Marco Sartirana

ISBN 978-94-028-1218-3
Printed by Ipskamp drukkers

"HYBRID MANAGERS"

AN INSTITUTIONAL PERSPECTIVE ON THE RISE AND REALIZATION OF MEDICAL MANAGEMENT

"Hybride managers"

Een institutioneel perspectief op de opkomst en vormgeving van medisch management

(met een samenvatting in het Nederlands)

Proefschrift

ter verkrijging van de graad van doctor aan de Universiteit Utrecht op gezag van de rector magnificus, prof. dr. H.R.B.M. Kummeling, ingevolge het besluit van het college voor promoties in het openbaar te verdedigen op vrijdag 23 november 2018 des ochtends te 10.30 uur

door

Marco Sartirana

geboren op 6 september 1985

te Milaan, Italië

Promotoren: Prof. dr. M. Noordegraaf
Prof. dr. J.P.P.E.F. Boselie

Part of this thesis was accomplished with the financial support of the Directorate General for Education (Dote Ricerca Applicata, RESEMM project, ID: 14929), Lombardy Region, Italy and the EU COST Action IS0903 "Enhancing the role of medicine in the management of European health systems - implications for control, innovation and user voice".

TABLE OF CONTENTS

SUMMARY

Background and research question

Management reforms in public professional fields like education, justice, social services or healthcare have increasingly required professionals to take efficiency into account alongside effectiveness, and to openly report performances and be accountable to the public rather than (only) to the profession (Ferlie et al., 1996). In healthcare medical-managerial "hybrids" arose, i.e. medical professionals engaged in managing professional work, colleagues, and other organizational resources. These individuals have been seen as a way to reduce the friction between traditional professional values and new organizational paradigms (Fitzgerald and Dufour, 1998; Montgomery, 2001; Numerato et al., 2011). Accordingly, they have diffused among health systems globally, from the US to the UK, Canada, New Zealand and Australia, to other countries in Northern, Central and Southern Europe.

Yet, research has shown that professionals taking up managerial roles responded to these conflicting demands in different ways. While some of them fully enacted their hybrid roles as they succeeded in finding meaningful combinations of professional and managerial values (Noordegraaf, 2007), others externally conformed to managerial practices but without doing so substantially (Kitchener, 2002). Rather than co-opted into managerial practice they have been described as co-opting management to pursue self-interest (Waring and Currie, 2009). Therefore, it is necessary to study the conditions of developing hybrid roles at both the collective and individual level, and to understand how they can be supported.

In order to explain variability in the development of hybrid medical managerial models at the collective level, a few studies addressed the mediating role of context. For instance Kirkpatrick et al. (2012) identify three dimensions that explain variability across countries, which include the governance of the hospital sector, the nature of organizational settlements with key professions and the nature and process of public management reforms. Yet this theoretical framework calls for empirical research capable to develop it and to explore national differences in the way hybrid roles are institutionalized and enacted by professionals.

But also the antecedents of individual doctors' hybridization require further research, as we need to look beyond hybrids' response strategies and study the organizational conditions as well as "the agency and social interaction processes that shape these responses" (Denis et al 2015: 285). In particular, we know relatively little with reference to the role of the social/organizational context on these individual dynamics, as most

studies in the medical field tend to focus only on interactions taking place within the professional community.

This work contributes to fill these gaps and studies the rise and realization of medical managers in order to provide evidence for scholars and health policymakers and executives. The research question of this study has been: "*how do medical managers hybridize over time, and if and how this evolution is influenced by the social/organizational context in which professionals work*?"

With the aim to contribute to the field of hybrid professionalism I draw mainly from the theoretical perspective of institutional theory, in particular institutional change and identity work, which offer a useful perspective to study complex professional organizations (e.g. Greenwood et al. 2011, Lockett et al. 2012), bridging it with the contributions of the sociology of professions.

Research design and case selection

After reviewing the existing literature the empirical analysis was performed. I adopted an interpretive and inductive approach opting for a qualitative case study research design. Data were collected from different sources, including semi-structured interviews with medical and non-medical managers, participant observation at board meetings and archival data. This allowed me to grasp the rich and real-world contexts in which hybrid managers arise, answering the "why" and "how" of this complex phenomenon.

The work studies hybrid roles outside the Anglo-Saxon world, since I analyze medical management in countries which have "imported" New Public Management reform templates from abroad. I studied hospitals in Italy and The Netherlands (opting for a teaching hospital) as these countries have similarities that make possible comparisons meaningful. Both countries began to focus on medical manager roles in the mid 90s, and overall the degree of development of medical management is comparable (Neogy and Kirkpatrick, 2009).

I studied two organizations. The first one is a large public hospital in Northern Italy, which was chosen as it underwent a progressive development and empowerment of hybrid roles and as it experienced – during the study period - a physical relocation and organizational reconfigurations. The second organization is a large public university hospital in the Netherlands, organized in managerially autonomous clinical divisions introduced in the early '90s.

Main findings

First of all, in this work I identified those antecedents explaining the rise of a collective of healthcare hybrid managers, finding that medical management is largely path dependent, that is: history matters. Kirkpatrick et al. (2012) identified three dimensions that impact on the development of medical-manager roles. I see the value of this framework but I show the relevance of a fourth dimension, i.e. the level of institutionalization of the pre-existing forms of medical management. If medical

managers are already institutionalized then new hybrid managers in formal roles strive to achieve legitimacy and power. This is a relevant finding as it contrasts the "standardization" of medical management policies internationally, which strive to implement reforms with similar hospital organizational structures and managerial roles across (sometimes very) different countries.

