some of the consultants wish to be involved and engaged:

> "… I also have my doubts about how much they are willing to take on. I at least can feel that if I look at the SM consultant, that there is some sort of limit to how much power he is willing to take, because it will also have some consequences for him as a colleague." (SM, Nurse C, 2013).

Furthermore, the section management nurses found time an ongoing challenge in order to perform management, especially regarding research and strategy management, as in the daily routines they are very busy with personnel and administrative management which they traditionally have taken care of. They struggled to find time for the joint meetings and activities, and at the same time perceived greater complexity in the individual sections, requirements for merger and cultural reunification, Electronic Patient Journal (EPJ) and quality development. A major challenge is to join forces with the other section managements and make time to do so. However, the nurses express that they are beginning to meet for lunch across sections in order to find the time.

In summary, the section management nurses perceived that the consultants were still listened to most keenly, but they were also aware of how they struggled and

negotiated internally in the medical group about the stratification of authority and decision making and furthermore about who should possess the management positions or not. Overall, they perceived that their position in the section management team has not changed significantly compared to their former position as ward nurses.

About capacity for action, the section management nurses perceived that the joint management teams possessed limited capacity to drive the process as the consultants in general possessed the dominant power. However, activities such as workshops and *ad hoc* meeting were appreciated and perceived to have contributed to pushing the work with the additional layer and section management teams forward, which indicated that the joint management possessed some capacity, according to the nurses. About the section management nurses' own capacity for action in the change process, they were limited to their own traditional jurisdictional management areas, due to persistent values about being a skilled medical expert if one were to be involved in management of consultants. However, the nurses' traditional structure and decision-making system was not perceived to be shaken as much as the consultants', which put in them their traditional management position of nurses.

6.5.2.4 The consultants

In this section I describe and explain how the consultants perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

The majority of the consultants involved in the section management teams were hesitant, although interested in the development of an alternative management model with an additional layer of management. Moreover, the consultants were involved in the process of negotiating who should be their sub-section managers/representatives. On this basis, the majority supported the developed section teams. However, the change process was perceived as blurred and diffuse for the consultants not involved in the section management teams, as expressed in the quote below:

> "It has been very clear that something was going on, and it has been clear that it is something that the joint management team highly prioritized. The fact that you have taken people out on some workshops in several consecutive periods, many days, many people. And they have come back and said that they think that it has been very constructive, and they also think that they have got something out of it. It has not been razor-sharp to the rest of us, what it exactly it is that they spent their time on. And it hasn't materialized razor-sharply, that here we have a

> razor-sharp section management, who with these competences take care of these things." (Consultant S, 2013).

The consultants had been informed at the consultants' meetings about the management strategy paper; a document they had the opportunity to read. However, they found they were unable to receive a specific document about the section management consultant's responsibilities in detail. This lack of detail made some of the consultants think that it is rather ambiguous whether the consultants have actually negotiated their responsibilities with the joint management, as expressed below:

> "No, I think that the hard question is to get it cleared upwards, how much you are sort of allowed to decide. And there you could imagine, that there was a difference from section management to section management, how much they fight for. Because it would also be personal dependent, given the fact that there lies a completely… I haven't at least seen anything written down that formulates explicit competences or decisions to be made by the section managers." (Consultant S, 2013).

The consultants found the management frame for section management very ambiguous, due to fact that it is also perceived that the joint management team had not delegated or subdivided the responsibilities specifically. The "delegation" should be done jointly with the section managers, but the consultants perceived the joint management to be absent from this in process. Furthermore, according to some of the more senior consultants, professional management, research management, strategic management and personnel management have never been placed on the executive administrative consultant's table in practice. These management responsibility areas were placed among the consultants, where they were traditionally negotiated. As mentioned, the consultants possess collectively the authority of the management responsibility in practice. Therefore, I think that it is a paradox that the joint management team delegated the four fields to the section management teams, as the management areas had always been negotiated at this level. Could the executive administrative consultant, who was not respected professionally, "delegate" management areas on the upper level, which traditionally and to that date had been driven by the community of consultants? In practice the consultants still negotiated with and consulted their colleagues and the most skilled experts in the field about medical strategies and management research, and when the issues was about organizational or personnel dilemmas, they consulted the joint management team, as expressed below:

> "Well professionally I will go to the other professors, and that has nothing to do with the fact that I don't acknowledge the SM consultant in a given section (ed.), or another section (ed.). But if it was a

> professional question, I would go to a consultant (ed.), who is a professor. If it was an organizational or staff question, it might also be a professional or research related, if it had a more logistical character I would approach the SM consultant (ed.). Whereas if it was that we have had some really good ideas, let's move forward in this direction professionally, it would be the professor." (Consultant M, 2013).

The majority of the consultants were aware of the work with the additional layer of management as reflected above, but the "outcome" of the work was not sharp in their perception, as expressed below:

> "Well, we're working on it, and it has a form, but I do not believe it is final, and I do not think it is clear to all. We know that they have to manage, and we also know that some decisions must be taken on a level, and then passed on. We also know that, for the moment, my section manager is positioning himself compared to the other section managers and the EAC. But it isn't all sharp yet." (Consultant S, 2013).

However, in some degree the consultants perceived the section management teams as more involved in the responsibility for daily operations and for creating clinical discussions where the output can be communicated to the other sections and the joint management team:

> "I don't know, whether they have it formally, but realistically I guess they have the responsibility for getting the work done in each section and making sure, that we get our work done, and that we take care of the work we have, apart from the scheduled hours of work. Also I believe that they have the responsibility for us discussing professional issues, so that we might give inputs or answer questions from higher levels." (Consultant S, 2013)

They perceived them as "foremen" (a nickname) with limited formal responsibilities but who should keep track of the section:

> "Well, I see them as a – for better or worse – foreman, who has been pushed inwards. They might not have the greatest experience and expertise, but as long as they make it work, there might be some things that the joint management won't interfere with if we can handle it ourselves." (Consultant S, 2013)

The consultants' (informal) dominance, power and also distance from the management phenomenon is reflected in some of the consultants' language about the section management teams who are "foremen" in their perception. There remains a lurking scepticism of management and administrative management

levels, which most likely is grounded in the values about authority, power, prestige and status arising out of clinical expertise and seniority:

> "But the administrative managers, there isn't a lot of prestige from it in the group. They're thought to be people who have run out of breath in the medical-professional run, forcing them to seek more administrative work." (Consultant O, 2013).

Most of the consultants perceived that the collegium of consultants possessed the (informal) top authority position to define which kind of management responsibilities their representative at both the joint management level and section level will be able to work with, especially regarding areas such as the clinical strategic work and research management. The most skilled experts still possessed the power to define those management boundaries. However, some of the consultants also expressed that the section management teams did not possess capacity for action to do anything without the executive administrative consultants agreement as expressed below:

> "Between us and the EAC they are the 'layer' who have been put in as foremen, to keep it quiet in the back. They can't fire or hire, they can't award extra payment, and they can't beat us with a stick, even if they wanted to." (Consultant O, 2013)

Some of the consultants expressed that the construction of section management teams in 2013 functioned as a buffer for the joint management team, on which there were different opinions, as expressed below:

> "So far I think it has worked as some kind of buffer, meaning an absorption of some of the frustration. Instead of formulating all our frustration and criticism of the joint management, we might have it absorbed in this middle layer of management, who say, that I will give it a try… 'The next time I'm going I will take this with me.' And it works for a period of time, but if the feeling is, that it isn't going any further than there, and it's just a way of absorption that has been put in, it won't last. And then they are going to get pinned, the section managers." (Consultant, 2013).

The consultants perceived that the section management teams were primarily responsible for the daily operation, personnel management, human resources and allocation of manpower and production. Many of them did not understand their representatives' involvement in the operation. Some argued that the secretaries should do the work, that the cohesiveness can be maintained by themselves by contacting the joint management team. Others of the consultants perceived that, through the process, the section management nurses would get more influence about medical issues and the consultants involved would get more influence on the

nursing side. This indicates that some of the consultants perceived the model from a more open approach, where the model in practice might change towards more interdisciplinary teamwork and function creep.

In summary, the consultants perceived that they possessed the power to be listened to in general regarding all the managerial areas. Especially in the core management areas of clinical professional management and strategy and research strategy they dominated regarding decision making. However, the majority of the consultants acknowledged the joint management team position formally as a top authority position. Regarding the decision system they defined the joint management team more as being their representative in the decision-making process. Regarding the nursing group, the consultants perceived themselves as dominating the jurisdictional clinical and managerial area, which makes the nurses perceived as the subordinate group of professionals. In other words the consultants perceived that they are the professionals who are listened to most keenly. However, as the DC has been growing in the number of employees and specialties they recognize that their traditional management forum is dysfunctional, with over 40 consultants participating in the discussions and negotiations. As described in the section above, they acknowledged the need for a different management model and in general supported the changes, by placing their representatives in the sub-sections "formally". However, they were more hesitant or reluctant about the stratification and delegation of specific management areas. Paradoxically, they expressed that it should be the executive administrative consultant who delegates the specific competences and power, but in reality the consultants in each specialty possessed the real power to delegate their responsibility, for example, of clinical management and research, to the section management consultant, or at least to define the boundaries of their responsibilities. This perspective makes the consultants those in the DC with the strongest capacity to force change forward towards the suggested management model with medical internal stratification and team structure. On the other side, they also possess the ability to pull against the proposal. As I perceive it, the group of consultants were more or less hesitant but still interested in the suggested model, despite a minority of consultants who primarily advocated for the prevailing model. This indicates that the consultants in general push the changes forward towards the suggested model, but the "results" from this process indicate that the real changes in practice are less than the more formalized changes.

6.5.2.5 The junior doctors

In this section I describe and explain how the junior doctors perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

The junior doctors expressed that those who are listened to most keenly in the DC are the medical group and especially those consultants with greater expertise and seniority.

Regarding the process of implementing the section management teams, the junior doctors expressed that they had not been involved in an open process and they had furthermore not noticed the section management teams' work in their daily operations. In other words, it was not clear to the junior doctors if the section management consultants and the teams had been delegated any management tasks, and moreover if they possessed any authority position or in which degree they possessed decision power to take overall sub-section management decisions. Furthermore, their specific management responsibility areas were very unclear to the junior doctors. In practice they did not have any knowledge about the process and they did not experience any outcome of the process, as in any changed activities or behaviour from those involved in the section management teams. They did not experience any difference in the daily operations compared to the period when the DC attempted to implement the eight functional partnerships.

It was expressed by the junior doctors that they did not have any knowledge of whether the joint management team in the DC possessed the availability to embrace activities in the DC to process the re-organization of the management model in DC.

In summary, the junior doctors did not possess any managerial power but pointed at the consultants as the ones who are listened to most keenly regarding the management of the DC. Regarding capacity for action, the junior doctors did not possess any skills or competencies to manage the management change process in the DC.

6.5.2.6 The nurses

In this section I describe and explain how the nurses perceived the power dependencies and capacity for action in the DC in 2013 in relation to the developed section management teams.

Regarding power dependencies, the nurses acknowledged that it is the group of doctors and especially the consultants with greater expertise and seniority who are listened to most keenly regarding clinical and management decisions in the DC. In this regard they also perceived themselves as subordinate to the medical group. However, in the daily operations the nurses focused on their relation to the nearest ranked ward nurses and their decision power, as they traditionally have been doing:

> "Well, again, it is going to be extremely difficult for me, since the most visible manager is the closest, and to us, that is the ward nurse. It is her we approach with the problems there might be, and it is her, who passes

> on whatever decisions the section management or higher make. And I certainly do not always know where it might come from." (Nurse Q, 2013)

Like the junior doctors, the nurses had not been involved in the implementation process of the section management teams. It appeared even more remote to them than to the junior doctors. All the nurses expressed how the crystallization of the section management team is not clear to them at all:

> "It is not in the least clear to me. We stand by our closest manager. And of course, there are things she passes on, but which are for section management, and which are for other parts of the management, that's not clear to me." (Nurse Q, 2013)

They expressed, however, that their section manager nurses were busier than before the additional layer was implemented. But whether this wasbecause of the growth of the sections or because of the construction of the section management teams was uncertain.[24] One explanation may be that they did not experience the large fluctuations in the positions of section management nurses or consultants position because section management team responsibilities were not visible. As we know from the sections above, they were negotiating about those responsibilities. It was also almost the same nurses who became section management nurses so that personal knowledge may also have an importance for whether they think there is constructed a new management position they can sense. They found it difficult to assess if the section management teams possessed any authority or decision power between the joint management team and the consultants and ward nurses. Furthermore, they could not differentiate between those tasks the joint management team possessed and those it was intended to take. Some of the nurses could not name the section managers who were involved in the teams. Information about the functional partnerships and the transition to section management teams had only been acquired by a few and often because of their own curiosity.

In summary, the nurses experienced a closed implementation process which seemingly did not affect their daily operation in 2013. The nurses' responses were remarkably similar even though those interviewed were from different sections and despite the differences in construction of the management team of each section. The nurses did not possess any managerial power but pointed at the medical group and especially the consultants as those who were listened to most keenly regarding the overall management of the DC. Regarding capacity for action, the nurses did not possess any skills or competencies to manage the management change process in the DC.

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[24] The merger in 2011–2012 could also be an explanation.

6.5.3. SUMMARY

After 2010 and the fusion in 2011 to 2012, the joint management team possessed the ability to cultivate and nurture the process in 2013. They organized management activities in the form of workshops and *ad hoc* meetings, but also scheduled meetings across the section management teams and especially in the newly created medical board, about the additional formal layer of management which were intended to advance the process and definition of the change. It was important to the joint management team that the teams did not feel that they had signed up for defined ”boxes” or finished management outcome, but had the ability to define it and be involved in the definition process. Yet the joint management team contributed insufficiently to defining the framework and involuntarily let the framing or definition of the responsibilities swim around more than they intended. In other words, over the course of three years the joint management was not able fully to clarify the task which they would delegate to the section management level, and they have not picked up on what the individual teams have defined or expressed enough, so the uncertainty spread further out in the organization than just within management forums. As a consequence of the greater degree of activities and involvement, the ambiguity among the professionals involved in management and the delegation of section management management responsibilities declined a little, however, it was still present, which can be explained by the capacity for action and the power dependencies among the professionals.

