A special role for the doctor-manager? How hybrid identities can help bridge managerial and professional worlds in hospitals.

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Abstract

In hospital organizations different parties and interests come together that continuously negotiate over means and ends. Medical specialists are often designated as key players but their position is also trouble-some. The continuous clash between professional and managerial worlds hinders service delivery. Executives bear the responsibility to create integration and bridge the different worlds. In this paper we explore how executives with and without medical backgrounds deal with this task. The empirical research is based upon extensive survey research, interviews and observations. The outcomes show health care executives are hybrid professionals with mixed identities. Their hybrid identity legitimizes executive efforts to bridge both worlds and can help executives in building a binding identity. Executives, however, need also to be careful not to get too bound up with their initial occupational group, and consequently risk loosing legitimacy for their 'boundary work'.

Introduction

In the Netherlands, like in many other European countries, changes in the health care system have lead to a 'displacement of politics' from the national level to the local level of service delivery (Bovens 1995; Beck 1994; Clarke & Newman 1997; WRR 2004; Grit 2005). Supported by a policy of regulated competition hospital executives are held responsible for realising both good quality of care and efficient and effective services. The role of government concentrates on setting goals and monitoring outcomes, while negotiations over means and ends are left to field parties as insurers, doctors, managers, and patients.

Consequently, expectations of hospital executives have changed. Executives have a 'double task'. They are expected to manage both in business-like but also in patient-oriented ways: to show concern for patients, to be well acquainted with the daily goings-on in the organization, but also to keep a 'professional' distance in order to act strategically (Stoopendaal 2008). Moreover, some call for yet another 'type' of management : managers from 'outside' health care, who are supposed to run health care organizations more as 'normal' businesses (Hood 1991;Pollit 1993; Harrison & Pollit 1994; Grit & Meurs 2005). Others, however, plea for exactly the opposite (e.g. Tonkens 2003; Van den Brink et. al. 2005). They fear for negative side-effects of the growing competition in health care and would like to reinstate the leadership of traditional professionals.

In this paper we address two related questions:
How important is the medical or professional background of executives for governing health care organizations; are the expectations about coping the 'double task' of keeping distance while at the same time being involved, the same for medical as for managerial executives? And, more in general, what consequences do backgrounds and expectations have on the professional identity and behaviour of health care executives?
Before presenting empirical results, we will shortly explain how the relationship between managers and doctors in Dutch hospitals is managed,

and we will explore the role of executives as ‘hybrid professionals’ who perform ‘boundary work’.

The doctor-management relationship in Dutch hospitals

Formally, in the Netherlands, the final responsibility for hospitals is assigned to the executive board. According to the ’Integration Act’ of 2000, medical specialists are integrated and incorporated in the hospital organisation at the lower management level, but do not participate in the formal governance structure of the hospital. In reality, however, medical specialists have been organising themselves collectively at hospital level since the mid 1990s. Therefore many hospitals have a dual structure at the operational level (a medical and a non-medical manager manage together a division or unit), while at the hospital level the Staff Executive represents the interests of all medical specialists. In the many relations executives maintain with internal and external stakeholders, the medical staff is often designated as a key player (Scholten & Van der Grinten 2002). Doctors and managers are dependent on each other: ‘specialists have to obey the organizational and financial framework recommended by the board, while the board obeys the framework of specialist care recommended by the specialists’ (Integration Act, translated by Kruijthof 2005).

In 2006 the new Health Insurance Act enabled new, more ‘businesslike’, ways of organizing the relationship between hospital management and medical staff. Further integration became possible - in which case medical specialists are likely to become employed by the hospital - but also further separation - in which case medical specialists become for instance shareholders - could become reality. Nevertheless, many Dutch medical specialists still work in hospitals with a shared governance responsibility (Kruithof & Stoopendaal 2005; Scholten & Van der Grinten 2002). About 80% of Dutch medical doctors work in hospitals partially managed by doctors (Kruijthof 2005).

Theorizing the relationship between managers and professionals

The theoretical point of departure of our study is that hospitals can be considered as negotiated orders in which multiple parties and interests are united (Strauss et. al. 1985; Kruijthof 2005; Glouberman and Mintzberg 2001 a & b) describe that in hospitals this negotiated order is often badly balanced. They distinguish four different 'worlds' or 'mind-sets' related to four different sorts of activities: cure, care, control and community. Health care executives bear responsibility for all four types of activities: for the realisation of optimal medical treatment (cure), for quality of care and the wellbeing of patients (care), for efficacy and efficiency (control), as well as for public accountability (community). Glouberman and Mintzberg warn that in many hospitals too much attention is attended to the worlds of cure – the domain of medical specialists - and of control – the domain of general managers. And that the struggle between these two dominant worlds hinders performances. It requires of managers to manage 'boundary conditions': to bridge worlds and to help others work collectively (Glouberman and Mintzberg 2001 b).