Also, I show that an organizational context providing opportunity for engagement in management is necessary for hybrid identity change to occur. Existing literature has seen professionals as passively influenced, in an overly deterministic way, by the dominant professional mindset (Griffiths and Huges, 2000), with individual professionals in hybrid roles called to exert agency acting as "heroic" individuals in a lonely strive to reconcile alternative logics (Creed et al., 2010). However, I show that a constructive interplay between individual action and the institutional structure can take place, as structure can enhance and not only prevent professionals' hybridization by providing sources of agency which enable change. Support in terms of involvement in decision-making, delegation of organizational power, endowment with management leverages and effective backing, has a key role for explaining the realization of hybridization.

Then I highlight the significance of relational and social dimensions in hybridization. Becoming a hybrid is not an individualistic process, but a distributed one to which many others participate. While existing research on professional identity had looked at the role of interdependencies of hybrids within the professional group (Llewellyn 2001; Pratt et al., 2006; Witman et al. 2011), I show that relevant actors - in particular support staff, non medical managers and executives - facilitate the interiorization of the new hybrid identity and the legitimization of the new role. And contexts enabling some types of social interactions have the potential for engaging in management also those professionals that initially appeared more reluctant towards hybrid roles.

Finally, this work also contributes to the recent literature on professionalism (Noordegraaf, 2105; Martin et al., 2015) suggesting that we need to overcome the notion of hybrid in our understanding of the evolution of medical management. In order to today's professional work it is necessary to explore the new forms in which management and professionalism are accommodating, which privilege connectivity within the organization, engagement with stakeholder as well as adherence to standards of practice.

Relevance

This analysis bridges health services research and health policy with organizational studies, responding to the calls (Currie et al., 2012; Kirkpatrick et al., 2016) to develop research with a stronger engagement between these complementary approaches. The findings of this work are relevant not only in theory but also for the practice of health policy and management which is facing a number of great challenges. Healthcare executives and policymakers struggling with the engagement of professionals in management need to understand the reconfigurations of medical management and if and how hybrid managers can be supported. This will increase the capacity to reconcile apparently contrasting values and priorities, i.e. balancing quality with efficiency,

accountability with informal professional relationships, or multidisciplinary and patient centeredness with clinical specialization. Similar dilemmas can be found in a number of public professionals fields in Western countries, and hybrid managers can be (one of) the solutions.

CHAPTER I: INTRODUCTION

The rise of hybrid managers

Multiple solutions were found to bring managerial practices and values in traditional public professional settings of (most) Western countries. New forms of coordination of the work of professionals like judges, doctors, teachers or social workers were introduced. Training programs were redefined in order to foster the development of managerial competences, and formal managerial roles were assigned to professionals within organizations (Noordegraaf, 2015). In this work I focus on the latter, i.e. public sector professionals which are involved in intermediate layers of hierarchy within an organization, responsible for staff or resources. These individuals are often referred to as "hybrid managers", or simply "hybrids", i.e. individuals capable to negotiate and merge professional and managerial cultures, values, and identities, accepting managerial responsibilities and a part-time or even full-time movement into a managerial position (Montgomery, 2001; Noordegraaf, 2007; Numerato et al., 2011).

Hybrid managers can be found in universities, where professors as deans or program directors have increasingly been called to appraise teaching or research performances, develop human resource management competencies, deal with strategic plans and periodical financial reporting (Deem et al., 2007; Telkeen, 2015). Seemingly, in the education sector the work of teachers and especially school directors has significantly experienced a process of managerialization and hybridization over the last three decades with the introduction of efficiency logics and performance models (Noordegraaf and De Wit, 2012). Numerous forms of hybrids can be found also in healthcare, both with reference to the nursing profession, especially among nurses (Croft et al., 2015) and in the medical professions, as doctors have increasingly been assigned different forms of managerial responsibilities within and across healthcare organizations (McGivern et al., 2015).

In all of these fields hybrid managers brought new managerial principles into the daily work of public professional organizations. I focus on healthcare, where public sector reforms promoting efficiency, accountability to the public or the overcoming of traditional disciplinary hierarchies reshaped the values and practices of medical doctors, especially those working in large organizational settings like hospitals.

Changing public professional services

The rise of hybrid managers was part of the process which brought managerial values and practices into public professional settings, which have challenged the classical forms of organising professional work. Traditionally, public sector professionals, even when working in organized environments like universities, law courts or hospitals, were granted high degrees of autonomy, necessary to apply specialized and tacit knowledges to highly complex cases at the service of citizens. Their work was subject to professionals values and social norms of behaviour, and supervised by the professional community, therefore it did not require external forms of appraisal and control (e.g. Abbott, 1988; Freidson, 1994). And they worked in professional organizations which could be described as "arenas", most often fragmented in autonomous groups formed around specialized knowledges and skills (Mintzberg, 1983).

However, political, economic and social forces have put pressures over public professionals questioning whether what they do and how they do it is still capable to respond to societal and individual needs. Starting in the 1980s, New Public Management reforms in public professional fields like education, justice, social services or healthcare have increasingly required professionals to take into account efficiency alongside effectiveness, and to openly report performances and be accountable to the public rather than (only) to the profession (Ferlie et al., 1996). Also, professionals have been asked to work together with other public and private stakeholders, and to reorganize service provision on the basis of citizens/clients demands rather than on fragmented professional bodies of knowledge. For instance, in order to solve complex cases in justice, social care or healthcare, it is no longer possible to adopt a traditional specialized approach, but inter-professional collaboration and the acquisition of cross-boundary knowledge is necessary. This challenges the ways in which professional knowledge is created and transferred, but also the very nature of professional autonomy and self-regulation (Kirkpatrick and Noordegraaf, 2016). At the same time, the evolving nature of professional services was not only the result of government-led reforms, but consequences of broader societal changes. Alongside exogenous forces, many professionals were proactive agents of change, understanding the need to adapt professionalism to the shifting nature of citizens' needs in order to continue to provide their service to society and to maintain the legitimacy of professional action (Noordegraaf, 2013).