In 2013 there was still the collegium of consultants and especially the consultants in collaboration with their representative, the executive administrative consultant, who possessed the informal but dominant authority position and legitimate decision power in the DC and thereby were listened to most keenly compared the other professions such as the nursing group in the DC. Their interest in and value commitment to the model with an additional formal layer of management is therefore very important in relation to explaining the changes in the management model in the DC. The consultants were overall in interested and committed to create an alternative management model such as the section management team model, due to the fact that they perceived that the growth of the DC had had a disadvantageous impact on the efficiency on their collective, collegial and consensus orientated decision system. The majority of the consultants were committed to the stratification process of the structure and decision system, which broke with their traditional values about being colleagues as equals and making decisions collectively in the whole collegium, as they perceived that local “collective” and consensus orientated decision making in each sub-sections would enforce the still present value that it should be the most skilled and experienced who take decisions, but also the value about that all consultants by definition possessing management competences. That made it possible for them to send a trusted and loyal representative of themselves to the executive administrative consultant. However, despite the intention, it is evident that it was primarily regarding management

responsibilities that they were mostly in touch with the joint management team, e.g. management administration, overall operational, personnel and logistical tasks, but also the nursing management area and their operational responsibilities, that the section management consultants have been involved in. The colleagues' core management responsibilities regarding overall strategy for each sub-section and research management were still possessed by each consultant in general. This indicates that the "delegation" and definition of the managerial boundaries and interdisciplinary management about those core areas was still in its infancy, and from the consultants' perspective it is questionable how interested and committed they were to start to open up negotiations about a section management strategic level of those responsibilities. Their behaviour and expressions make it ambiguous whether they would engage powerfully in the further development and definition of the concept of section management teams and the cross-sectional and overall helicopter perspective, as they possess the capacity to take action on the further process, changing the model.

6.6. THE MANAGEMENT MODEL IN 2013

In this section I construct how the management archetype in 2013 was perceived by the professionals after the process of adaption of the additional layer of medical management had proceeded over a period of three years. This constructed archetype model is to be the analytical ending point of the formally intended transformation of the management model in the DC.

6.6.1. THE AUTHORITY STRUCTURE

In this section I will describe and present the expressions and perceptions of how the authority structure was perceived in spring 2013.

In 2013 about 36[25] consultants were affiliated to the DC. This number shows that the amount of consultants had increased even more as a result of growth and development in the field of cardiology.

In 2013 the executive administrative consultant and head nurse, as the joint management team, still possessed the formal top authority position of the DC. Furthermore, there was no perception of change in their internal positions from 2010 to 2013. However, their internal collaboration was perceived to be moving even closer in the daily operations. This meant that they performed more and more as a team in practice during this period. However, they also still possessed traditional positions in the DC, where the head nurse managed the nursing group

[25] From 2011 to 2013, nine consultants were replaced in the DC in relation to the fusion. Later one position was cut back, which meant an increase in the number of doctors from around 26 in 2011 to 36 in 2013.

and the executive administrative consultant was perceived as the representative of the collegium of consultants, which constituted the traditional parallel professional management structure (pillar structure). However, their position as a joint management team became pushed even more towards the general administrative responsibilities and external commitments and away from the more daily clinical matters and nursing work as they constructed the section management teams, which I will describe below.

The constructed and articulated section management teams formed a middle level of formal management which meant that the DC management structure consisted of two formal medical management levels. This meant that the "mid-level" management became even more formalized in its description as a "management" layer and not a set of "functional partnerships", and thereby the additional layer took an even more stratified form in appearance as the section managements were formally "the managers" of each section and no longer "functional partners" or "functional friends", which had formerly indicated a position that was more collegial than stratified in relation to the collegium of consultants, and thereby consistent with the collegiate values that dominated the DC. This also meant that the formal "management" term in the new "definition" of the teams broke with the value about being colleagues as equals.

Regarding the authority of the nurses in the section management teams, they formally possessed an even stronger authority position compared with their functional partnership positions, as there was no described difference between the professionals in the formal strategy document that was developed. In other words, their position was equivalent in the section management teams, as set out. This meant that the section management nurses formally possessed a higher authority position in the overall management hierarchy than consultants, as the section management nurses in collaboration with section management consultants should manage each sub-unit. This meant that the position of the collegium of consultants, who traditionally possessed the authority collectively, was made more clear as a management layer below the joint management team and section management teams.

However, informally, another picture of the management authority structure can still be drawn in 2013. In practice the executive administrative consultants was still perceived as a colleague among equals by the consultants, however primarily representing the DC regarding the overall administrative and external issues. The collegium of consultants did still possess the dominant authority position, especially regarding clinical management and research management areas. Despite the enhanced internal collaboration between the head nurse and the executive administrative consultant, it was not perceived that the head nurses in practice possessed a management position above the consultants in the collegium in the authority structure, especially not regarding clinical management and research

management responsibility areas. The head nurse was perceived as subordinate to the medical group, despite the head nurse's management of the general administrative responsibilities. The executive administrative consultant's management position was also mainly agenda-setting about the administrative and external tasks, despite the general wide formal description of the position, whereas the more in-depth clinical and research related management responsibilities were taken care of primarily in a traditional clinical manner in each specialty unit/ domain.

When constructing the section management teams, the position of the joint management team became even more pushed away from the clinical operations and day-to-day routines, changing their position to an even more superior administrative position. Regarding the authority positions of the section management teams, the section management teams, especially the consultants in the teams, possessed an authority position as the consultants' representatives, which meant that the section management teams in 2013 in practice experienced some conflict of interest between the joint management team and their colleagues in the sub-units and sections. However, the construction of the section management teams was still in its infancy in 2013, which also meant that the degree of cross-pressure was minimal, as the joint management team, the four section management teams and partly the consultants were still focusing on defining and elaborating the management responsibilities of the section teams and how it would influence the responsibilities for both the joint management team and the consultants. Out of this process a "board structure" was elaborated. The board was a forum across the section management teams, but only constituted by the consultants from them. I would describe it as a "breakaway forum" from the section team structure, as only the consultants from the section management teams and the executive administrative consultant attended those board meetings, leaving out the head nurse and nurses from the section management teams. In practice, it also meant that that some of the authority power was moving away from the consultants to their "representatives" in the board and section management teams, as the section management consultants expressed that they felt that they possessed a mandate from their colleagues giving them authority to make decisions, which also is backed by the expressions from the majority of the consultants interviewed. This means that the traditional authority structure in practice was changing towards being stratified internally in the group of medical professionals. However, the degree to which and the kinds of responsibilities that were affected was still ambiguous in 2013. This also means that the collegium of consultants still possessed a strong authority position within the DC in the daily operations and decision making in 2013, especially regarding the clinical work, clinical strategy work and research. This meant that the authority structures in the DC overall were still a combination of a traditional professional collegium, however more stratified, and an administrative hierarchy with the executive administrative consultant at the top of this hierarchy.

In summary, the joint management team and the construction of the section management teams intensified the formal management stratification of the authority structure in the collegium of consultants, which previously was dominated by a collective approach. In practice, the authority of the collegium of consultants dwindled with the formalization of the section management teams as the consultants in the section management teams became involved in a superior representative board structure, which also could be called the section management consultants forum.

6.6.2. THE DECISION SYSTEM

This section focuses on the decision system in 2013. The expressed rationale of the system and how the professionals perceived the decision system is examined. Lastly a focus on how the decision system operates in either a reactive or proactive way to gain competitive advantage is described.

The rationale of the decision system in 2013 was still perceived to be dominated by the professionals and especially the medical profession who possessed the overall legitimate power in the decision system. At the beginning of the process, in 2010, it was expressed that the most of the decisions were made collectively among equals in the collegium of consultants and the executive administrative consultant possessed a top position in the stratified decision system as a "chair" or representative. However in 2013 it was perceived by the majority of the consultants, juniors doctors and nurses that the section management teams and especially the board had evolved a more legitimate and powerful position in the decision system. What is interesting is that with the formalization of the section management teams, management decision making was still performed as collective, collegial and consensus orientated, however, it was performed more and more locally in each section. The decisions were then carried forward by the section management consultants to the consultants' board, where they were further discussed and negotiated in collaboration with the executive administrative consultant. This meant that the Monday meetings where all the consultants met to discuss and negotiate collectively and in consensus orientated way became less powerful, more hollowed out. It was still relevant for the consultants regarding important decisions, however, because of each individual consultant's decision power. This tendency in the decision system fits the general development and perception of this collective forum, as it is perceived to have changed towards being more an informative forum. This change also meant a stronger mutual dependence between the different levels of management in the DC. The formal stratification among the medical professionals became even more evident with the further "formalization" of the section management teams influencing the consultants' collective authority position even more.

The group of nurses did still possess management positions in their traditional professional hierarchy. This indicates that the strong parallel professional decision systems were still functioning in the DC in 2013.

This development with further formalization of the additional layer of management linked closely to the administrative work of the joint management team, on the one hand, and the legitimate but informal decision power of the rest of the consultants based on their seniority and expertise on the other hand, underlines the increasing complexity regarding the decision system as in the beginning of the process. However, the overall commitment to the addition layer of management in the form of section management teams made the formal stratification of the decision system come alive in practice. In 2013, nine management forums existed in the DC: (1) The joint management team; (2) the board; (3–6) the section management teams; (7) the collegium of consultants and (8) the head nurse and ward nurses. Furthermore, when the section management teams met, they constituted the ninth forum. Additionally, every consultant possessed legitimate position to make decisions in their professional domain, which complicated the decision system even further. It is still blurry who possessed the responsibilities for different kinds of management tasks. However, roughly outlined, the joint management team, the section management teams and the ward nurses primarily possessed administrative tasks in 2013. The consultants primarily focused on the clinical, strategic and research management. The nine forums reflect a dramatic stratification in the decision system, but the complexity makes the delegation of responsibilities rather blurry or ambiguous as the professional negotiations are still underway. Finally, I will argue that the decision system in 2013 was still operating in a proactive way as the section management teams were meant as a proactive solution to cope with the increasing amount of employees and specialties and the derived effects of the less effective collective decision system. This construction enabled the medical profession to regain their decision power and effectiveness in their decision making.

6.6.3. THE INTERPRETIVE SCHEME

This section presents different expressions of what was expected and believed of regarding how the management organization of the DC should be doing, how the management should be appropriately organized and finally how performance evaluations should be judged in 2013.

In 2013 it was still expressed that the management of the DC is a matter of professional concern. It was still a very strongly expressed value and belief that it should be those with medical expertise and seniority who manage the DC, which was the medical consultants and the executive administrative consultant. However, with the implementation of the section management teams, a belief that is it not necessarily those who possess the greatest expertise and seniority in a specialty who should possess a legitimate position as a manager was changing the above described

beliefs. There was instead a belief that it could be a compromise, where a skilled consultant (but not the foremost in the specialty or section) who is also interested in management, could be acknowledged as the representative for the consultants in the specialty/section. However, the power in the position is diffuse, as it is ambiguous what kind of management tasks there can be or what is delegated to or carried out by the section management teams, as the process was in its infancy. Most of all, it appears that administrative tasks can be handled legitimately by the section managements, but clinical management and research management were still primarily performed by the foremost in the specialty. This acknowledgement of the section management consultants' positions tended to influence the capacity of the section management consultants to manage the DC. However, the value that professionalism goes in front of management was still reflected in the responsibilities the section management teams held, as the responsibilities regarding clinical research and strategy were primarily handled by the most skilled and respected consultants.

The powerful and persistent value of professionals managing the sub-specialties, also affected the way the medical group related to the section management team constellation. When involved as managers in the teams, it also reflected how the medical professionals sought to maintain their jurisdictional area regarding the overall management of the sections but also the administrative work, which according to all involved section management consultants was previously handled by ward nurses. So besides the majority of the consultants' perception that it was necessary to develop an additional layer of management, and their expressed need for a more effective management forum for consultants, their involvement in the additional layer of management was also a power struggle with the group of nurses, regaining the administrative (in the first place) domain of section management units. Furthermore, the value about being recruited as manager among colleagues was contained or "regained" and maintained through the recruitment process of section management teams in 2013. This may explain their willing engagement, as the consultants themselves assessed and negotiated internally in the sub-section, however, also in collaboration with the joint management team, whom their representatives for the units should be.

Furthermore, the interpretive scheme still did not support the head nurse as a legitimate manager of the consultants and their medical work, since the head nurse did not possess medical expertise and seniority, which as mentioned was a strong value and belief regarding managing the DC. In the same respect the values embedded in the interpretive scheme around 2013 did not support the authority position of the nurses in the section management, as they did not possess the medical seniority and experience which was imperative to manage the consultants' and junior doctors' clinical work.

The above expressed values about the authority structure and decision system in the DC in 2013 illustrate that despite the value about having a (professional) collective and collegial authority structure being broken with the medical stratification of the collegium, the majority of the consultants committed to the idea and concept of the section management teams, as another value, about being able to negotiate and discuss clinical management issues, could be fulfilled in the established sections.

6.6.4. THE MANAGEMENT ARCHETYPE MODEL IN 2013

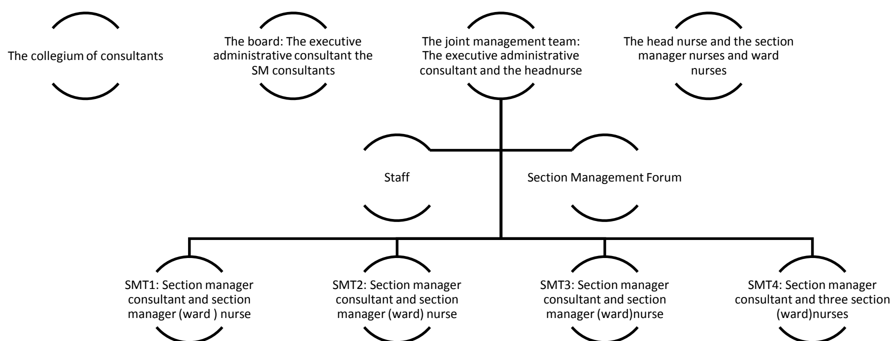
In this section I construct a picture of how the management archetype was expressed and perceived around 2013.

The informal legitimate authority structure and decision system supported by strong values and beliefs that had been present in the DC from the late 1980s continued to be expressed very strongly in 2013. Especially, the expressed value that clinical managers should possess high expertise and seniority in order to possess legitimate clinical management positions in the DC was still present. However, in 2013, another (competing) value of who should or could be a manager (the most experienced consultants) emerged, as in 2013 it was expressed by the majority of the consultants that it was possible, acceptable and legitimate for a recruited consultant with interest in management but not necessarily being the foremost to negotiate a position as a manager for section. This meant that the interpretive scheme in 2013 included a competitive expressed value that, opposite the presented value, justified a more pragmatic approach to become a legitimate section manager among consultant colleagues.