Lipsky (1980) typifies organizations like hospitals as street level bureaucracies where there will always be an 'appreciative gap' between managers and professionals, based on the professional autonomy and discretionary space required for professional service delivery. According to the theory of the 'appreciative gap' it is very complex to govern organizations with an indirect form of control, from a distance (Lipsky 1980; Alvesson 2004), Nevertheless executives bear responsibility to create social integration by managing the boundaries of these 'worlds' (Alvesson 2004:124). In this 'boundary work' health care executives could be seen as 'boundary objects' or as 'boundary persons' who balance bindings with separated 'worlds' (Star & Griesemer 1989). Boundary objects are defined by Bowker and Star (1999) as "those objects that both inhabit several communities of practice and satisfy the informational requirements of each of them. Boundary objects are thus both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use and become strongly

structured in individual-site use. These objects may be abstract or concrete... Such objects have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting communities." (Bowker & Star, 1999: 297).

According to Noordegraaf (2007) 'managerial professionals' (executives with a medical background) could be the ideal boundary persons to overcome contradictory types of control and to establish meaningful connections between clients (patients), professional workers, and organizations. In his theory of 'hybrid professionalism' he describes the struggle between managerial and professional worlds as a struggle over occupational or professional identities. While the position of classic professions weakens, public managers professionalize. Persons with 'mixed' occupational identities, who have the ability to speak both languages, might help bridge the gap between the different 'worlds' of managers and professionals. Witman (2008) however shows this 'hybridization' is complex. She observed first line specialist managers in academic hospitals and found that medical managers run the risk to be seen too much as an 'outsider' by their own professional 'clan' and consequently run the risk to lose their ability to bridge the different worlds of managers and professionals.

To conclude, in hospital organizations different parties and interests come together that continuously negotiate over means and ends. Medical specialists are often designated as key players but their position is also trouble-some and the continuous clash between professional and managerial worlds hinders service delivery. A twofold solution to cope with 'the gap' is articulated. Firstly *negotiation* in order to reach a sense of shared responsibility and work collectively. Secondly, *hybridization* which enables executives to become themselves 'boundary persons'. In the next sections we will explore empirically the role hospital executives with and without medical backgrounds can play in bridging managerial and professional worlds and what strategies are undertaken.

Mixed methods

For the study we used multiple methods. Firstly, the outcomes of a large scale survey were studied to find out whether executives with and without a medical background interpret their role and function differently. The survey we used was sent to all (around 800) members of the Dutch association of Health Care Executives (NVZD), in 2000 as well as in 2005. The survey was basically a self-assessment tool. Executives were asked about their personal backgrounds, their organizations, their perceptions and actions. The survey provides therefore insight in meanings executives attribute to their role and actions. Respondents are all end-responsible health care executives. In 2000 the overall response rate was 46%, in 2005 the overall response rate was 42% (i.e. 17% of all Dutch health care executives). Earlier, cross-sectoral and longitudal, results have been published elsewhere (see among others Noordegraaf et al. 2005; Van der Scheer 2007). For this paper we selected only respondents who worked in hospitals and explored differences between hospital executives with and without a medical background. Only significant outcomes ($\alpha \leq 0.05$) are mentioned. Table 1 provides a summary of the types of data, as well as operational measures.

Table 1. Questionnaire: variables, data, indicators

Variables	**Type of data**	**Operational indicators**
Personal background	• Work experience	• Years and number of positions: management/executive positions, inside/outside the organization, inside/outside health care
	• Educational background	• Initial and additional education: university/vocational schooling, management programs/training
	• Professional activities	• Intra-occupational learning: forms of peer-review, forms of knowledge-

		sharing.
Organizational characteristics	• Size • Structure	• Budget, number of employees, number of professionals, number of locations • Organization structures, management structures, management participation of professionals
Executive perceptions	• Role • Frame-of-reference • Entrepreneurship	• Role importance and role strength • Identification, strategies for change, accountability, criteria for success • Interpretations of entrepreneurship
Executive actions	• Time spent • Planned and realized changes • Participation in public debates	• Internal/external contacts, strategic/operational • Types of changes • Preferences in participation

Secondly, interviews were held with hospital executives - with and without medical background -, members of supervisory boards, doctors -chair of the medical staff- and executive searchers. In total fourteen interviews were conducted. Ten different hospitals were involved. The outcomes of both the survey and interviews were presented at the conference of the Dutch association of medical executives of hospitals. Reactions of members of the association have also been taken into consideration (Van der Scheer & Putters 2008).