The opportunity and challenges of medical hybrids

In this work I study the opportunities and challenges related with the introduction of healthcare hybrids in organized professionals contexts like hospitals. As effectively illustrated by Braithwaite et al. (2005), medical managerial hybrids have the potential to promote clinical governance, develop multi-disciplinary and inter-professional collaboration and reorganize services to achieve cost savings without compromising the

quality of care. They can do it more effectively than general managers, who lack the understanding of clinical problems and the status and legitimacy among the professional community. Furthermore, they have the ethical drive to serve patients and their needs, and can understand the relevance of patient centeredness and new expectations from patients and their families. For these reasons medical management has become a very fashionable topic for health policymakers across a number of countries and the development of medical management competences is now one of the goals of healthcare reforms across the globe (Kirkpatrick et al., 2013). Following the US example, first in the United Kingdom and then in a number of Western countries, medical managerial roles were introduced the top of organizations and in intermediate layers (Neogy and Kirkpatrick, 2009). Accordingly, a great effort has been placed on developing management training programs for doctors and (more recently) for medical students, due to the initiatives of Departments of Health, medical societies and medical faculties.

However, despite the political enthusiasm that brought the introduction of medical managerial roles into most healthcare systems, staying in a hybrid position can be uneasy, and not all professionals are capable or willing to perform in these roles. Being in a medical managerial role does not automatically mean becoming a professional capable to bridge the gaps between the world of medicine and management and to incorporate new values into the traditional medical culture; accordingly, the responses of professionals to management and the practice of medical management greatly varies (Numerato et al., 2011). Many times professionals resisted management as looked at "managerialization" as a threat and an impoverishment of medical culture, therefore being unable to find meaningful combinations of management and professionalism (Griffiths and Hughes, 2000). Other times professionals adopted subtle strategies of resistance, as they retained those external facets typical of formal management roles, but did not conform to managerial practices substantially (Kitchener, 2002). Often doctors accepted formal management responsibilities just to gain a new source of power to pursue self-interest (Waring and Currie, 2009), without really engaging in management and making it more difficult for executives to coordinate their behaviours. In a number of instances, however, medical professionals succeeded in negotiating and merging professionalism and management, making these apparently competing values compatible, and developing hybrid identities (Llewellyn, 2001; McGivern et al., 2015).

In light of this variability, it is highly relevant to understand in depth the process of doctors' managerial roletaking and the factors that support or hamper it at different levels, including the level of the individual professional, the organizational environment and the health system at large. This is necessary to provide guidance to professionals and their associations, healthcare managers and health policymakers, in how to solve the challenging yet fundamental puzzle of medical management. That is, how to develop hybrid roles capable to bridge management and medicine, in ways that are both meaningful for individual professionals and functional for the organization of service delivery.

Although my analysis focuses on the medical profession in the hospital sector, many of these issues are common also to other environments and professions within healthcare. For instance, hybrid managers can be found in healthcare contexts other than hospital, for instance as heads of interorganizational clinical networks or of Public Health units, which McGivern et al. (2015) found more willing to redefine their identity than clinical directors. Recent research on hybrid managers within the nursing profession underlines the challenges of hybridity, showing how nurse hybrids tend to suffer a double bind, in which they lack professional and organizational legitimacy, and to perpetuate identity conflicts which undermine their effectiveness as hybrids (Croft et al., 2015). But, as anticipated, hybrid managers can also be found in other professional organizations within the public sector which have been object of managerialization reforms, in particular in higher education, police, social work or justice. Understanding the trajectories of identity change and the factors that hinder or favour hybrid managers may provide useful reflections for understanding and managing the dynamics taking place in other public professional organizations.

The academic debate on hybrid managers

The evolution of professionalism in organizational settings is a dynamic field of academic research, especially – but not limited to - within the public administration domain (e.g. Brock et al., 2014; Denis et al., 2015; McGivern et al., 2015; Croft et al., 2015; Blomgren and Waks, 2015, Olakivi and Niska, 2017; Reay et al., 2017), and has generated a number of papers in leading journals, special issues (e.g. *Journal of Management Studies*, 2013, or *Public Administration*, 2015) and the set up of a new *Journal of Professions and Organization*. As illustrated by Brock and Sachs (2016) this research field originated from the intersection of the literature on sociology of professions, initially developed in the United States by authors like Freidson or Abbott, and the organization studies literature focusing on the managerial aspects of professional work, thanks to the work of scholars from the United States, Canada and Western Europe with a specific interest in professional service firms and public professional organizations. Organization studies literature has addressed the issue using different levels of analysis, including the behaviors of individual professionals and their groups, professional organizational structures and processes, broader institutional fields in which organizations and professional associations are located. As anticipated, in the public sector this literature is particularly flourishing, especially as reforms inspired by New Public Management attempted to make the public sector more "disciplined" and business like. These reforms have been continuously modifying and are - still today - challenging traditional professional boundaries, work practices, hierarchies and coordination mechanisms, values and identities of professional groups and individuals (Noordegraaf, 2015).