Below I have constructed an organizational diagram of how the management model was expressed in 2013. I take point in departure in both the formally expressed management organization but also incorporate the informal management structures and decision system. Figure 10 illustrates how the executive administrative consultant and the head nurse form the formalized “joint management team” which represents the top authority position in the DC. Below them are the four section management teams, where each team consists of a consultant and one or more nurses. The section management teams refer to the joint management team in the hierarchy. Regarding the collegium of consultants, I have placed the medical group besides the two layers of formal medical management because the collegium of consultants did not possess a formal position of authority, but informally they still possessed and practised a strong legitimate authority position and dominated the decision system of the professionals in the DC. In 2013 I have added “the board” to the diagram as they also as a collectively management forum have become powerful as this construction seems to build a closer management collaboration, together with executive administrative consultant, while in a convincing degree are recognized as the consultant representatives of the four sections. This constellation makes the forum powerful in the authority structure. I would, in this regard, argue

that the administrative hierarchy has become stratified with the joint management team and the section management teams, as before described, however, the board could also be perceived as a stratification of the collegium of consultants and the collective, collegial and consensus orientated structure and system, as the values about being colleagues as equals and making consensus-orientated decisions in the board are present here at the “top level”. What is not visible in the diagram is that even though the joint management team and section management team are “teams”, the traditional professional pillar structure were still very present in daily work, where the section management consultants are connected to the executive administrative consultant and the section management nurses refer to the head nurse primarily in daily work. In this regard, the head nurse met with the section manager nurses and other nurses with management responsibilities regarding nursing issues.

Figure 11 The management archetype in 2013



CHAPTER 7. DISCUSSION AND CONCLUSION

In this chapter, I discuss the contributions of this dissertation to the medicine and management research in public professional health care service organizations, the theory about organizational change and transformation, more specifically the concepts of archetype and concepts of intra-organizational dynamics, and practice. First, I discuss how this dissertation contributes to the existing research literature in medicine and management in public professional health care service organizations by providing detailed and rich descriptions of the process of medical professionals adapting changing hospital management models within hospital organizations in the Danish health system. Second, I discuss how this dissertation informs the concepts of archetypes and of intra-organizational dynamics by providing insight into the dynamic nature of intra-organizational management change in public professional health care service organizations and their transformation processes at a micro institutional level. Third, I discuss how the dissertation informs professionals involved in changing hospital management organizations by providing insight into how medical professionals adapt and negotiate hospital organization management processes. Fourth, I discuss the caveats and future directions for research. In the final section I conclude the dissertation.

7.1. RESEARCH IN MEDICINE AND MANAGEMENT

In this section I discuss how this dissertation contributes to the existing research literature on medicine and management in public professional health care service organizations by providing detailed and rich descriptions of the process of medical professionals adapting changing hospital management models within hospital organizations in the Danish health system.

As presented in the literature review, the international research literature has primarily concentrated on the outcome of processes of hospital management model implementation. However, we know very little about how management templates have been adapted, negotiated and interpreted over time in changing hospital management organizations, especially in-depth details about the processes of medical professionals' involvement in management in hospitals (Kirkpatrick, Dent and Jespersen, 2011). This dissertation contributes to the further literature of medicine and management in public professional health care service organizations by providing detailed and rich descriptions of the process of medical professionals adapting changing hospital management models within hospital organizations.

Furthermore, the literature review illustrated that most of the empirical research of medical professionals' process of adaption and response to changing hospital management models are studied in an Anglo-Saxon health system context. In addition much of the Anglo-Saxon literature on medical professionals' response to changing hospital management models has primarily emphasized the reaction and response from the medical profession, and has not to a great extent emphasized the change process or other management shaping activities. This dissertation contributes to the literature of medicine and management in public professional health care service organizations by focusing empirically on the more underexposed Nordic health system context, illustrated by the Danish health system, where the medical profession has not responded to management change driven from the top, but on a larger scale has been involved in negotiating the management change at different levels in the health system, and showing interest in management.

Furthermore, the dissertation contributes to the Danish research literature on medicine and management in public professional health care service organizations by providing detailed and rich descriptions of the process of medical professionals adapting changing hospital management models within hospital organizations in the Danish health system. At present in the literature there are limited studies of medicine and management within Danish hospital organizations. Lacking from the Danish literature are studies of how medical professional managers adapt and interpret changing hospital management models over time within a Danish hospital context, despite the fact that the general picture of the Danish studies of medicine and management illustrates that the medical professional associations, but also the medical professionals in the hospitals, have played an important role in the development and structuration of professional management models at field and hospital level.

In the remainder of this section I discuss my main findings. First I discuss the process of management change in the DC from 2010 to 2013. Then I discuss the medical professionals' reactions to the changing hospital management models, and finally I discuss the outcome of the management change process, focusing on the management archetype model in 2013.

7.1.1. THE MANAGEMENT CHANGE PROCESS

In this section I discuss the process of the management change in the DC from spring 2010 to spring 2013.

In relation to the organizational development of the management model in the DC, the medical professionals possessed a significant opportunity in the process to influence how their management model should be organized. Both from the top management level and from the centre management level at AUH the DC received support for its development initiative to re-organize its management organization,

as well as support to manage its own process regarding this management re-organization. Hence the DC as an organization had almost unrestricted authority or "free hand" to drive or manage the management change process but also to design the management model it would favour. This finding supports the expectations that medical professionals in a Danish hospital context possess the possibility and authority to get engaged in managerial changes process at a local level.

Internally within the DC the idea of implementing an additional formal layer of management in the form of functional partnership teams was perceived to have been initiated, elaborated and decided in a closed process by the executive administrative consultant and head nurse, hence without the consultants' involvement in this profound decision. However, in the subsequent change process after 2010 the medical professionals had an extensive impact on the way the managerial change process progressed, as the joint management let the professionals involved in the functional partnerships define and elaborate the content and boundaries of the functional partnership teams in collaboration with the joint management team but also other professionals with management responsibilities such as other ward nurses and consultants. In this, hence, the process was characterized by a low degree of information about the purpose, content and further strategy of the functional partnerships from the joint management team. Few strategic meetings were held in 2010 for those involved in the management process. The results were that the professionals involved in the process found it rather ambiguous what kind of responsibilities were delegated to them, the boundaries of the management responsibilities, who should delegate those responsibilities and how much time the functional partners should dedicate to the responsibilities, despite their possibility to form the management model in the DC. This development can primarily be explained by the collegium of consultants' interest in and commitment to the initiative elaborated by the joint management team. They had traditionally held a managerial position of power in the department and possessed the ability to drive and transform the management model as a single group, but the medical group was divided in their interest and commitment regarding the proposed stratified management model with management teams, which meant that there were several perceptions of how the management organization should develop. This meant that for the medical professionals the change process occurred slowly and gradually. However, in 2012 the initiative was driven forward with the development of four section management teams and the process was primarily driven by the section management consultants involved in the management change process. In 2013 was it acknowledged by most of the section management consultants that they themselves had to negotiate and define their positions in close collaboration with the joint management team. This meant that the process around 2013 could still be characterized by slow steps towards an "undefined endpoint in details" as the details regarding the delegation of responsibilities was still unclear despite the joint management team's intention and purpose hereof. On the other side, the consultants were not as hesitant as they were

perceived to be around 2010 and 2011, as they had become more and more interested in and committed to working with the articulated alternative management template and at the same point they acknowledged that they had to define and develop their positions and responsibilities, internally in the section teams, across the section teams and with the joint management. Overall, the pace of change of the DC management model can be characterized as “evolutionary”, despite the formal intentions of implementing the additional management layer, as the data shows that the change in the structure, system and values occurred slowly and gradually.

7.1.2. REACTIONS TO THE MANAGEMENT CHANGE

In this section I discuss how the medical professionals reacted and adapted the management change in the management model in DC from 2010 to 2013.

7.1.2.1 The medical professionals’ interest and value commitment

In this section I discuss the medical professionals’ interest and value commitment to the changing management model in the DC from 2010 to 2013.

Regarding the medical professionals’ interest in the additional layer of management in the DC in 2010, different perceptions and expressions about the advantages and disadvantages of implementing functional partnerships in the DC were expressed. Overall, the dominant profession was divided in their interest and perception of the initiative. Some of the consultants, especially the most experienced ones found the functional partnership a disadvantage as they believed that the management organization should reflect a collegial and collective authority structure and a consensus orientated and collective decision system in order to be clinically innovative, motivated and competitive, which they believed the medical management stratification with the formalization of the functional partnership not would be able to bring forward. However other consultants, especially those engaged in the functional partnerships, but also junior doctors and other professionals such as the group of nurses found it an advantage (and the prevailing archetype template a disadvantage) to implement an additional layer of management in the form of functional partnerships, especially because they believed that this construction could support them in their daily operations, but also create overall clinical consistency in a growing department and thereby secure the overall competitiveness of the DC. This meant that in 2010 an overall interest in the functional partnerships was present; however, a minor, but powerful group of the consultants were very dissatisfied with the initiative. What is interesting is that, according to Greenwood and Hinings (1996), intense pressure from dissatisfaction with the prevailing archetype management template will not lead to change unless the dissatisfied groups recognize the connection between the prevailing template and their position of disadvantage. In this case some of the consultants, the junior doctors and the nurses recognized that the prevailing archetype model was a

disadvantage for the DC and their position. Another part of the medical group, some of the consultants with most expertise and seniority, did not recognize that the prevailing template as a disadvantage for the DC. This is interesting as this group of consultants already possessed the distributed privilege through the prevailing template. The consultants' privilege (and power) would in general be stratified as the functional partnership gained an enhanced position which in theory would leave the collegium of consultants with less power or privilege. What is more interesting is that Greenwood and Hining (1996) are discussing "dissatisfied groups". In this case it is not about dissatisfactions expressed between different groups of professions, as e.g. nurses and doctors, but within a specific group – the medical group. As the medical group was perceived to be the dominant group in the DC, their power to drive the transformation of the management model depended on the overall extent of medical professionals' "interest" in the management changes. This meant that the degree of pressure for an alternative management template was dependent on how the power and negotiations internally in the collegium of consultants unfolded. In 2010 the general interest and commitment to the functional partnerships was hesitant, despite some consultants' approval of them.

In 2013 the majority of the medical professionals were becoming increasingly interested in the management teams at the mid-level of the DC. The majority of the consultants expressed that they found the prevailing management template a disadvantage, as they had recognized more clearly that it was necessary to re-organize the management of the DC. They were interested in the section management teams as they found it an overall better solution to develop a version of this model because, in their opinion, it strengthened the medical decision system, which had been weakened in the light of the prevailing management template for a number of years. As in 2010 a minor part of the consultants did still prefer the prevailing management template in 2013, however, in 2013 a greater medical professional pressure for change towards implementing the section management teams as a legitimate level of management was occurring.

Regarding the pattern of value commitment, in 2010 competitive commitments to different management templates were supported. The professionals were primarily committed to the prevailing management template-in-use, however with the joint management team introducing an additional layer of management in the form of functional partnership teams, the nurses and the junior doctors expressed an increasing value commitment to this articulated alternative, as they perceived that the prevailing management template forced them into dissatisfying situations, and they expected the articulated alternative could resolve those issues. In other words. these groups expressed that the dominating authority structure and decision system was not "functioning" favourably to the daily operation of the DC. It was perceived that the value about managerial competences linked to the definition of consultant and to the degree of clinical skills and seniority and the value about being colleagues as equals in the consensus-orientated management decision process

created frustrations and rigidity in the daily collaboration and decision making system. A sort of hesitancy but also curiosity was expressed by some of the consultants, and especially among those who had agreed to be involved in the functional partnership teams, as they also expressed some dissatisfaction with the prevailing management template as described in the above sections. This expressed dissatisfaction resulted in a pattern of commitment in 2010, where the nursing group preferred the articulated alternative management template, as did a part of the medical group; the junior doctors and a minor part of the consultants. The rest of the consultants preferred the prevailing template in use at that time. This pattern of value commitment also reflects that the dominant medical group was divided in their commitment to the competing management templates, however, there was no occurrence of a large fragmentation in the group.

The pattern of value commitment in 2013 was still dominated by competitive commitments to the different management templates. However, in 2013 the majority of the professionals supported the prevailing management template in-use rather less than before. Instead the articulated alternative with an additional layer of management was increasingly strongly supported by the majority of the professionals compared with their expressions in 2010. In 2013 the pattern of value commitment had changed as the majority of the medical group did increasingly support the alternative management template and at the same time the group of nurses and the junior doctors still preferred the articulated alternative template as in 2010. This increasing support from the medical group and in particular the consultants can be explained by the consultants' increasing frustration at the (dys)functionality of the consensus-orientated and collective decision making in the collegium of consultants. They perceived that the collegium had lost some of its decision power to negotiate valid overall management decisions due to the definition that every consultant per se possessed self-management competences (and veto rights), the values about being colleagues as equal and the increasing amount of consultants. The consensus-based decisions were in 2013 perceived as almost impossible to make in the collegium by the consultants. With that in mind the consultants involved perceived that the articulated alternative template would create stronger clinical medical discussions which would re-strengthen the coherence in the DC. However, a minor part of the consultants in 2013 still preferred the prevailing management template-in-use as they valued their self-management positions and collegial structure and the derived opportunities, which in their opinion created motivation and drive for clinical innovation. These consultants expressed a great concern that the alternative model would suffocate these dynamics. Overall, the pattern of value commitment had moved towards favouring the introduced mid-level management layer in a larger extent than in 2010.

The increasing professional dissatisfaction with the prevailing authority structure and decision system amongst professionals for various reasons, but also the pattern

of competitive value commitment, can explain the increasing temper and pressure for the articulated alternative management template instead of the prevailing template-in-use. However, the interest and pattern of value commitment can also explain why the prevailing management template-in-use was not replaced, as the value commitment to it was still strong among some of the consultants, which means that the some of the dominant group possessed the power to create radical change had not put any effort into shaping the alternative management template. The medical group's internal division regarding this value commitment made the process drive in two management model directions, which may explain the layering of a new management model down on another more traditional management model. According to Greenwood and Hinings (1996), competitive commitment encourages a more evolutionary pace of change, which was the case here, as the intensity of the pressure is moderate, despite the changes in the value commitment. Furthermore Greenwood and Hinings (1996) argue that radical change is only enabled if appropriate power and supportive power dependencies are present among those groups with power. I therefore discuss the power dependencies and also the capacity for action among the professionals in the DC in the next section.