Thirdly, the findings were combined with the outcomes of an ethnographic study in which the work of three executives of different types of health care organizations is explored 'from the inside out' (Stoopendaal 2008). In this paper we will elaborate on the boundary and identity work of the observed executive of a large Dutch Hospital. The work of the executive was observed

during six working-days, and managers and employees from various organizational layers and locations were interviewed. The research focuses on the relationship between health care executives and professionals. This relationship was studied from the perspective of the executive himself, middle managers and professional workers, for instance doctors and nurses.

Results

Constructed identities

The survey outcomes show executives with medical backgrounds are very experienced managers (they have more than 14 years experience in management), but they are less experienced in management than executives with other backgrounds. Likewise, it appears executives without a medical background are very experienced in health care. They had multiple positions in health care, but significantly less than executives with medical backgrounds. Medical executives, on the contrary, rarely have experience in managing other types of organizations ‘outside’ health care. Besides their initial medical training medical executives followed the same sorts of additional, mostly managerial and financial, courses as executives without a medical background.

With respect to role perceptions of the respondents, it appears that hospital executives operate on the border of internal and external affairs. Medical executives however, show more attention for internal affairs than other executives do. They give more attention to and seem to feel more responsible for matters of care and quality of care than for finances. Medical executives have less attention for entrepreneurial activities and interpret them different than other executives do. More in terms of stimulating professionals to innovate than, for instance, in terms of entering new markets and commercial activities.

Besides, medical directors are less inclined to take part in the public debate about health care.

To conclude, both executives with and without medical backgrounds seem to have *hybridized*. Both are educated largely alike and are almost equally experienced in management and in health care. Yet executives with medical backgrounds preserve a strong professional disposition. They are hybridized but still interpret their function very 'professionally'. They present themselves as the 'quality conscience' of the organization.

Making sense of 'roles'

Analyzing the interviews we saw a natural distribution of roles, functions and tasks between executives with and without a medical background. Medical executives are e.g. mostly the first to address with respect to patient and professional affairs. It became also clear a medical background alone, does not suffice to become an executive. Experience as a chair of the medical staff is also not enough. A medical specialist who aspires an executive function needs to invest in management training and a management career before being able to make the step towards an end-responsible position. Respondents however appear to have different opinions about the (importance of the) role of the medical executive in the hospital board. We clustered them as follows:

- Cultural/situational opinions: in which local traditions (pointing out to 'how we are used to do things here') or specific circumstances ('the specific circumstances at that specific moment') play an important role.
- Relational opinions: in which the difficult relationship between managers and doctors is emphasized as explanatory for the role of the medical director.
- Knowledge-based opinions: based on opinions about the required knowledge and experiences for executive positions.
- Principle-based opinions: some respondents simply found it unthinkable when the most important professional group would not be represented in the executive board.

It also became clear that different groups of respondents interpret the role of the medical director differently and *expect* different things from him/her.

According to members of the medical staff the medical director is primarily a *representative*, who understands and represents the doctors' interests.
For the members of the supportive board the medical executive is mostly a *risk manager*, who can prevent problems between executive board and medical staff . Executive searchers believe medical executives are in a good position to *build bridges* between the managerial and the medical 'world', though much depends on their communication skills.
The non- medical executives, see their medical colleagues primarily as *connectors*, who are capable to realize more support from medical staff for hospital policy.
The medical executives themselves at last make also sense of their own role, identity and function. They think that they are *not very different* from other directors, though they do believe they are able to understand doctors better. In fact they seem especially careful not to be held 'hostage' in the roles of representative of professional interests.

Into the wild

The hospital director we observed in the ethnographic study had no medical background and neither had his colleague – the hospital has a two headed apex. The medical specialists appreciated this fact. They did not feel threatened in their professional autonomy. Though not represented in the board, the medical specialists of the hospital have a strong voice based on the dual structure at the lower organizational levels. All doctor-managers still work as doctors.
As an 'involved outsider' the executive encourages professionals to improve the quality of their work by starting lots of quality projects. In these quality-committees all kinds of professionals from different wards meet in a functional way. The outcomes of the quality projects are used by the executive for public relations. The project meetings and positive pr contributed to a shared pride and identity of being a "best practice hospital".