Originally these changes appeared to professionals – and were understood by most scholars, especially from the field of sociology - like a threat for professional work, autonomy and values. This process was described as a "re-stratification" (Freidson,

1985), in which professional elites are coopted into managerial/bureaucratic roles to manage change among the "rank and file" colleagues, or a "bureaucratization", as professional work is standardized and rationalized through procedures, guidelines and rules of conduct (Ritzer and Walczak, 1988). Accordingly, professionals set up strategies to either protect themselves from managerial "intrusions", or to draw management into professional practice to pursue self-interest reinforce their power position (Waring and Currie, 2009).

The academic debate, in line with practical evidence reported above, has progressively moved beyond this dichotomic view by stressing new intertwined combinations of management and professionalism where neat boundaries are blurred and more overlapping and hybrid arrangements emerge. Hybrid roles were found capable to balance balancing intrapersonal and interpersonal conflicts and to reconcile the two apparently conflicting worlds (Noordegraaf, 2007; Numerato et al., 2011). They have the potential to bridge the gap between colleagues and administrators, maintaining the professional status and legitimacy but being "loyal" and committed towards the organization and its top management (Hoff, 2001; De Wit, 2013). They have can reinterpret professionalism, favouring a smoother transition from old to new values, and facilitating the introduction of managerial practices like financial management, reporting, human resource management, process reengineering, etc. The popularity of this view was favoured by the pervasiveness of managerial and organizational reforms in professional service sectors in the past 20 years, not only in the public sector, as described above, but also in accounting or law (Brock et al., 1999). However, although these trends can be observed in a number of diversified professional contexts, a relevant proportion of this research strand was developed in the healthcare sector, most often with reference to the medical profession. And recently Noordegraaf (2015) has shown, with specific reference to the public sector, how this process has evolved in recent years, with a progressive move beyond hybridity, to a stage in which the practice of organizing becomes an intrinsic element of professional action, and is incorporated into professional education and socialization processes.

Different theoretical angles have been adopted to increase our understanding of hybrid managers, including the sociology of professions, institutional theory, identity theory and leadership, to name a few. Although this literature is rich, it still tends to tell us about the responses of professionals to management and most often the problems associated with the implementation of hybrid roles, e.g. in terms of open or tacit resistance, circumvention, co-optation of management to pursue professional interests (Waring and Currie, 2009; Numerato et al., 2011). Yet, it offers limited understanding of the conditions for the development of hybrids and the role of the social/organizational context in this process.

The missing role of context

First of all, the risk of a-contextual approaches to hybrid professionalism is largely present in the practice of public sector organizations. International guidelines mandating or suggesting standardized organizational structures and roles, inspired by NPM reforms, acquired momentum internationally. It is the case of medical management structure and roles, as in the case of clinical directorates (Kirkpatrick et al., 2013). It has been argued that in a number of cases such common managerial solutions have been applied on the basis of isomorphic pressures but with a limited understanding of the different national, social and organizational contexts (O'Really and Reed, 2011).

However, this is a risk also for theory. As argued by Denis et al. (2015) it is necessary to overcome the focus on hybrid professionals' response strategies that has prevailed in public administration and organization studies literature recent years and, following Noordegraaf (2007), to explore the *relational* dimension of professionalism, and its links with the outside world, organizational rationales and other professions. This requires avoiding approaches that overlook the situatedness of hybridization processes and do not study the broader social organizational order and the contextual antecedents at the organizational level which might explain them.

A few studies addressed the mediating role of context in order to explain variability in the development of hybrid medical managerial models at the collective level. For instance Kirkpatrick et al. (2012) identify three dimensions that explain variability across countries: the governance of the hospital sector and the degree of market-like pressures on hospitals; the nature of organizational settlements with key professions and their ability and power to resist change; the nature and process of public management reforms, including the timing, objective and capacity of implementation. Yet this theoretical framework calls for empirical research capable to develop it and to explore national differences in the way hybrid roles are institutionalized and enacted by professionals.

At the individual level, existing studies have shown how the development of professional identities and roles is inherently relational, yet most research in the medical field tend to look at contexts in which interactions take place within the professional community. For instance Pratt et al. (2006) who have analyzed the importance of socialization and role modelling when young doctors' identities are developed, while other authors have studied the construction of the new role of hybrids among colleagues and their legitimization as "primus inter pares" (Llewellyn, 2001; Witman et al., 2011). On the other hand, the recent work by Reay et al. (2017: 1051) acknowledging the gap in current literature in which "the importance of interactions between professionals and others has been relegated to the background", showed the potential for change to be orchestrated by *others*, i.e. business managers, who supported doctors in incorporating managerial values. This work is extremely interesting but it studied general practitioners, frontline professionals working in individual or small practices, while I

mean to study hybrid medical managers working in complex organized settings like hospitals.

Research question

My qualitative study wishes to contribute to a research looking beyond hybrids' response (often, resistance) to management and attain an institutional understanding of hybridization, capable to take into consideration the context and the surroundings of this process. Accordingly, the overall research question driving this book is: *How the rise of hybrid medical managers and the hybridization processes are affected by social and organizational conditions?*

In particular, the analysis is guided by three specific subquestions, organized according to a line which goes from the collective to the individual level. The first subquestion, building on Kirkpatrick et al. (2012), intends to explore hybrids at the collective level and the environmental factors that explain why hybrid roles are institutionalized in different ways. Therefore, it is formulated as: *Which historical, cultural and organizational antecedents explain the rise of a collective of (healthcare) hybrid managers?*

The second subquestion focuses on individual hybrids and addresses the impact of contextual antecedents at the organizational level on hybridization processes. Hybrids have often been intended as lonely individuals rowing against the tide. I study whether organizational environments can enhance and not only prevent hybridization: *How does the organizational context influence the development of individual hybrid managers?*

The third and final subquestion develops the analysis of individual hybrids by concentrating on the relational dimension of hybridization. A anticipated most of existing literature has looked at how conventional interactions within professional environments hamper hybridization. However, I focus on relations beyond the professional group by studying: *How medical managers' hybrid identities are shaped and enabled by social interactions?*

An institutional perspective on hybrids and hybridization

This work combines the different theoretical and empirical contributions of sociology of professions, organization studies, human resource management and health services research. In particular, in order to achieve a context sensitive understanding of hybrids and hybridization, I will mainly draw from institutional theory, which offers a useful perspective to study the interactive processes that take place in complex professional organizations (e.g. Greenwood et al., 2011; Lockett et al., 2012).