7.1.2.2 The medical professionals' power dependencies and capacity for action

In this section I discuss the medical professionals' power dependencies and capacity for action in relation to the changing management model in the DC from 2010 to 2013.

Regarding the power dependencies in 2010 it was perceived and expressed that the group who was "listened to more keenly than others" was the group of medical professionals and in particularly the consultants in the DC. In other words, the collegium of consultants possessed the dominant authority position and the power and control to define their managerial jurisdictional area and thereby the DC's overall response to the introduced functional partnership teams. As the medical professionals overall in 2010 were rather hesitant and reluctant about the functional partnership teams and their formalization, was it sparsely how the consultants actually did "promote" the articulated alternative template. The joint management team did also possess an authority position formally but was more "listened to" regarding the administrative and personal management areas, than in the more clinical strategic and research areas, as they functioned as the collegium of consultants "representative" regarding those issues. This meant that the idea of the functional partnerships was vaguely pushed forward, as the joint management team "only" in practice had the legitimacy to delegate and push to the more administrative and personal management areas in the articulated management template, and they possessed to a lesser degree the potential and power to direct the clinical strategy and research management of the DC.

The power dependencies in 2013 were still perceived to be dominated by the medical group, and especially the consultants in collaboration with their representative; the executive administrative consultant, were still the ones who were listened to most keenly compared with the other professions such as the nursing group in the DC. The medical group and the consultants' increasing interest and value commitment to the articulated alternative management template with an additional formal layer of management was very important in relation to explaining the changes in the management model in the DC. As described above, a competitive pattern of value commitment had developed. The majority of the consultants were increasingly interested in and committed to creating an alternative model like the construction of the section management team model, due to the fact that they perceived that the growth of DC had had a negative impact on the efficiency of their collective, collegial and consensus orientated decision system. A minor part of the consultants did still prefer the prevailing management template-in-use as described in the above section. This meant that in 2013 the majority of the consultants possessed the ability to influence and promote the organizational change as they possessed the dominant power to push their management model in the desired direction towards the articulated alternative management archetype. However, as some of the very experienced consultants still drew on the values linked to the prevailing management template-in-use (which every consultant was "brought up in" and therefore also valued) it meant they also possessed the power to resist the potential alternative. These opposing dynamics created internal struggles and negotiations in each management forum and especially in each section. The output of these negotiations are in 2013 reflected in that despite the formal intention of delegating strategic management, clinical management, administrative and personnel management and research management to the section management teams, it is clear that the consultants are mostly in touch with the traditional joint management team area of management responsibilities, e.g. management administration, overall operational, personnel and logistical tasks, but also the nursing management area and their operational responsibilities. Core management responsibilities regarding overall strategy for each sub-section or specialty and research management are still possessed by each consultant in general, but the section management consultants in 2013 were increasingly pushing their colleagues to enhance their (the section management consultants') representative managerial position in each section, which means that their colleagues should delegate some of their power and control over key decision processes. So the special thing in this case is that the competitive commitment regarding the outcome of the management change process was placed internally in the dominating medical group, and not between different professional groups, which meant that the "balance of power" among those consultants in the group controlled the medical group's power to transform a management template.

The ability to manage the transition process from the prevailing management template-in-use to the articulated alternative template is described as "the capacity

for action". The joint management team possessed the authority position and power to create and establish the eight functional partnerships, and perhaps also the skills and competences (in collaboration with the other involved consultants) to assess who should and could legitimately be recruited to those positions. However, the joint management teams' clinical skills and competences to define and specify what kind of management competences and responsibilities the functional partnerships could and should develop regarding the clinical management and research strategy management to fulfil the position was not present, as the executive administrative consultant and the joint management team was not perceived by the consultants in the dominating collegium to be the most skilled expert in those specialties, which meant that the executive administrative consultant did not possess legitimate power to make decisions about the specific intended responsibilities. This meant that at the beginning of the transformation process (2010–11) it was questionable to which extent the joint management team actually possessed the ability to embrace this process. In other words, the joint management team lacked capacity for action in the decision process of who should be responsible for what in the DC, including the revitalization of the consultants' management space. Greenwood and Hinings (1996) argue that radical change would not occur without capacity for action and even more there has to be motivation for driving the change by the precipitating dynamics. As the joint management team did not possess "enough" capacity for action to drive the change process, the progress of this initiative became dependent on those with the real power to drive the change process – the consultants. At the beginning of the process the consultants' interest and value commitment was more or less hesitant about the articulated alternative management model, which meant that the process did not get the fastest and most powerful start. This slow, almost experimental steps by which the start was characterized can also be explained by the fact that the professional perception that the new "destination" or endpoint of the articulated alternative management template developed by the joint management team, and how this process should progress towards this "endpoint", was lacking clarity and expertise.

Around 2012 and 2013 the joint management teams still possessed a formal authority position and (administrative) power to create management activities in the form of several workshops for the involved professionals, *ad hoc* meetings and scheduled meetings across the section management teams, and especially meetings of the "clinical board" with the section management consultants. However, the joint management team's ability or "capacity for action" to manage to get to the intended destination was seemingly increasing as the consultants involved in the management became more and more interested and committed to the articulated alternative template. For example, the joint management team possessed the ability to create four section management teams instead of the eight functional partnerships. Most likely because the consultants (with legitimate decision power) were interested in and increasingly committed to down-scaling the amount of management teams, which meant that they encouraged and supported the executive

administrative consultant and the joint management team to make this decision. This meant that the consultants involved in the section management teams possessed the resources and skills to mobilize the construction of the teams in collaboration with the joint management team. This dynamic can also be applied to the section management consultants' construction of their board. Moreover, the consultants' involvement in the board seemed to empower the joint management team, as those consultants to a greater or lesser extent possessed the clinical skills, knowledge and resources to define how the clinical strategy and research management responsibilities could be unfolded in those forums. At least they possessed negotiated support from their colleagues in the sections. This meant that the joint management team's overall ability to refine and nurture the process increased towards 2013 because of the commitment of the majority of the consultants. In other words, the joint management team's skills and competences to define and specify the responsibilities of the section management teams was very dependent on the section management consultants' willingness to engage and drive this process.

The power dependencies and the capacity for action in the DC can to some extent explain how the articulated alternative management template was promoted and the slow and sometimes experimental steps by which the consultants adapted the process. Overall the medical group and especially the consultants dominated the power dependencies during the period from 2010 to 2013. There has been no reticence here about who was most listened to most keenly. However, internally differentiated developments in the interest in and value commitment to the articulated alternative management template among the consultants eroded the power differential, and thereby the control over who should decide which management template should be favoured. This meant that during the period some of the consultants sought to promote the section management teams by being involved and developing them. Other consultants were more conservative and committed to proceed with the prevailing management template-in-use, however they were behaving more tacitly, being indifferent to the attempts to develop a management model to the DC. Regarding capacity for action, it has been clear that the joint management team did possess the administrative skills to initiate the process and during 2012 and 2013 they possessed the ability to create workshops that were perceived as meaningful, and framing networks among the involved professionals. However, they did not possess the ability to define and specify what kinds of management competences and responsibilities should be delegated to the section management teams from the joint management team or from their consultant colleagues through the process. Neither did they manage to establish across-section management work, however, in 2013 it was on the drawing board. This meant that over the three years the joint management team had not been able to clarify fully the responsibilities they would delegate to the section management level. As a consequence of the increasing work load and involvement with management activities and involvement around 2012 and 2013, occurred the

described ambiguity and lack of clarification among the professionals involved in management and the delegation of management responsibilities declined a little.

7.1.2.3 Summary

The introduction of management teams below the joint management team challenged the consultants' dominance and authoritative position within the DC. A smaller share of the consultant group expressed no interest in the proposed management model, but favoured instead the traditional management model. A majority of the doctors responded, however hesitantly, but with positive interested in developing a formal stratification of their traditional collective, collegial and consensus-orientated management model. A majority of the doctors thus articulated dissatisfaction with prevailing management model and concern for the future maintenance of the department's professional work and cohesion, which meant that they would like to engage in solving these challenges. The dominant consultant group was thus divided in their interest and commitment to the development of a new management model. The involved and interested consultants tried, in collaboration with the joint management team and the ward nurses, to shape and design multidisciplinary management teams and sections, as well as getting involved in discussions and negotiations about the types of clinical and administrative management responsibility and cooperation they would take care of internally in the section management teams, in relation to the joint management team and in relation to their consultant colleagues. Studying the medical professionals' adaption process over time reveals that the medical professionals possessed some sort of entrepreneurial opportunity to design the actual development of the DC's management model as they increasingly attempted to shape the nature of their management model and responsibilities related thereto.

Although the majority of the doctors in the department found it interesting to work on the proposed management model, the divided interest within the collegium of consultants meant that they as a group did not agree on what final goal they were working towards, which had great significance for the outcome of the management the organization practised around 2013, which I discuss in the next section.

7.1.3. THE OUTCOME – A HYBRIDIZED MANAGEMENT MODEL

In this section I discuss the outcome of the management change process. More specifically, I discuss the scale of change of the management archetype model from 2010 to 2013.

7.1.3.1 The authority structure

In this section I discuss the change in the authority structure from 2010 to 2013.

The authority structure in the DC moved towards being increasingly medically stratified both formally and informally. Overall, the movement enhanced a tendency for consultants to be more and more formally involved at different management levels in the management of the DC due to the growth of the department. The top management authority position of the joint management team, consisting of an executive administrative consultant and the head nurse, did not changed significantly. However, the joint management team and the professionals say that their position as top management team has become one of more administrative authority during the process of implementation of the additional layer of management. Their internal collaboration across their professional boundaries has moved towards a closer teamwork despite their professional boundaries and traditional management behaviour. Both top managers have become more involved in the overall administration of the daily operation and external affairs for the DC. In 2010 the collegium of consultants collectively dominated the authority structure informally, despite the intention of stratifying the collegium of consultants by formally constructing eight management team teams named “functional partnerships”. However, through that process, the subsequent renaming of functional partnerships as “section management teams” and the reduction of the eight management teams to four, each consisting of a consultant and one or more nurses, a more formal medical stratification of the management positions and responsibilities also became a reality in 2013. This meant that the collegium of consultants’ previous overall collective domination of the authority structure diminished as the consultants in collegium still dominated the authority in the DC, but the section management teams, and especially the additional board constituted by the executive administrative consultant and section management consultants enhanced their administrative and clinical power, which made the medical authority structure more stratified. It could be argued that the developed medical authority structure mirrored the management hierarchy of the nursing group as the board of section management consultants could be a counterpart to the nurses’ management forum attended by head nurse, the section management nurses and the ward nurses. The section management teams, below the joint management team, the consultants’ board and the nurses’ management forum, represented both consultants and ward nurses with section management responsibility. Below the section management level were the consultants who were affiliated different sections and the nurses employed in each section.

7.1.3.2 The decision system

In this section I discuss the change in the decision system from 2010 to 2013.

The decision system in the DC moved towards being medically stratified both formally and informally, by implementing the section management teams. Overall, the consultants – individually, collectively and in collaboration with their representative, the executive administrative consultant, possessed a dominant

decision-making position, despite the formal introduction of the functional partnerships in 2010. However, due to the fact that it became more and more visible to the consultants that their collective and consensus orientated decision power and cohesion had become fragile because of the increasing numbers of consultants and specialties and the growth of the department in general and the individual managerial decision power every consultant possessed, the introduction of the section management teams in 2013 was acknowledged by the majority of the consultants as management positions where the consultants in each section once again were able to discuss and negotiate important clinical and managerial issues. With the later construction of the formalized four section management teams, the collective, collegial and consensus orientated decision system broke down, as the decision-making power and negotiations moved down to each sub-section and the section management teams, and especially in the consultant's board, leaving what had been the primary forum of important management negotiations and decisions (the collegium of consultants) as a forum for information dissemination.

7.1.3.3 The interpretive scheme

In this section I discuss the change in the interpretive scheme.

In 2010 it was expressed by the majority of the professionals that the management of the DC should be a matter of professional concern. This powerful and persistent belief drove the doctors and other professionals to maintain their jurisdictional area regarding the management of the administrative tasks that was linked to the medical area of the DC. Regarding appropriate organization, it was strongly believed that it should be those with greatest seniority and expertise who should and could possess the overall management positions in the DC, being the dominating medical group. This value was reflected in 2010 in discussions and dissatisfaction amongst the consultants about the position of their representative, the executive administrative consultant, and his perceived lack of seniority and expertise and the consequent lack of recognition of his management/representative position among his consultant colleagues. Consultants, junior doctors and even nurses were committed to this value about being a skilled medical professional before being able to get a management position, and it was present in 2010. Furthermore, there existed the belief that the most skilled consultants could and should manage themselves (medical self-management) and that there were limits to what an executive administrative consultant was capable to manage. This value underlines the informal decision system of the DC where the most skilled consultants were involved in collective and collegial decision making, with the executive administrative consultant and the head nurse taking care of the more administrative work which ws placed on the edge or boundary of their medical jurisdictional area of clinical work and decisions. Moreover, in 2010 the dominant medical profession possessed an authority position in the DC whereby they could make decisions favourable to their clinical issues and performance within a political and economic

context. In 2010 the values about the consultants' authority position versus the position of the joint management team showed an increasing incoherence between the embedded values of the consultants' strong authority position and decision power and the power of the more and more formalized top management of the DC.

In 2013, the majority of the professionals still felt that the management of the DC is a matter of professional concern. Overall, the value was still held that those professionals with the greatest seniority and expertise should and could possess the management positions in the DC, which was still the medical group in 2013. Regarding appropriate values and beliefs about organizing, it was still an expressed belief that it should be those with greatest expertise and seniority who managed the DC, being the medical consultants and the executive administrative consultant. However, a competing value about who should possess a management position in the DC and thereby how the management organization should be appropriately organized emerged during the process of implementing an additional layer of management in the DC. The rising belief is that is it not necessarily only those who possess the highest expertise and seniority in a specialty who should or could possess a legitimate position as a section manager. Instead it is expressed by the majority of the consultants that it could be a compromise, where a skilled consultant (but not the foremost in the specialty or section) who is also interested in management could be acknowledged as the representative for the consultants in the sub-specialty/section. This belief breaks with the idea that the foremost consultant should possess the managerial responsibilities but it also breaks with the value about being colleagues as equals, especially in the sub-specialties. However, the specific section management responsibilities were still quite ambiguous in 2013 and thereby the knowledge about what the section management consultant were managing was still ambiguous. However, the "basic" fundamental value that professionalism goes in front of management was still reflected in the section management teams as the responsibilities regarding clinical research and strategy were primarily handled by the most skilled and respected consultants, which in 2013 left the administrative and personnel responsibilities primarily to the section management teams, despite other intentions. Furthermore, the formalization of a nurse in the section management teams also touch the values about medical professionals being the dominant management group, as the section management nurses *per se* possessed equal managerial responsibilities with certain of the consultants. However, in 2013, the traditional authority structure and system still in functioned, where the nurses were perceived as a subordinate group despite their formal positions in the management organization. Furthermore, the value about being recruited as manager or representative among one's own colleagues was still maintained through the recruitment process of section management teams in 2013.