The hospital we studied is divided in different compartments which are sometimes described as (unreachable) isles and kingdoms. The most important task of the executive seemed to be 'to keep all different kind of

medical specialists in line’. The executive talked a lot with them about their vision and wishes. But besides medical specialists, there are more (also highly educated) professionals, like nurses, paramedical personnel, laboratory workers, technicians working in this hospital. The executive tried to visit their wards and departments regularly to drink coffee and to talk with them. . As the executive tries to get closer tot the medical work, he is kept at a distance. He has to be involved, but at the same time has to stay an outsider. The executive uses the patient perspective ‘patients first’ to emphasize the shared values en to create collectiveness. His personal attention motivates employees to improve their work. In their opinion the executive talks and ‘walks’ the values that are made up for the entire organization.

Combined with the outcomes of the other two case-studies, this ethnographic study, showed four different methods of ‘boundary work’:

- Managing by means of *extensions* is aimed at dispatching people and information (into the organisation) in order to bring the different worlds that are separated in contact with each other and to exert influence ‘at a distance’.
- Managing by means of *connections* mainly focuses on overcoming mental differences. Different mental frameworks are brought together by translators. That, provided that they are familiar with both ‘worlds’, can form a new entity both parties can agree with and commit to.
- Managing by means of *creating meeting places* is based on the importance of share experiences. When individuals get to know each other they will be more open to each other’s ‘worlds’. Formal meetings create possibilities to share experiences. Informal meetings have a certain casualness or autonomy.
- Managing by means of *boundaries* creates mental and social frameworks that are sometimes also given a physical (locations, separate management building) or temporal (then and now) form. Boundaries protect and create working space, but also exclude and screen off. They must be respected, but must also remain permeable in order to make collaboration possible.

These methods, derived from the ‘grounded’ description of the work of three different health care executives, provide points of departure for executives to deal with the fragmentation of health care organizations in a manner that is balanced and tailored to the situation and to their own personal backgrounds.

Discussion

In this paper we studied the specific role medical and managerial executives can play in governing health care organizations. Because of their hybrid or mixed identity much is expected from medical executives as boundary persons in bridging the different worlds of cure (medical professionals) and control (management). Our empirical study confirm these expectations. Respondents all in their own way make sense of the role, identity and function of the executive (see also Parry 2003). Often their interpretation is related to their own interests. The hybrid position of medical executives, however, not only has advantages but also disadvantages. Medical executives need to stay trustworthy to all parties involved. Mixed backgrounds can provide opportunities but can also paralyze. To be effective as an executive, medical executives need to manage expectations carefully and cherish their independence.

Though a role as ‘boundary person’ between managerial and professional affairs especially seems to suit executives with medical backgrounds, this role is not prohibited to them. Observations of a non-medical executive resulted in four different methods of bridging different organizational worlds. This particular executive had a lot of experience in health care organizations. He too has a hybrid identity. The survey outcomes show he is not unique in this respect. Many non-medical executives are managers specialized in health care. Apparently, being a well-informed and involved outsider has its advantages too. Our case-study showed an executive with an important role in forming a shared identity. Though he did not have a medical background he did function as a boundary person. Thanks to both familiarity and unfamiliarity

the health care executive was able to join and open up different worlds towards each other.

We found health care executives are hybrid professionals with mixed identities. They are managers who have acquainted themselves with the professional's world and language, or professionals who have specialized in management. Yet, differences remain. The survey outcomes showed medical executives focus significantly more on internal and professional affairs, and feel especially responsible for quality of care. Though they say to have taken distance of the professional role, their medical disposition still appears to be strong in daily practices. Executives with other backgrounds are more oriented on external affairs and matters of control. They feel responsible for quality of care, but also for financial results and public ends. In daily practices their distance to work floors remains large. Though hybridized, professional managers still partly identify (and are being identified) with the professional world, and professionalized managers still identify more easily with the managerial world.

Managers with hybrid identities can help bridge the appreciative gap between managerial and professional worlds in hospitals. From their detached position 'outsiders' can play an important role in keeping the negotiated order 'fluid' by asking 'wicked' questions. But involvement, to understand and speak the languages of multiple worlds, is needed too. Professionalized managers might profit from their position as 'informed and involved outsider' and managerial professionals might profit from their position as a 'detached insider'. However, both types of *hybridized* executives need to watch out not to get too bound up with the managerial or professional world, so that they are free to play the very situated game of distancing and approaching.

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