Institutional theory examines how beliefs and values structure social interactions and organizations, favoring conformity and resiliency to change (DiMaggio and Powell, 1983; Meyer & Rowan, 1977). Institutions are social structures that give stability and

meaning to social life (Scott, 2001) as they are provided with legitimacy, i.e "a generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions" (Suchman, 1995). And professionals have been described by Scott (2008: 223) as powerful "institutional agents – as definers, interpreters, and appliers of institutional elements"; they "are not the only, but are – I believe – the most influential, contemporary crafters of institutions". In particular, in the health sector values, identities, practices and settlements between professional groups are highly institutionalized (Barley, 1986; Kitchener, 2000). However, although institutions are stable, they can be object of change as a consequence of functional, political or social pressures (Oliver, 1992), and the potential for transforming institutions increases in circumstances of institutional complexity, in which diverging prescriptions for behavior coexist (Greenwood et al., 2011).

In this scenario, "hybrid" medical managers, who are assigned managerial/ organizational responsibilities, are important actors in institutional processes as they bridge the institutional worlds and logics of professions and organizations (Ackroyd, 1996; Muzio and Kirkpatrick, 2011). In some cases hybrid professionals can favour institutional creation and change as, being exposed to contradictions, they are in a social position which favours the continuous reshaping of existing roles and practices and the creation of new ones (McGivern et al, 2015). In other cases resistance behaviors can be found, with professionals carrying out maintenance work to preserve their professional dominance when threatened by external changes (Currie et al., 2012). Therefore, in order to increase our knowledge on the enabling conditions for professional agency we need to take into consideration the social context in which professionals' institutional processes take place (Daudigeos, 2013).

In this work I explore this topic from two different angles. On one side, in order to answer to the first research subquestion, I study hybrids at the collective level, exploring how the relationship with their institutional environment supports or hinders the rise of medical managers. I draw from the notion of institutionalization to study how organizational roles and practices become an institution through the acquisition of legitimacy (Suchman, 1995). If a social order is highly institutionalized stability prevails, the existing norms will not be questioned and change will be hampered. This scenario is implied by the literature on path dependency in health systems, according to which actors become "tied to previous decisions and existing institutions" (Wilsford, 1994: 252).

On the other side, I study hybrids at the individual level and their relationship with the social and organizational environment in order to understand how it impacts on the hybridization process. This will allow to answer the second and third research subquestions. Among the various forms of institutional work, i.e. the activity of creating, maintain and disrupting institutions (Lawrence et al., 2013), I focus on identity work, defined as the "process by which people strive to shape relatively coherent and distinctive notions of their selves" (Brown and Toyoki, 2013: 876). The concept is useful in understanding hybridization as it emphasises the dynamics of identity construction

and its intrinsically processual nature. Through identity work professionals may become capable to solve the apparent contradictions of professionalism and management and embed organizing within professional action (Noordegraaf, 2015). Furthermore, it has been acknowledged that identity construction is "more interactive and more problematic than the relatively straightforward adoption of a role or category" (Pratt et al., 2006: 237), and that identities are inherently relational and embedded in interactions (Stryker, 2007).

My analysis therefore aims at contributing to the debate on hybrid professionalism drawing from the theoretical perspective of institutional theory, in particular institutional change and identity work, bridging it with the contributions of the sociology of professions. However, while studying how the organizational context supports (or hampers) the development of individual hybrid managers, I also draw from the "ability-motivation-opportunity" (AMO) framework (Blumberg and Pringle, 1982; Lepak et al., 2006; Boxall and Purcell, 2011; Jiang et al., 2012) rooted in the human resource management tradition. This behavioural perspective of HRM has been used to study what drives individual role behaviors and the practices that organizations can put in place to support them, and underlines the importance of the interaction between the opportunity provided by the context and the capacity and willingness of the individual. This framework appears promising for the fields of public administration and organization studies (Currie at al., 2015), and it is coherent with a view of organizational actors as embedded in a social order which acts as a hindrance or a facilitator of individual behaviour. For this reason in Chapter 3 I follow Currie et al. (2015) in applying this concept to hybrid managers in professional organizations, and I draw conclusions on the benefits of this complementary approach to understand how the organizational context influence can the development of individual hybrids.

Finally, I wish to clarify that understanding the factors enabling professionals and their hybridization is highly relevant not only for theory on professionalism, but also for practice, as it allows to understand if and how the process of managerial role-taking might be supported. This is the reason why one of the aims of this work is also to favour the contacts between public administration and organization studies literature with the world of and health services/policy research, a scientific field that examines how health care services and practitioners are affected by social factors, including organizational structures and processes and roles, with a specific attention for the managerial and policy implications of research findings. The coupling and interaction between these different fields aim at providing synergy and insight beyond that produced by disparate perspectives, and wish to favour the dialogue between disciplines, approaches and audiences; the outlets in which the book chapters have been (or will be) published reflect this variety.