Regarding the nurses' management position the interpretive scheme still did not support the head nurse as a legitimate manager of the consultants and their medical work since the head nurse did not possess the valued medical expertise and

seniority. In the same respect, the expressed values embedded in the interpretive scheme around 2013 did not support the authority position of the nurses in the section management, as they did not possess medical seniority and experience which was imperative to manage the consultants' and junior doctors' clinical work. This meant that the nurses involved in the management at section level and the head nurse still performed very traditional management nurses' roles and positions concerning specific administrative and nursing responsibilities as they used to do.

The above expressed values about the authority structure and decision system in the DC in 2013 illustrate that the value about having a professional collective and collegial decision system was slowly breaking down, although still present, while a new belief in the necessity of stratification of management positions was arising. Overall, the value was still present in the collegium of consultants, however, it was less powerful as the forum had lost some of its power, as described above. What is interesting is that it survived in a lesser role as the value about collectivity and collegiality in the decision-making process was strongly present locally in the sections among sub-specialty colleagues and in the consultants' board. Despite the introduction of section management teams and thereby medical stratification of the authority structure, the value about being colleagues as equals and taking collective and consensus-orientated decisions was still practised on a minor scale. However, what is radical is that the emerging value about stratification of the management positions breaks with the powerful values of equality amongst colleagues and taking collective consensus-orientated decisions.

7.1.3.4 The outcome – A hybridized model

In this section, I discuss the outcome of the management change process.

Regarding the scale of change of the management template, I argue that the movement of the archetype of management from 2010 to 2013 does not represent a radical change, as the overall authority structure, decision system and interpretive scheme has not "busted loose" (Greenwood and Hinings, 1996:1024) from its existing orientation. It is still the medical profession that possesses the overall top authority position in the DC. The overall decision system is still dominated by a collegial, collective and consensus orientated approach to decision making, despite the medical stratification. Regarding the interpretive scheme, values such as being professional managers, being colleagues as equals, and taking collective decisions still dominates the archetype template in the DC in 2013. Moreover, I argue that the changes or movement in the archetype model cannot be characterized as convergent changes as the movement in the set of archetype structure and system that consistently embodies the interpretive scheme in DC is not limited, as the medical stratification of the authority structure and system, likewise the belief and values that one may possessing less expertise and seniority than some colleagues but still

hold management positions in the DC legitimately, break with the prevailing interpretive scheme.

Instead, I argue that the movement and changes in the authority structure, system and interpretive scheme can be characterized as a hybridized archetypal change or sedimentation, which means that the prevailing archetype template-in-use occurs side by side with the new management interpretive scheme, making the archetype model even more complex.

Basically, the prevailing structure, system and interpretive scheme persist and co-exist with the development of a new management interpretive scheme embedded in the new formal medical stratification of the authority structure and decision system (the formalization of the section management teams and the development of the section management board).

This means that the prevailing structure, systems, values and ideas of how to organize the management in the DC are persistent and at the same time new competing values, but also structures and systems are being committed to by the majority of the consultants. This means that a new archetype template based on medical stratification of the system and structure is being laid down on top of the prevailing management template with collective and collegial structure and system. This means that the prevailing structure, system and values and beliefs such as consultants' commitment to being professional managers, colleagues being equal, taking collective and consensus-orientated decisions, thus increasingly unfolds more locally in the stratified structure and system, as e.g. in the sub-sections and in the section management board, where the consultants actually possess a real opportunity to pursue discussions and negotiations as traditionally has been done. Furthermore, the value about colleagues being equals, is more locally practised in the context of the sections. The value about being able to possess a section management position despite not being the foremost consultant in the sub-specialty is also practised. Finally, there has been a movement of the decision power from the collegium of consultants towards being more stratified with section management consultants in a board and the section management teams below the joint management team. These changes in the interpretive scheme, structure and systems meant that a form of hybridized archetypal management models were constructed over time in the DC. However, the alternative template based on the medical stratification was still perceived to be in its infancy.

Overall, the consultants divided interest and (competitive) commitment in the new archetype template, together with their dominating power and ability to drive the change process, can explain why the articulated alternative template was seemingly layered at the top of the prevailing management template-in-use and no radical change was accomplished, and why the new hybridized management template then occurred. In this case we witness that the dominating medical group was divided in

their interest in the new management template internally, which meant that two quite equally powerful and legitimate groups of consultants in the medical group possessed the ability to "drive" the transformation process. As they were divided in their understanding of the end point of the transformation process, a hybridized management model occurred, as both parts of the powerful medical group were able to maintain the structure, system and interpretive scheme, but also negotiate and design the outcome. This may also explain why the outcome of the medical stratification on the day-to-day routines are rather ambiguous as the delegation of management responsibilities in practice is ambiguous, as different interests in the medical group negotiate different end points in the daily practice.

7.2. THEORETICAL CONTRIBUTIONS

In this section, I discuss how this dissertation informs concepts of archetypes and concepts of intra-organizational dynamics by providing insight into the dynamic nature of intra-organizational management change in public professional health care service organizations and their transformation processes at a micro institutional level.

This dissertation contributes to the few studies that have applied the concepts of archetype theory, including concepts of intra-organizational dynamics, to professional health care service organizations, and of which are empirically based on changes in Anglo-Saxon health systems, as I have focused empirically on medical professionals' adaption process of a changing hospital management archetype template within a hospital organization in a Danish health system. For example, some of those studies have examined the extent to which a traditional hospital archetype actually has changed towards another intended archetype configuration (Kitchener, 1999) They have examined how an archetype configuration has been interpreted and negotiated during a transformation process (Mueller et al., 2003) and the challenges of effecting a transformational shift to a new form of process organization in large and complex organization (McNulty and Ferlie, 2002, 2004). This study contributes to this specific literature as I have focused on how the medical professionals have adapted, interpreted and negotiated a hospital management archetype template during a management change process within a hospital organization, but I have also focused on the extent to which a hospital management archetype has actually changed towards another intended management archetype within an organization.

A part of the theoretical framework aims to explore and describe the process of movement within and between institutionalized archetypes. As outlined in the chapter on the theoretical framework, the theoretical emphasis has traditionally been outlined at two levels of analysis within archetype theory. At the macro or the institutional field level, the purpose has been to discover which organizational forms or archetype templates are legitimated in the institutional sector. At the meso

or the organizational level, the purpose has often been to examine the extent to which those organizations approximate the sectoral archetype in the individual organization.

This dissertation further informs the concepts of archetype theory as it reveals insights into the process of movements between archetypes at a micro institutional level, as the purpose has been to examine how an management archetype template within a hospital organization becomes adapted or institutionalized by medical professionals through an organizational management change process.

However, the use of the concept of archetypes does not reflect upon why some organizations adopt radical change, whereas others do not. In order to understand how institutionalized management practices break down and are replaced by new ones it is interesting to focus on the inner mechanisms and dynamics of management change that control and propel the movements between hospital management archetypes within the hospital organization. The concepts of intra-organizational dynamics, that have traditionally focused on the process by which individual organizations retain, adopt or discard templates (archetypes) has been elaborated by Greenwood and Hinings (1996). I inform these concepts by revealing insight into the micro institutional level of analysis, as I focus on the process by which individuals as medical professionals *within* a hospital organization adapt, interpret and negotiate management archetype templates.

I found it very useful to take point in departure in the combination of the concepts of archetypes and of intra-organizational dynamics in order to reveal in-depth explanatory details about the medical professionals' management adaption process within a hospital organization, but also to be able to explain the extent to which the change process of the hospital management organization had changed. More specifically, I found it useful to apply the concepts of archetypes when analysing the management change process within an hospital organization, as I was able to define and construct empirically the point of departure of the management archetype template in 2010 but also construct a stopping point in 2013 in the institutionalization process of the management change in the DC. The differences in the constructed archetype templates' authority structure, decision system and interpretive scheme from 2010 to 2013 also strengthened my analytical understanding of how the management change process had developed towards hybridized change within the hospital management organization.

However, it was rather challenging analytically to decide when the management archetype template in the hospital organization actual had transformed from one archetype to another. I searched in the empirical material for "pictures" of the degree of incoherence in the archetype template, but when the change "only" represented fine tuning of the template and when was it clear that it was a case of sedimentation or radical change was rather tricky to decide, as the hospital

organization (the DC) was constructed by a multitude of different professional groups with different beliefs and values, who possessed different kinds of jurisdictional authority power and different kinds of parallel management decision systems, such as the medical collegial decision system and the nurses' hierarchy decision system. The construction of each component (authority structure, system and the interpretive scheme) in each archetype model reflected then a very complex and multifaceted picture of the structure and the decision system in each archetype, despite the general portrait of the medical professionals' overall dominance. I believe that pushing the concepts of archetype theory to the micro institutional level boosted the complexity in the analysis regarding the transitions between the different types of archetypes. The hospital organization consisted of a complex authority structure, system and interpretive scheme, which made it even more difficult to assess the different kinds of change in the structure, system and interpretive scheme. As a result, I have probably not captured all the nuances in the descriptions of the different management archetype templates in the case.

Furthermore, I also found it useful to apply the concepts of intra-organizational dynamics to explain how the medical professionals within the hospital organization were involved and engaged in the management change process of the DCs management model. However, the complexity in the internal management organization becomes even more apparent at this micro level as the power-relations between the diversity of different professions and professionals and their interests and commitments are expressed. Also *within* the different professional groups, such as the medical group, different interests in management and change processes are expressed. This diversity in interest and commitment, but also formal and informal professional power and capacity, made it rather complicated to figure out the dynamics of how management archetype moves. In this regard I experienced the boundary conditions of the concepts of intra-organizational dynamics, as they e.g. did not focus on the different interest and commitment within the professional groups, and also the differentiated power and capacity of the professional groups and individuals, and moreover the different social, professional, psychological and team-orientated processes taking place in relation to the different management processes, that might have an impact on the dynamics of the professionals' interest, value commitment, power and capacity.

7.3. IMPLICATIONS FOR PRACTICE

This dissertation reveals detailed insight into how and why medical professionals adapt a hospital management model within a hospital organization in the Danish health system. In this section I present some practical implications.

Regarding the medical professionals' involvement and engagement in management changes, the dissertation illustrates that it is crucial whether doctors (especially consultants) take interest in and feel commitment to create management changes in

their organization, before any management change process in an organization (e.g. a Danish hospital department) can be propelled or driven towards a defined end point which the medical professionals also should have agreed upon.

In this regard, the extent to which the medical professionals have an understanding of and insight into the issues that create managerial and organizational challenges, and also the ability to figure out what kind of managerial solutions can be established to address these challenges might have implications for medical professionals' engagement and involvement in a management change process in a Danish hospital organization. It is perhaps too much to ask of professionals trained in medicine, to be able to think in managerial and organizational terms, however they possess a deep understanding of the medical technical processes which are imperative if a management organization it to change to a better version, from a clinical perspective. This makes it particularly important that doctors are or become aware of managerial and organizational issues that challenge their overall professional work and performance. In this Danish case the executive administrative consultant systematically examined challenges through interviews by those who possessed management responsibilities in the DC. Furthermore, the joint management team facilitated the professionals' focus and awareness on organizational and managerial issues that were perceived to have an impact on the daily operation as well as the clinical performance and cohesion in the DC, by involving them in several workshops on this very topic. Those initiatives are examples of how the DC created a platform for addressing these challenges about organizational and managerial issues in the daily operations, where it can be difficult to see beyond one's specialty.

Furthermore, the dissertation illustrates that the whole medical group, by virtue of their superior authority position, largely had the ability and capacity to operate a managerial change process in the direction they deemed advantageous to their authoritative status and professional work. In this case the consultants developed a management model with several management forums, as a consequence of challenges experienced regarding their authority structure and decision system that emerged with the increasing growth and complexity the hospital department was facing. Concretely, outcome of the process was thus a diversity of vertically and horizontally placed management forums; the joint management team, the section management team forum, the four section management teams, the section management consultants' board, the nurses' council, as well as the traditional collegium of consultants. Overall, six new management forums were developed during the management change process, five of which were interdisciplinary teams. The various management forums established opportunities for creating additional managerial insights into the different sub-specialties' needs, clinical priorities, professional challenges and problems, which had the possibility to strengthen the department's overall base of clinical decision making, prioritization and operation but also interdisciplinary activities. The more formalized and visible structures and

systems had greater potential to help to maintain the professional work and innovative cohesion across the sub-specialties in the DC, compared with the prevailing structure and system. However, the nine management forums created particularly high demands on the various professional managers in the management forums, in the form of knowledge sharing, communication and coordination of management information across the many forums, but also regarding organizational insight and overview. Creating several management forums with different types of responsibilities might have implications for the intentional objectives, if the medical professionals at the different layers of management and forums did not become aware of or engage in the more organizational, communicative and interdisciplinary aspects of the managerial knowledge sharing in the department, including the more crosscutting communication lines in the management model and the overall interest in the organization rather than solely one's own section or specialty. There is a risk of fragmentation and lack of understanding of each other's clinical priorities, or professional capacity if they lack insight into each other's clinical needs, challenges and professional problems. There is thus a great communicative management task both in utilizing the potential in these interdisciplinary management forums, but also in forwarding relevant information in the system, so the right decisions can be discussed and taken.

7.4. CONCLUSION

This section concludes the dissertation by summarizing the gaps in the existing body of knowledge, and recapitulating the main contributions to the research on medicine and management in public professional health care service organizations, the concepts of archetypes and the concepts of intra-organizational dynamics, and practice. Hereafter the caveats of the research and directions for future research are highlighted.

In this dissertation I have presented how existing research in medicine and management in public professional health care service organizations has primarily been focused on how medical professionals across Europe have reacted and responded to implementation of new hospital management templates, and the outcome of processes of hospital management model implementation. However, we know very little about how management templates have been adapted, negotiated and interpreted over time in changing hospital management organizations, especially in-depth details about the processes of medical professionals' involvement in management in hospitals. This dissertation contributes to the research literature by providing detailed and rich descriptions of the process of medical professionals adapting changing hospital management models within hospital organizations.

The literature review illustrated that most of the empirical research on medical professionals' adaption processes and responses to changing hospital management

models are studied in an Anglo-Saxon health system context. In addition much of the Anglo-Saxon literature on medical professionals' response to changing hospital management models has primarily emphasized the reaction and response from the medical profession, and has not in a larger extent emphasized the change process or other management shaping activities. This dissertation contributes to the literature of medicine and management in public professional health care service organizations by empirically focusing on the more underexposed Nordic health system context, illustrated by the Danish health system, where the medical profession has not responded to management change driven from the top, but in a larger scale has been involved in negotiating the management change at different levels in the health system, and showing interest in management.

This dissertation contributes to the concepts of archetype theory (Greenwood and Hinings, 1988, 1993, 1996), as it reveals insights into the process of movements between archetypes at a micro institutional level, as the purpose has been to examine how a management archetype template within a hospital organization has become adapted or institutionalized by medical professionals through an organizational management change process. As outlined in the chapter on the theoretical framework, the theoretical emphasis has traditionally been outlined at two levels of analysis within archetype theory. At the macro or the institutional field level, the purpose has been to discover which organizational forms or archetype templates are legitimated in the institutional sector, and at the meso or the organizational level, the purpose has often been to examine the extent to which those organizations approximate the sectoral archetype in the individual organization.

As the use of the concepts of archetypes does not reflect upon why some organizations adopt radical change, whereas others do not, I have applied the concepts of intra-organizational dynamics, that focus on the process by which individual organizations retain, adopt or discard archetype templates (Greenwood and Hinings, 1996). More specifically, they focus on how institutionalized practices break down and are replaced by new ones, by focusing on the inner mechanisms and dynamics of change that control and propel the movements between archetypes within organizations. This dissertation contributes to the concept of intra-organizational dynamics by revealing insight into the micro institutional level of analyses, as I have focused on the process by which individuals as medical professionals have adapted, interpreted and negotiated changing management archetype templates within a hospital organization.

Furthermore, this dissertation contributes to the research studies that have applied the concept of archetype theory, including concepts of intra-organizational dynamics, to professional health care service organizations (Kitchener, 1999, Mueller et al., 2003, McNulty and Ferlie, 2002, 2004). The dissertation contributes to this specific literature as it studies how medical professionals have adapted,

interpreted and negotiated a hospital management archetype template during a management change process within a hospital organization at the micro institutional level and how we can explain this process, but I have also focused on the extent to which a hospital management archetype has actually changed towards another intended management archetype within an organization.

Regarding the medical professionals' involvement and engagement in management change processes within hospital management organizations, the dissertation reveals that it is crucial whether doctors (especially consultants) take interest in and feel commitment to management change in their organization, before any management change process in an organization (e.g. a Danish hospital department) can be propelled or driven towards a defined end point which the medical professionals also should have agreed upon.

In this regard, the dissertation reveals insights that might have implications for medical professionals' engagement and involvement in a management change process in a Danish hospital organization, the extent to which the medical professionals have an understanding of and insight into the issues that create managerial and organizational challenges, and also the ability to figure out what kinds of managerial solutions can be established to address these challenges.

Furthermore, the dissertation reveals that it is particularly important for doctors to be aware of managerial and organizational issues that challenge their overall professional work and performance. In this regard, it is also revealed how the management of a hospital organization should be aware of organizational and managerial issues that may have an impact on their daily operation but also clinical performance and cohesion in the hospital organization, by involving the professionals in initiatives that address these challenges about organizational and managerial issues in daily operations, where it can be difficult to see beyond one's specialty.

Furthermore, the dissertation reveals insights into how the whole medical group by virtue of their top authority position largely had the ability and capacity to drive a managerial change process in the direction they deemed advantageous to their authoritative status and professional work. In this regard, the dissertation also reveals insights into how the medical professional as individuals and as a group possess the power and capacity for action to shape and design a hospital management model they find advantageous within a hospital organization in a Danish health system.

A caveat of this research relates to the choice of theory. Choosing theoretical concepts as a theoretical framework or lens can often lead the researcher to focus on particular elements while pushing others into the background. In order to grasp the medical professional adaption process, my focus has been on the components of the

endogenous dynamics of intra-organizational behaviour, which is only a part of the concepts developed by Greenwood and Hinings (1996) to understand how institutionalized practices break down and are replaced by new ones. Overall, they focus on the interplay of contextual forces and intra-organizational dynamics. It may have been fruitful for the study also to have emphasized how the external processes of de-institutionalization could be understood together with the internal dynamics of interpretation, adoption and rejection of the hospital organization by encompassing exogenous (market context, institutional context) dynamics: there are findings that point to the context of the cardiology department having great importance in the matter of why the medical professionals felt it necessary to reorganize the hospital management model in their department. Another caveat relates to the single case study design. The medical professional adaption process of changing management models in hospital organizations was investigated in the Department of Cardiology at Aarhus University Hospital in the Danish health system. The theoretical generalization from the medical professional's adaption process of the changing management model in the Department of Cardiology as a case study should be limited to conditions similar to those of this process and context. Generalization of results to other types of organizational environment must be done carefully.

The findings of this study reveal insight into the fact that the medical professionals in a Danish hospital organization in a Danish health system context possess an extensive opportunity to be deeply involved in the management model change processes locally within a hospital organization, designing local management model solutions. Findings also reveal insight into the fact that the medical professionals have to be interested in and engaged in shaping and designing their own management model, but they also possess both the power and the ability to drive or propel management changes in a Danish hospital organization. Finally, the findings reveal that in terms of the outcome of hospital management model change in Danish hospital organizations, the medical professionals have designed a stratified management model within the hospital organization that nevertheless supports their traditional dominance. In this regard, the findings indicate that the initial assumptions about medical professionals' adaption process of changing hospital management models in hospital organizations in a Nordic health system context are largely supported, as the medical professionals clearly possess the opportunity to have an innovative role in the local management change process, but also possess the autonomy to interpret, negotiate and design their own management models. In this regard, the findings indicate a distinct pattern in the way medical professionals respond to management change, different from other studies in Anglo-Saxon health system contexts. In this regard, it would be interesting to investigate these aspects through a comparative case study between different national health system contexts in order generate more systematic and robust results which can be generalized.

Regarding future research, it could be interesting to investigate the institutional work of the medical professionals regarding their management activities, actions and responsibilities within a hospital organization in a Nordic health system context, but also to study more deeply what motivates them for changing or maintaining their hospital management models within their hospital management organizations. The study finds that the medical professionals possess the opportunity, ability and power to drive those change processes forward but also resist them in a hospital organization in the Nordic health system context. More concretely, it would be interesting to explore how the medical professionals at the micro institutional level in practice negotiate, cooperate, elaborate and display their specific management responsibilities (jurisdictional management areas) over time in relation to other professionals with management responsibilities—e.g. the nurses with management responsibilities—but also internally in their medical groups. It could prove crucial to ascertain whether the medical professionals find interest in the more administrative, cross-organizational and communicative issues and aspects of managing a hospital organization.

REFERENCES

Abbott, A. (1988) The system of professions: An essay on the division of labour, Chicago and London: University of Chicago.

Ackroyd, S., Kirkpatrick, I. and Walker, R. M. (2007) Public management reform in the UK and its consequences for professional organization: A comparative analysis. Public Administration, 85 (1), 9–26.

Alban, A. Knudsen, J. L. and Thomsen, I. S. (1990) Ledelse i Sygehuse. Dansk Sygehus Institut. Copenhagen.

Andersen, L.B., Hansen, K.M. and Klemmensen, R. (ed.) (2012) Metoder i statskundskab. Hans Reitzels Forlag. Copenhagen.

Antoft, R., Jacobsen M. H., Jørgensen, A. and Kristiansen, S. (ed.) (2007) Håndværk og Horisonter Tradition og nytænkning i kvalitativ metode. Syddansk Universitetsforlag.

Antoft, R. and Salomonsen, H. H. (2008) Dynamic qualitative comparative case-studies in organization studies, European Group for Organization Studies, 24rd EGOS Colloquium, Vrije University, Amsterdam, The Netherlands.

AUH (2007) Consultants Management Function, Aarhus University Hospital. Central Denmark Region.

Bentsen, E. Z. (1999) Trojkaledelse i Danmark - linedans for et blandet publikum in Når styringsambitioner møder praksis : Den svære omstilling af sygehus- og sundhedsvæsenet i Danmark og Sverige. Handelshøjskolens Forlag. Copenhagen.

Bentsen, E. Z. (2000) Sygehusledelse i Danmark. Trojkamodellens opståen, spredning og funktion. Institut for Organisation og Arbejdssociologi ved Handelshøjskolen i København. Nyt fra Samfundsvidenskaberne. Copenhagen.

Berg, L. N., Byrkjeflot, H. and Kvåle, G. (2010) Hybridledelse I sykehus – engjennomgang av litteraturen. Nordiske Organisasjonsstudier, 12 (3), 30–49.

Binderkrantz, A. S. and Andersen, L. B. (2011) Guide til NVivo 9, Hans Reitzel Forlag. Copenhagen.

Bode, I. and Maerker, M. (2014) Management in medicine or medics in management? The changing role of doctors in German hospitals. International Journal of Public Sector Management, 27(5), 395–405.

Borum, F. (1976) Organisation, magt og forandring. Nyt Nordisk Forlag Arnold Busck. Copenhagen.

Borum, F. (2002) Ledelse blandt læger. Ledelse & Erhvervsøkonomi, 66(1), 15–27.

Borum, F. (2004) Forskning i sygehuse under forandring: Hovedpointer fra fem års studier af ledelse og organisering i det danske sygehusvæsen. Nyt fra Samfundsvidenskaberne. København.

Borum, F. and Bentsen, E. Z. (1999) Centerstrukturen på Rigshospitalet i København : en analyse af organisatoriske og ledelsesmæssige aspekter, FLOS Forskningsrapport.

Brinkmann, S. and Tangaard, L. (2010) (ed.) Kvalitative metoder - En grundbog. København: Hans Reitzels Forlag.

Brock, D. M., Powell, M. J. and Hinings, C. R. (1999) Restructuring the professional organization: Accounting, health care and law. Routlegde

Byrkjeflot, H. and Jespersen, P. K. (2005) Ledelse og organisering i helsevesenet; endring og kontinuitet. Nordiske Organisasjonsstudier, 7(2), 5–18.

Byrkjeflot, H. and Jespersen, P. K. (2014) Three conceptualizations of hybrid management in hospitals. International Journal of Public Sector Management, 27(5), 441–458.

Cooper, D.J., Hinings, B., Greenwood, R., and Brown, J.L. (1996) Sedimentation and transformation in organizational change: The case of Canadian law firms. Organization Studies, 17(4), 623–647.

Denis, J.-L., Langley, A. and Cazale, L. (1996) Leadership and strategic change under ambiguity. Organization Studies, 17, 673–699.

Dent, M. (2003) Remodeling hospitals and health professions in Europe. Medicine, Nursing and the State. Palgrave Macmillan.

Dent, M. (2005) Post-New Public Management in public sector hospitals? The UK, Germany and Italy. Policy & Politics, 33(4), 623–636.

DiMaggio, P. J. and Powell, W. W. (1991) The new institutionalism in organizational analysis. The University of Chicago Press.

DiMaggio, P. J. and Powell, W. W. (1983) The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. American Sociological Review, 48, 147–160.

Domagalski, T. (2007) Organisation and subjectivity in the US medical profession: physician responses to structural changes within advanced capitalism. In Muzio, D., Ackroyd, S., and Chalant, F. (eds) Redirections in the study of expert labour. Law, Medicine and Management Consultancy. London, Palgrave

Doolin, B. (2001) Doctors as managers. New Public Management in a New Zealand hospital. Public Management Review, 3(2), 231–254.

Dopson, S. & Fitzgerald, L. (Eds) (2005), Knowledge to action? The diffusion of innovations in health care. Oxford, Oxford University Press.

Ejersbo, N. and Greve, C. (2005) Moderniseringen af den offentlige sektor. Copenhagen. Børsen.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996) The New Public Management in action. Oxford, Oxford University Press.

Fitzgerald, L. (1994) Moving clinicians into management: A professional challenge or threat? Journal of Management in Medicine, 8(6), 32–44.

Fitzgerald, L. and Dufour, Y. (1998) Clinical management as boundary management: A comparative analysis of Canadian and UK health-care institutions. Journal of Management in Medicine, 12(4/5), 199-214.

Fitzgerald, L. and Ferlie, E. (2000) Professionals: back to the future? Human Relations, 53 (3), 713–739.

Flyvbjerg, B. (2004) Five misunderstandings about case-study research. In Clive Seale, Giampietro Gobo, Jaber F. Gubrium, and David Silverman, eds., Qualitative research practice. London and Thousand Oaks, CA: Sage, pp. 420-434.

Freidson, E. (1985) The reorganization of the medical profession. Medical Care, 42(Spring), 11–35.

Gerring, J. (2004) in Bøgh Andersen et al. (2012) Metoder i statskundskab, Hans Reitzel Forlag. Copenhagen.

Greenwood, R. and Hinings, C. R. (1996) Understanding Radical Organizational Change: Bringing Together the Old and the New Institutionalism. Academy of Management Review, 21 (4), 1022-1054.

Greenwood, R. and Hinings C. R. (1988) Organizational Design Types, Tracks and the Dynamics of Strategic Change. Organization Studies. vol. 9 no. 3, 293-316.

Greenwood, R. and Hinings, C.R. (1993) Understanding Strategic Change: The Contribution of Archetypes. Academy of Management Journal. Vol. 36, No. 5 (Oct., 1993), pp. 1052-1081.

Greve, C.(2007) Offentlig ledelse og styring. Djøf Forlag. Copenhagen.

Harrison, S. and Pollitt, C. (1994) Controlling the health professionals: The future of work and organisation in the NHS. Buckingham: Open University Press.

Hartley, K. and Kautsch, M. (2014) Polish and UK doctors' engagement with hospital management. International Journal of Public Sector Management, 27(5), 430–440.