Case selection

This book studies hybrid managers among medical doctors, the more traditional healthcare profession. It also focuses on healthcare professional organizations in the

acute sector, i.e. hospitals, as they are the environment in which professional power was historically more concentrated (Kirkpatrick et al., 2009) and in which, following the New Public Management wave of reforms, medical managerial roles and management tools were first introduced challenging traditional organizational structures and professional work practices.

I look at medical professionals working in hospitals in clinical director roles, i.e. doctors with a part time involvement in management, in charge of a group of clinical specialties, reporting to the hospital top management. Clinical directorates were first introduced at John Hopkins Hospital in Baltimore in the 1970s, with the aim to move away from the practice of governing hospitals through parallel hierarchies, with doctors represented by senior medical committees, often with the power to veto management decisions. Specialties were now grouped in directorates, i.e. intermediate tiers managed by a medical manager, often supported by nurse manager and an administrator, which were given the responsibility for budgets and performance, as well as for human resource management (Kirkpatrick et al., 2013). Clinical directorates and clinical director roles spread rapidly in North America and in the United Kingdom - where the model was championed by Professor (later Sir) Cyril Chantler of Guy's and St Thomas' Hospitals - and then in Australia, New Zealand and Western Europe, including: The Netherlands, Norway, Denmark, Italy and France (e.g. Chantler, 1993; Doolin, 2002; Neogy and Kirkpatrick, 2009). Being in a hybrid role, clinical directors are in the position to effectively bridge management and professionalism through the development of hybrid practices like multi-disciplinarity, clinical governance, performance management, policies and procedures to foster safety and quality, etc. (Braithwaite et al., 2005).

I studied two organizations. The first one is a large public hospital in Northern Italy. The hospital was chosen as it underwent a progressive development and empowerment of CD roles and as it experienced – during the study period - a physical relocation and organizational reconfigurations. I accessed the site after establishing a research partnership between the hospital and Bocconi University, as a part of a research scholarship sponsored by Lombardy Region. The first interviewees were the members of the top management team, as one of them was the partnership contact point. The research involved then data gathering from semi-structured interviews with medical and non-medical managers (in particular, all the clinical directors of the hospital), participant observation at board meetings, participation in two executive meetings and archival data. The analysis took place over a period of two years from 2012 to 2014.The second organization is a large public university hospital in the Netherlands. I chose an academic center since, as described below, in the Netherlands this is the category of hospitals in which medical management has been implemented more radically, while many non teaching hospitals still lag behind in terms of doctors' involvement in management. It is organized in managerially autonomous clinical divisions, introduced in the early '90s, and each division is run by a management team led by a medical manager (the clinical director). I obtained access to the site thanks to a research partnership established between the hospital and Utrecht University. Data were collected through semi-

structured interviews and document analysis in 2013. The first interviewees were clinical directors identified by the partnership contact point, a clinical director herself. Then the selection of respondents took place over time through purposeful sampling based on the analysis of data. More detailed information regarding the case selection, data collection and analysis is provided in the methods section of Chapters 3, 4 and 5.

I wished to study hybrid professionalism and medical management outside of the Anglo-Saxon world, where most of existing research has been carried out in the past, in order to bring new insights from countries which have "imported" NPM reform templates in different sectors of public service provision, including healthcare (Dent, 2003). The rationale for selecting hospitals Italy and The Netherlands (opting for a teaching hospital) is twofold (Burau, 2016). On one side, there are similarities that make possible comparisons meaningful. Both countries began to focus on medical manager roles in the mid 90s, and overall the degree of development of medical management is comparable (Neogy and Kirkpatrick, 2009). In Italy medical management is at a relatively high level of formal development, thanks to strong nation wide policies and incentives, and the effective level of engagement of doctors is increasing. In The Netherlands, although there is a greater variability within the system especially due to the varying nature of doctors' contractual arrangements, university hospitals have strong management structures and clinical director roles have been in place for years.

On the other side, the way in which medicine and management in Italy and in Dutch teaching hospitals are intertwined differs. For the purpose of my analysis, one of the main differences regards hospital resource endowment and the level of central/regional regulations and bureaucracy over organization and human resource management. In The Netherlands hospitals receive more funding than in Italy (the total per capita healthcare expenditure in 2014 was 3.206 $ in Italy, 5.276 $ in The Netherlands) and enjoy a higher degree of autonomy in the organization of work, hiring, firing as well as in defining compensation and incentive plans. One relevant consequence is that, in The Netherlands, the group of non medical managers who work at hospital and directorate levels supporting doctors in leading positions is relevant, both in terms of heads and in terms of resources and competency level. On the contrary, in Italy the organization of work and contractual arrangements remain strongly centrally regulated, and hospital executives as well as clinical directors have far less managerial autonomy. As far as non medical managers are concerned, in Italy they are few and less skilled: an administrative profile prevails, with a focus on bureaucratic or operational procedures with limited managerial competences.

However, I should clarify that this work was not intended as a comparative research, as in the study design I opted for an in depth analysis of two cases rather than a larger study of more cases, a choice which would have been more adequate for a proper comparative work. With the available resources of time and funding I preferred to develop more thorough qualitative analysis of a smaller number of hospitals, in order to illuminate key processes within the different local contexts. More information on the two health systems

are provided in the Appendix of this chapter, while some comparative considerations will be discussed in the conclusions paragraph.