Heyssel, R.M., Gainter, J.R., Kues, I.W. Jones, A.A. and Lipstein, S.H. (1984) Decentralised management in a teaching hospital. New England Journal of Medicine, 31;310(22), 1477–1480.

Hildebrandt, S., Klausen, K. K. and Nielsen, S. F. (ed.) (2003) Sygehusledelse. København, Munksgaard Danmark.

Hildebrandt, S. and Schultz. M. (ed.) (1997) Fokus på sygehusledelse, København, Munksgaards Forlag.

Holsti, O. R. (1968) in Miles and Hubermann (1994) Qualitative data analysis: an expanded sourcebook, SAGE Publications.

Hood, C. (1991) A public management for all seasons? Public Administration, 69(1), 3–19.

Indenrigsministeriet (1984) Sygehusenes organisation og økonomi, Betænkning fra Indenrigsministeriets produktivitetsudvalg. Copenhagen, Direktoratet for Statens Indkøb.

Jacobs, K. (2005) Hybridisation or polarisation: Doctors and accounting in the UK, Germany and Italy. Financial Accountability & Management, 21(2), 135–161.

Jacobsen, M. L. F. in Andersen, L. B., Hansen, K. M. and Klemmensen, R. (ed.) (2012) Metoder i statskundskab. Hans Reitzels Forlag.

Jespersen, P. K. (2001) New Public Managementreformer i det danske sygehusfelt., Nordisk Administrativt Tidsskrift, 82(1), 22–41.

Jespersen, P. K. (2005) Mellem profession og Management. Købehavn, Handelshøjskolens forlag.

Jespersen, P. K., Kirkpatrick, I., Dent, M. and Neogy, I. (2007) Dancing to different rhythms: Exploring the role of professional 'strategies' in healthcare management reform in Denmark and the UK. Paper presented at 23rd EGOS Colloquium 'Beyond Waltz – Dances of Individuals and Organisations', Vienna University of Economics and Business Administration, Vienna, Østrig.

Jespersen, P. K., Nielsen M. L., and Sognstrup, H. (2002) Professions, interests, and processes of institutionalization in the Danish hospital field. International Journal of Public Administration, 25(12), 1559–1578.

Kirkpatrick, I. and Ackroyd, S. (2003) Archetype theory and the changing professional organization: a critique and alternative, Organization, 10(4), 739–758.

Kirkpatrick, I., Bullinger, B., Lega, F. and Dent, M. (2013) The translation of hospital management models in European health systems: A framework for comparison. British Journal of Management, 24, S48–S61.

Kirkpatrick, I., Bullinger B., Dent, M., and Lega, F. (2012) The development of medical-manager roles in European hospital systems: A framework for comparison. International Journal of Clinical Practice, 66(2), 121–124.

Kirkpatrick, I., Dent, M. and Jespersen, P. K. (2011) The contested terrain of hospital management: Professional projects and healthcare reforms in Denmark, Current Sociology, 59(4), 489–506.

Kirkpatrick, I., Jespersen, P. K., Dent, M. and Neogy, I. (2009) Medicine and management in a comparative perspective: the case of Denmark and England. Sociology of Health & Illness, 31(5). 642-658.

Kitchener, M. (1999) Quasi-market transformation: An institutionalist approach to change in UK hospitals. Public Administration, 76(1), 37–95.

Kitchener, M. (2000) The ‘bureaucratization’ of professional roles: The cases of clinical directors in UK hospitals. Organization, 7 (1). 129–154.

Kulmann, E., Burau, V., Correia, T., Lewandowski, R., Lionis, C., Noordegraaf, M. and Repullo, J. (2013) A manager in the minds of doctors: ‘A comparison of new modes of control in European hospitals’, BMC Health Service Research, 13:246.

Kurunmäki, L. (2004) A hybrid profession – the acquisition of management accounting expertise by medical professionals. Accounting Organizations and Society. 29(3-4): 327–347.

Kvåle, S. and Brinkmann, S. (2007) Interview. Det kvalitative forskningsinteview som håndværk. Hans Reitzels Forlag. Copenhagen.

Københavns Hospitalsvæsen (1974) Betænkning om ny organisationsstruktur på Bispebjerg hospital: Afgivet april 1974 af et af hospitalsdirektøren nedsat udvalg, Københavns Hospitalsvæsen.

Layder, D. (1998) Sociological practice: Linking theory and social research. SAGE Publications.

Llewellyn, S. (2001) Two-way window: Clinicians as medical managers. Organization Studies. 22 (4): 593–623.

Lykkesfeldt, G. and Christensen, I. (1994). Afdelingsledelse på kliniske og tværgående afdelinger. København: Dansk Sygehus Institut.

Magnussen, J., Vrangbæk, K., and Saltman, R. B. (ed.) (2009) Nordic health care systems: Recent reforms and current policy changes. Maidenhead: McGraw-Hill and Open University Press.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., and Waring, J. (2015) Hybrid manager-professionals’ identity work: The maintenance and hybridization of medical professionalism in managerial contexts, Public Administration, 93 (2), 412–432.

McNulty, T. and Ferlie, E. (2002) Reengineering in health care: The complexities of organisational transformation. Oxford, Oxford University Press

McNulty T., and Ferlie, E. (2004) Process transformation: limitations to radical organizational change within public service organizations. Organization Studies, 25(8), 1389–1412.Meyer J. W. and Rowan, B. (1977) Institutionalized organizations: Formal structure as myth and ceremony. The American Journal of Sociology, 83(2), 340–363.

Miles, M. B. and Hubermann, A. M. (1994) Qualitative data analysis: An expanded sourcebook, SAGE Publications.

Miller, D. and Friesen, P.H. (1984) Organizations: A quantum view. Englewood Cliffs, NJ: Prentice Hall.

Mintzberg, H. (1979) The structuring of organizations: a synthesis of the research. Prentice-Hall.

Mintzberg, H. (1983) Structure in 5's: Designing effective organizations. Prentice-Hall.

Mo, T. O. (2008) Doctors as managers: moving towards general management?: The case of unitary management reform in Norwegian hospitals. Journal of Health Organization and Management, 22 (4), 400–415.

Montgomery, K. (2001) Physician executive: the evolution and impact of a hybrid profession. Advances in Health Care Management, 2, 215–241.Mueller, F., Harvey, C. and Howorth, C. (2003) The contestation of archetypes: negotiating scripts in a UK Hospital Trust Board. Journal of Management Studies, 40(8), 1971–1995.

Maaløe, E. (2002) Case studier af og om mennesker i organisationer. 2nd rev. edn, København, Akademisk Forlag,.

Neogy, I. and Kirkpatrick, I. (2009) Medicine in management: Lessons across Europe. Centre for Innovation in Health Management, University of Leeds, UK.

Noordegraaf, M. (2007) From "pure" to "hybrid" professionalism: Present-day professionalism in ambiguous public domains. Administration & Society, 39(6): 761–785.

Noordegraaf, M. (2011) Remaking professionals? How associations and professional education connect professionalism and organizations. Current Sociology, 59(4), 465–488.

Oliver, C. (1992) The antecedents of deinstitutionalization. Organization Studies 13(4), 563–588.

Perspektivplan I (1971) Perspektivplanlægning 1970-1985: Redegørelse fra den af regeringen i november 1968 nedsatte arbejdsgruppe, København, Schultz.

Perspektivplan II (1973) Perspektivplan-redegørelse 1972-1987, Statens Trykningskontor, København.

Pollitt, C. and Bouckaert, G (2000/2004) Public Management Reform: A comparative analysis. 2nd edn. Oxford, Oxford University Press.

Sartirana, M., Prenestini, A. and Lega, F. (2014) Medical management: Hostage to its own history? The case of Italian clinical directors. International Journal of Public Sector Management, 27 (5), 417–429.

Sehested, K. (2002) How new public management reforms challenge the roles of professionals. International Journal of Public Administration, 25(12), 1513–1537.

Sognstrup, H. (2003) Professionelle i afdelingsledelse. Ph.D. afhandling. Institut for Økonomi, Politik og Forvaltning. Aalborg Universitet, Aalborg.

Spehar, I., Frich, C. J., and Kjekshus, L. E. (2015) Professional identity and role transitions in clinical managers. Journal of Health Organization and Management, 29(3), 353–366.

Spehar, I. and Kjekshus, L. E. (2012). Medical management in Norwegian hospitals. Professions and Professionalism 2(1), 42–59 . doi: 10.7577/pp.v2i1.178.

Sygehuskommissionen (1997) ‘Udfordringer i Sygehusvæsenet’, Betænkning fra Sygehuskommissionen, København: Betænkning nr. 1329.

Thomsen, I., Christensen, V. and Hatting, A. (1986) Struktur på sygehuse. Hvordan er mønsteret, i afdelingen? DSI-rapport 86-04. København, Dansk Sygehus Institut.

Utzon, J. (1997) Ledelse på sygehusafdelinger – fokus på den administrende overlæge. Specialisten som leder. København: DSI Institut for Sundhedsvæsen.

Vinge, S. (2000) Fra trojkamodel til entydig ledelse : en analyse af debatten om ledelsesmodeller i sygehussektoren med fokus på Århus Amt. København.

Vinot, D. (2014) Transforming hospital management à la francaise. International Journal of Public Sector Management, 27(5), 406–416.

Vrangbæk, K. (1999) New Public Management i sygehusfeltet - udformning og konsekvenser. In Når styringsambitioner møder praksis - Den svære omstilling af sygehuse-og sundhedsvæsenet i Danmark og Sverige. København, Handelshøjskolens Forlag, pp. 33–56.

Vrangbaek, K. and Christiansen, T. (2005) Health policy in Denmark: Leaving the decentralized welfare path? Journal of Health Politics Policy and Law. 30 (1-2), 29–52.

Waring, J. and Currie G. (2009) Managing expert knowledge: Organizational challenges and managerial futures for the UK medical profession. Organization Studies, 30 (7), 755–778.

Wikström, E. and Dellve, L. (2009) Contemporary leadership in healthcare organizations: Fragmented or concurrent leadership. Journal of Health Organization and Management, 23(4), 411–428.

Yin, R. K. (2003) Case study research: Design and methods. Third Edition. Applied Social Research Methods Series, Volume 5. Sage Publications, Inc. California.

Webpages

AUH (2014) Aarhus University Hospital. Available from: http://www.en.auh.dk/about-the-hospital/ [November 2014]

AUH–DC (2014) Aarhus University Hospital, Department of Cardiology. Available from: http://www.en.auh.dk/departments/head-and-heart-centre/department-of-cardiology/ [28 November 2014].

APPENDICES

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Appendix A: Interview guides 2010

Executive administrative consultant and head nurse

Introduction:

- Introduce myself
- Presentation of the project
- Your answers will be anonymized in the study.

Presentation of the informants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?

The management of the Department of Cardiology before establishing the functional partnerships:

- Will you please describe how the Department of Cardiology was managed before the functional partnerships were established in 2007/8?
    - Did you experience any advantages by organizing the management in that way?
    - Did you also experience any disadvantages?
    - Prior to establishing the functional partnerships were there any areas or specific issues that appeared repeatedly or were not handled satisfactorily?
- Will you please describe how the management has been organized in the department for the last couple years?
    - Were there any advantages to the organization of the management?
    - Were there also some disadvantages to the way the management was organized?

Expectations of the functional partnership.

- How did the idea of the functional partnerships arise?
- How do you assess the process you have been through from the idea to where you are now?
- Have you been in agreement with the model or have there been different assessments? Which?

- Then what expectations do you have of the functional partnerships as they look now?
    - (Expectations – a form of competence/responsibility handover? Finance handover?)
- What challenges do you assess for the new way of organizing the management of the department?
- What advantages do you assess for this way of organizing the management of the department?
- How do you expect the partnerships will evolve?

Distribution/demarcation of tasks/areas between the joint management, the functional partnerships as well as doctors and nurses:

- What do you assess that the employed *doctors and nurses* expect from the functional partnership?
- How do you expect the collaboration and coordination between the functional partnership and the *department management* will be?

Functional partners

Introduction

- Introduce myself
- Presentation of the project
- Your answers will be anonymized for the study.

Presentation of the informants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?
    - Why is it you that are part in the functional partnership?

The management of the Department of Cardiology before establishing the functional partnerships:

- Will you please briefly describe how the Department of Cardiology was managed before the functional partnerships were established in 2007/8?
    - Did you experience any advantages by organizing the management in that way?
    - Did you also experience any disadvantages?

    - Prior to establishing the functional partnerships were there any areas or specific issues that appeared repeatedly or were not handled satisfactorily?
- Will you please describe how the management has been organized in the department for the last couple years?
    - Were there any advantages to the organization of the management?
    - Were there also some disadvantages to the way the management was organized?

Expectations of the functional partnership.

- How did the idea of the functional partnership arise?
- How do you assess the process you have been through from the idea to where you are now?
- Have you been in agreement with the model or have there been different assessments? Which?
- Then what expectations do you have for the functional partnership as they look now?
    - (Expectations – a form of competence/responsibility handover? Finance handover?)
- How do you expect the partnerships will evolve?

Expectations for the internal interdisciplinary collaboration in the partnerships:

- What do each of you as a member of the functional partnership find to be the most important management tasks? On the other hand, are there tasks you do not emphasize as much?
- How do you expect to divide the management tasks/responsibility areas between you internally?
- Do you have expectations for the collaboration in the functional partnership?
- What challenges do you assess will be present when organizing the department in this new way?
- Are there tasks/responsibility areas that will be new to you?
    - E.g. handling new types of tasks within strategic management, research management, organizational management, professional management and personnel management (HR)
        - Do you feel you are prepared for these tasks? (Time, education, experience, etc.)
- What advantages do you assess to be present for this way of organizing the department management?
- The joint management team has the expectation that the functional partnerships in general will bring faster and more qualified decisions, as

well as make the organization of the department flatter, which will unite the Department of Cardiology. Do you have the same expectations?

Distribution/demarcation of tasks/areas between the department management, the functional partnerships as well as doctors and nurses.

- What do you assess that the employed *doctors and nurses* expect from the functional partnership?
- What expectations do you assess the *joint department management* has of you as the functional partnership?
- How do you expect the collaboration/coordination between the functional partnership and the *department management* will be?
- When / regarding what tasks do you expect that the *doctors and nurses* at the department will approach you as the functional partnerships?

Doctors

Introduction:

- Introduce myself
- Presentation of the project
- Your answers will be anonymized for the study.

Presentation of the informants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?

The management of the Department of Cardiology before establishing the functional partnerships:

- Will you please briefly describe how the Department of Cardiology was managed before the functional partnerships were established in 2007/8?
    - Did you experience any advantages by organizing the management in that way?
    - Did you also experience any disadvantages?
    - Prior to establishing the functional partnerships were there any areas or specific issues that appeared repeatedly or were not handled satisfactorily?

- Will you please describe how the management has been organized in the department for the last couple years?
    - Were there any advantages to the organization of the management?
    - Were there also some disadvantages to the way the management was organized?

Expectations of the functional partnership:

- How did the idea of the functional partnership arise?
- How do you assess the process you have been through from the idea to where you are now?
- Have you been in agreement with the model or have there been different assessments? Which?
- Then what expectations do you have for the functional partnerships as they look now?
    - (Expectations – a form of competence/responsibility handover? Finance handover?)
- What *challenges* do you assess for the new way of organizing the management of the department?
- What *advantages* do you assess for this way of organizing the management of the department?
- The department management has expectations that the functional partnerships in general will bring faster and more qualified decisions, as well as make the organization of the department flatter, which will unite the Department of Cardiology. Do you have the same expectations?
- How do you expect the partnerships will evolve?

Distribution/demarcation of tasks/areas between the department management, the functional partnerships as well as doctors and nurses.

- What expectations do you assess the *department management* have of you as the functional partnership?
- How do you expect the collaboration/coordination between the functional partnership and the *department management* will be?
- When / regarding what tasks to you expect that the *doctors and nurses* at the department will come to you as the functional partnerships?

Nurses

Introduction

- Introduce myself
- Presentation of the project
- Your answers will be anonymized for the study.

Presentation of the participants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?

The management of the Department of Cardiology before establishing the functional partnerships:

- Will you please briefly describe how the Department of Cardiology was managed before the functional partnerships were established in 2007/8?
    - Did you experience any advantages by organizing the management in that way?
    - Did you also experience any disadvantages?
    - Prior to establishing the functional partnerships were there any areas or specific issues that appeared repeatedly or were not handled satisfactorily?
- Will you please describe how the management has been organized in the department for the last couple of years?
    - Were there any advantages to the organization of the management?
    - Were there also some disadvantages to the way the management was organized?

Expectations of the functional partnership.

- How did the idea of the functional partnership arise?
- Have you assessed the process you have been through from the idea to where you are now?
- Have you been in agreement with the model or have there been different assessments? Which?
- Then what expectations do you have for the functional partnerships as they look now?
    - (Expectations – a form of competence/responsibility handover? Finance handover?)

- What *challenges* do you assess for the new way of organizing the management of the department?
- What *advantages* do you assess for this way of organizing the management of the department?
- The depyarment management has expectations that the functional partnerships in general will bring faster and more qualified decisions, as well as make the organization of the department flatter, which will unite the Department of Cardiology. Do you have the same expectations?
- How do you expect the partnerships will evolve?

Distribution/demarcation of tasks/areas between the department management, the functional partnerships as well as doctors and nurses.

- What expectations do you assess the *department management* have of you as the functional partnership?
- How do you expect the collaboration/coordination between the functional partnership and the *department management* will be?
- When / regarding what tasks do you expect that the *doctors and nurses* at the department will come to you as the functional partnerships?

Appendix B: Interview guides 2013

Executive administrative consultant and head nurse

Introduction

- Presentation of me and the project

Presentation of the informants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?
    - Why was it you that entered the section management?
    - Management experience?

The management model (image of the actual archetype):

Background story

- Why was section management introduced? What was the intention?
- Why were the functional partnerships cut down from 8 to 4 sections of management?

The section management internally:

- What types of management tasks do you handle in the day to day management work in the department?
    - Responsibility for budgets, responsibility for finance
    - Quality assurance and development
    - Education
    - Clinical management responsibility
    - Performance responsibility (production targets, service targets, etc.)
    - Project work
    - Administration
    - Vision, strategy for: research, education, competence programmes, professional development, technology: local strategies, action plans and decisions as well as intersectional collaboration, down, up)
    - Policies, guidelines

  - Norms, values
  - Cooperative relations (egoism of sections)
  - Personnel management
  - Operations, development, educational commitments, work environment
  - Strategy document: Professional management, Strategic management, HR, research management
- Are you experiencing that the section management is able to exercise/practise the management competences/the position it has been empowered with?
  - How do you perceive e.g. the abilities to exercise leadership with regards to the professional, strategically research and personnel – and the administrative matters? (Do they have the authority for it?)
- Who do you assess has the authority to decide/define what types of management tasks and actions are the correct ones to execute/ legitimate including what management behaviour has to apply?
- Do you assess the section management as well equipped to handle the management tasks?
  - Management experience, education?
- What do you assess to be the biggest advantage and disadvantage of the current management model that is given by section managements?
- Do you perceive that this management model, with four section managements, breaks with some of the values that characterize this department?

Interdisciplinary cooperation: between section managements and the department management:

- What types of management tasks are coordinated across the section managements?
- Which challenges exist in the cooperation between the section managements?
- Which challenges exist in the cooperation between the department management and the section managements?
- Is it clear which management tasks the department management are responsible for? And which the section management is responsible for?

About management in the department in general:

- What is the main purpose of this department? Why has it been founded?
- Which current management activities do you value in your department?
  - Which management values are rewarded / are there some values that are not rewarded?

- Which management challenges are the most important ones in your department?
- Does this model break significantly from the way the department has previously been organized?
    - How and what does that imply for practices?
- Regarding performance in the department; who do you see having the managerial legitimacy to evaluate the performance, i.e. who meets the given standards/requirements?
    - Regarding both professional and organizational – is it the department management or is it also the section managers? Or is it the professional managers? Consultants/wardnurses)
    - Self-management
    - Judgemental or in a development perspective.
- Who has the managerial authority to distribute resources in the department? How are they distributed?
    - Is it individuals or collective decisions that do it with regard to distributing the resources in the department?
- What type of managerial behaviour/action is rewarded in this department?

The process about implementing the management model:

- Did you have a vision or strategy for this management chance process?
- What expectations did you have for the model? (The implementation process?)
- During this management change process, do you perceive the decision making to have been given direction by this vision/strategy?
- What has been the biggest challenge when regarding the process of implementing this management model with a new management level? (four section managements?)
- From your perspective, who have you seen driving forward this change of implementing/establishing four section managements? Interests
    - How have you facilitated/planned this management change process?
- Has the implementation of section managements broken with the traditional recruitment for e.g. management positions in the department? (not the candidate with the most professional experience for the position)
- Has the section management made way for new career paths or patterns?
- With the implementation of section managements have there been introduced new ways of qualifying managerially for management tasks?
- How did you make sure you got knowledge of how far in the implementation process the four section managements was?
- Have you been considering how in the department you will ensure that the achieved changes in your management model are kept?

- Have you established any kind of reward structure regarding getting implemented a new management level?
    - With this management change process have you associated any specific reward structure or sanctioning structure? Bonus?
- What is your evaluation of how far you really are with the implementation of the management model?
- Could you imagine alternative ways of organizing the department managerially?

Section manager

Introduction:

- Presentation of me and the project

Presentation of the participants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?
    - Why was it you that entered the section management?
    - Management experience?

The management model (image of the actual archetype):

Background story:

- Why was the functional partnerships cut down from 8 to 4 sections of management?

The section management internally:

- What types of management tasks do you handle in the day to day management work in section management?
    - Responsibility for budgets, responsibility forfinance
    - Quality assurance and development
    - Education
    - Clinical management responsibility
    - Performance responsibility (production targets, service targets, etc.)
    - Project work

  - Administration
  - Vision, strategy for: research, education, competence programmes, professional development, technology: local strategies, action plans and decisions as well as intersectional collaboration, down, up)
  - Policies, guidelines
  - Norms, values
  - Cooperative relations (egoism of sections)
  - Personnel management
  - Operations, development, educational commitments, work environment
  - Strategy document: Professional management, Strategic management, HR, research management
- Which management tasks are the most important ones in the section management?
- How do you perceive you distribute the management responsibility between you internally in the section management?
- Do you perceive you are enabled (have real authority) to exercise/practise the management competences/the position you have been empowered with?
  - (How do you perceive e.g. your ability to exercise leadership with regard to the professional, strategically research and personnel – and the administrative matters? (Do they have the authority for it?)) Do you have authority to decide which types of management tasks are done locally and to define tasks?
- Do you feel well equipped to handle the management tasks you are assigned formally? In what areas do you/do you not? And why/why not?
  - Management experience, education?
- What is the biggest advantage and disadvantage of the current management model that is given by section managements?
- Do you perceive that this management model with four section managements breaks with some of the values that characterize this department?

Interdisciplinary cooperation: between section managements and the department management:

- Which challenges exist in the cooperation with the other section managements?
- Which challenges exist in the cooperation with department management?
  - Is it clear which management tasks the department management is responsible for?
  - Is it clear which management tasks the units are responsible for?

About management in the department in general:

- What is the main purpose of this department? Why has it been founded?
- Which current management activities do you value in your department?
    - Which management values are rewarded / are there some values that are not rewarded?
- Which management challenges do you perceive as the most important ones in your department?
- Does this model break significantly from the way the department has previously been organized?
    - How and what does that imply for practices?
- Regarding performance in the department; who do you see as having the managerial legitimacy to evaluate the performance, i.e. who meets the given standards/requirements?
    - (Regarding both professional and organizational – is it the department management or is it also the section managers? Or is it the professional managers? Consultants/ward nurses)
    - Self-management
    - Judgemental or in a development perspective.
- Who do you assess to have the managerial authority to distribute resources in the department? How are they distributed?
    - Is it individuals or collective decisions that do it with regard to distributing the resources in the department?
- What type of managerial behaviour/action is rewarded in this department?

The process of implementing the management model:

- What expectations did you have for the model? (The implementation process?)
- What do you assess to have been the biggest challenge when regarding the process of implementing this management model with a new management level? (four section managements?)
- Who do you assess to have been driving this change of implementing/establishing four section managements forward? Interests
- Has the implementation of section managements broken with the traditional recruitment for e.g. management positions in the department? (not the candidate with the most professional experience for the position)
- Have the section managements made way for new career paths?
- With the implementation of section managements have there been introduced new ways of qualifying managerially for management tasks?
- Who is interested in this management model getting implemented? And why?
- What was managerially important to you during this management change process?

- What is your evaluation of how far the implementation of the management model really is?
- Could you imagine alternative ways of organizing the department managerially?

Doctors and nurses

Introduction

- Presentation of me and the project

Presentation of the informants:

- Will you please introduce yourself?
    - Job title, employment/tasks?
    - How long have you been associated with the department/ward/unit?
    - Why was it you that entered the section management?
    - Management experience?

The management model (image of the actual archetype)

Background story

- Why was section management introduced? What was the intention?

The section management internally:

- What types of management tasks do the section management teams handle in the day to day management work?
    - Responsibility for budgets, responsibility for finance
    - Quality assurance and development
    - Education
    - Clinical management responsibility
    - Performance responsibility (production targets, service targets, etc.)
    - Project work
    - Administration
    - Vision, strategy for: research, education, competence programmes, professional development, technology: local

strategies, action plans and decisions as well as intersectional collaboration, down, up
    - Policies, guidelines
    - Norms, values
    - Cooperative relations (egoism of sections)
    - Personnel management
    - Operations, development, educational commitments, work environment
    - Strategy document: Professional management, Strategic management, HR, research management
- Which management tasks that the section management is handling are the most important?
- Are you experiencing that the section management is able to exercise/practise the management competences/the position it has been empowered with?
    - How do you perceive e.g. the abilities to exercise leadership with regard to the professional, strategic research and personnel – and the administrative matters? (Do they have the authority for it?)
- Who do you assess has the authority to decide what types of management tasks and actions are legitimate, including what management behaviour has to apply?
- Do you think the section management is well equipped to handle the management tasks?
    - Management experience, education?
- What do you assess to be the biggest advantage and disadvantage of the current management model that is given by section managements?
- Do you perceive that this management model with four section managements breaks with some of the values that characterize this department?

Interdisciplinary cooperation: between section managements and the department management:

- Is it clear to you which management tasks the department management is responsible for?
- Is it clear to you which management tasks the section management is responsible for?
- Is it clear to you which management tasks the unit is responsible for?

About management in the department in general:

- What is the main purpose of this department? Why has it been founded?
- Which current management activities do you value in your department?

  - Which management values are rewarded / are there some values that are not rewarded?
- Which management challenges do you assess to be the most important ones in your department?
- Does this model break significantly from the way the department has previously been organized?
  - How and what does that imply for practices?
- Regarding performance in the department; who do you see having the managerial legitimacy to evaluate the performance, i.e. who meets the given standards/requirements?
  - (Regarding both professional and organizational – is it the department management or is it also the section managers? Or is it the professional managers? Consultants/ward nurses)
  - self-management
  - Judgemental or in a development perspective.
- Who has the managerial authority to distribute resources in the department? How are they distributed?
  - Is it individuals or collective decisions that do it with regard to distributing the resources in the department?

The process of implementing the management model

- For this management change process, have the vision and strategy from the department management been evident?
- What expectations did you have for the model? (The implementation process?)
- From your perspective, who have you seen driving forward this change of implementing/establishing four section managements?
- Has the implementation of section managements broken with the traditional recruitment for e.g. management positions in the department? (not the candidate with the most professional experience for the position)
- Has the section management model made way for new career paths?
- With the implementation of section managements, have there been introduced new ways of qualifying you managerially for management tasks?
- Who do you assess to have interest in getting this management model implemented?
- How have your perceptions of the process regarding the new management level/section managements been? (clear/unclear)

SUMMARY

Health care administration in many OECD countries has undergone substantial changes in recent years as a consequence of NPM reforms, rising costs, the pace of technological innovation, heightened competition for patients and resources, quality of managed care and demographic shifts. Hospitals especially have been reformed due to the high proportion of resources they absorb and the apparent difficulty of prioritizing and coordinating health care within hospitals. There is abundant research literature on the topic of reforming hospital management models. Lacking from the literature, however, is insight into how we can understand and explain how medical professionals adapt hospital management over time in relation to changing hospital management models that are global in their influence in hospital organizations. The aim of this dissertation is to understand and explain how medical professionals adapt, interpret and negotiate hospital management over time in relation to changing hospital management models in hospital organizations in the Nordic health system context, illustrated by the Danish health system.

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