Research design

Epistemologically, this study lies within the interpretive tradition, which looks at the voice of the people in the process of interpretation of those actions in which they are engaged (Van Maanen, 1979), and acknowledges that in order to increase our understanding of the world it is necessary to investigate how actors think and feel. This approach also admits that different interpretations can be applied to the world, and that some realities – especially those referred to values and identities - are subjectively and socially constructed. Of course, an interpretive approach does not imply a suspension of the researcher's judgement: as a researcher I also had a role in further organizing and framing these interpretations in light of a number of individual and environmental factors, as well as prior theorizing.

I mostly adopted an inductive approach, building theory cycling among data, emerging theory and extant literature (Braun and Clarke, 2006), as this is considered appropriate to study those research questions for whom existing theory has not offered convincing and testable answers (Eisenhardt and Graebner, 2007). In the three empirical papers (Chapters 3, 4 and 5) I built theory using a qualitative case study research design, i.e. rich, empirical descriptions of particular instances of a phenomenon based on a variety of data sources (Yin, 2009). Two are cross-sectional while one, as anticipated, is longitudinal. I collected data from different sources, performed interviews, analysed documents, observed and took notes at meetings. This allowed to describe complex processes, to integrate multiple perspectives and interpretations as well as to develop holistic descriptions, making it possible to grasp the rich and real-world contexts in which hybrid managers arise, answering the "why" and "how" of this complex phenomenon. This capacity to make sense of individual and collective experiences of professionals within their specific organizational context, with its tacit political arrangements and informal information flows, explains why the same methodology had been successfully used by previous studies on hybrid roles of professionals in management in healthcare (e.g. Kitchener, 2000; Forbes et al., 2004; Witman et al., 2011; Correia and Denis, 2016). I selected representative cases (Yin, 2009) suitable to study the processes of hybridisation of medical professionals in managerialised public service organizations. Most of the work draws evidence from Italy (Chapters 2, 3, 5 and 6) while the study reported in Chapter 4 is based in the Netherlands.

Relevance

This work has the aim to contribute to illuminate theoretically some real dilemmas faced by healthcare managers and policymakers. As a matter of facts, hybrid medical

managerial roles were introduced internationally in hospitals with the aim to face a number of today's healthcare challenges that often require the capacity to reconcile apparently contrasting values and priorities. First of all, reforms in most Western countries have increased the pressure for cost containment in response to the rise of healthcare expenditure secondary to both ageing populations and new technologies. This has determined, especially concerning those physicians who are in charge of medical staff and resources, the need to take efficiency into consideration in the use of scarce resources.

Furthermore, clinical needs have evolved, as today patients suffer from multiple co-morbidities and their average age has increased dramatically. Patients struggle to find adequate answers from within fragmented healthcare organizations, where service provision is broken into pieces according to rigid disciplinary boundaries. Integrated pathways and multidisciplinary approaches are now necessary, meaning that the traditional healthcare organization made of independent professional "clans" with autonomous hierarchies, fenced areas of practice and working rules is no longer adequate.

Also, the spread of evidence based medicine and accountability for results to patients directly and the general public has determined a shift away from the informal, peer based and "opaque" performance appraisals. Hospitals are now measuring performance, collecting data and reporting on it. Organizations are continuously compared on the basis of results and outcomes, as are individuals and groups within each organization. This has generated new managerial needs, and calls for new competences such as performance management, value-based approaches and operations management (Lega and Calciolari, 2012).

Finally, patients' expectations in terms of quality of non-clinical services (e.g. hospitality, waiting times, flexibility or customer support) have increased dramatically. "*Nowadays people say: if I fly KLM, I can change my seat in the airplane the night before I fly, I can choose to be at the window. And here I have to wait six, seven weeks before somebody reads a letter of a colleague to see whether he can see me: that is not possible anymore! […] We are living in different times. We have different clients, people have a completely different idea about hospitality, and of course also efficiency*": this quote from one of the interviewees of my study clearly shows how healthcare services are increasingly exposed to societal pressures that call for more streamlined and patient centred professional services.

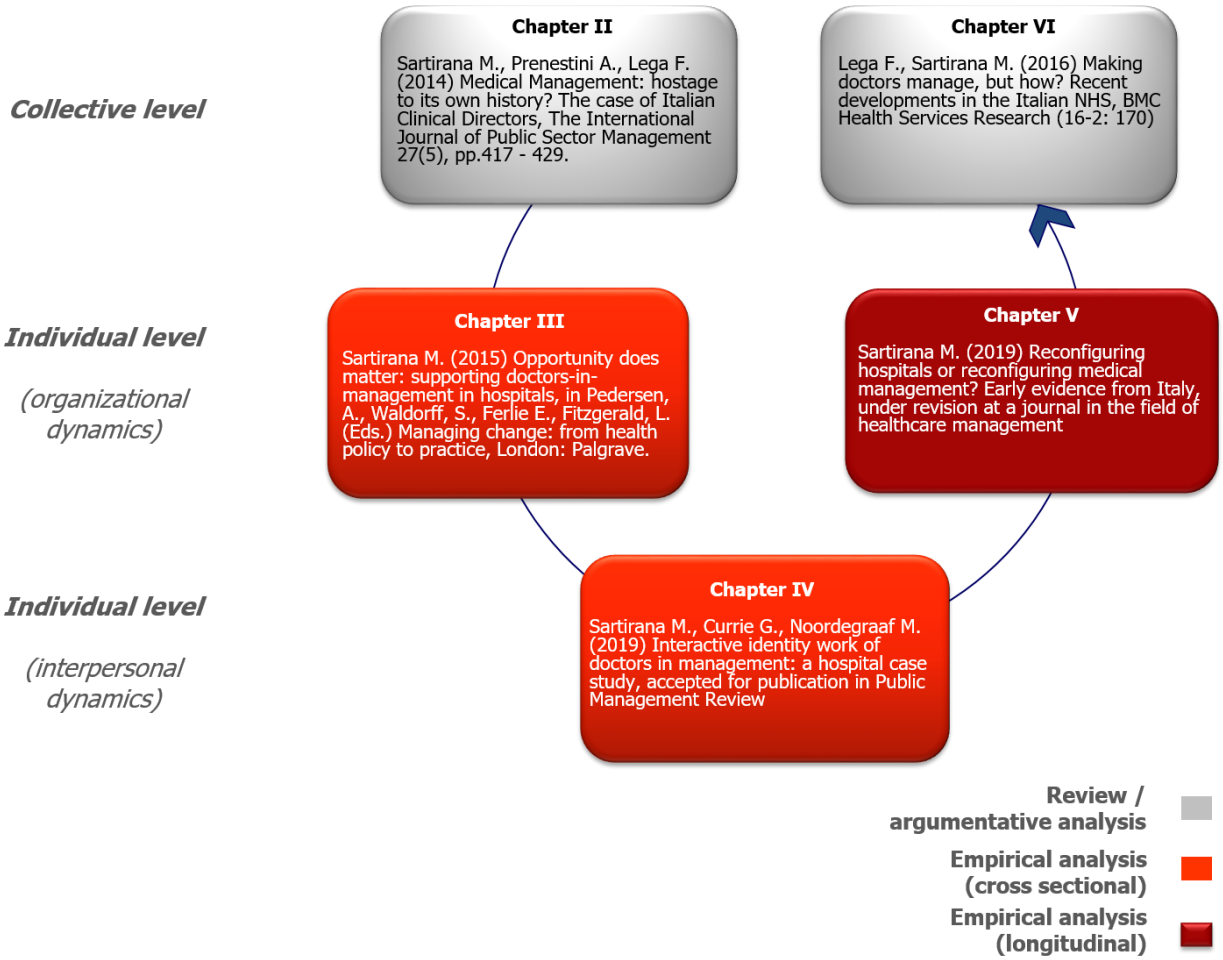
Therefore, clinical directors have been envisioned as one of actors capable to find sustainable solutions to these complex, contradictory and ethically sensitive demands. Knowing why doctors' take up managerial roles and the factors that support or hamper this process can provide guidance to professionals, healthcare managers and policymakers. As a consequence, with this research I aim to offer a small contribution in facing these grand challenges of healthcare today.

Scope and structure of the book

A synopsis

Figure 1.1 describes how book chapters are organized, illustrating how across the volume different theoretical angles are presented. The storyline follows the phases of my research path. I started with a literature review studying hybrids at the collective level, with the aim of understanding why they rise looking at the system dynamics with organizational impact (Chapter 2). Then I moved to the empirical analysis of individual hybrids and how organizational dynamics play out in the hybridization process in order to understand how they can be supported (Chapter 3). Chapter 4 then empirically focuses on hybridization processes and the interpersonal dynamics influencing them. Chapter 5, a longitudinal case study, illustrates the second stage of the analysis reported in Chapter 3, when I went back to the research site to deepen my understanding of contextual factors explaining professionals' hybridization. Furthermore, it discusses the development of new and redefined forms of hybrids, focusing less on formal role (like Clinical Directors) and more on work processes. Finally, an argumentative paper (Chapter 6) closes the book going back to the analysis if hybrids at the collective level and looks back at the research journey reflecting on some of the evidence collected during the work.

Figure 1.1 – Studying institutional perspectives on medical management: different approaches and methods



A "hybrid" approach

The research has the aim to combine different approaches and fields, in particular public administration, organization studies and health services research. This explains why some book chapters were meant for publication on outlets read by public administration and organization studies scholars (in particular Chapter 4), while the others are designed for sector specific journals in the field of healthcare. For this reason different chapters vary in the theoretical approaches adopted, structure, methods and length. For instance, papers designed for healthcare audiences, due to journal requirements, are typically shorter (between 5.000 and 7.000 words), and have lighter theoretical background and methodology sections. I added appendices providing further methodological details at the end of Chapters 2, 3 and 4.

I consider this *hybridity* as a strength of the work, as it aims at favouring the dialogue between different disciplines and between audiences. This effort is in line with the call by Currie et al. (2012) to develop research capable to reduce the divide between

organization studies, often developed in public administration field, and health policy/management. Theoretical synergy among these disciplines can allow, on side, the development of contextualised studies arising from major practical challenges that make generic organization studies contribution. On the other, it provides healthcare researchers, managers and policymakers analysis and conceptual tools capable to interpret the influence of different organizational contexts when explaining variance in the implementation of healthcare reforms. In this, my work favours the bridging of macro-level research (e.g. on the evolution of professionalism) with the meso-level (organization and management) and the micro-level (group and individuals), and contributes to our understanding of the dynamics of structure and agency in professional organizations. Finally, this is also fully in line with my professional profile, being a hybrid myself divided between academic research and teaching, in the field of public administration and healthcare management, and healthcare practice, working as a consultant and trainer for a number of healthcare organizations.

At the same time, I understand that this variety of approaches makes the work less homogenous, possibly reducing the book "readability". Indeed, this is a risk of all dissertations based on a collection of papers in which chapters are like the acts of a play, where different scenographies and different characters appear that surround the development of a common storyline. For this reason, using this theatrical metaphor, I added short *intermezzos* between some of the chapters. Unfortunately not comic pieces, as those of the tradition of the Italian opera, but still two paragraphs which accompany the passage between the main "acts" of the book. The first one between Chapter 2**,** a conceptual one studying medical managers at the collective macro level, and the following three empirical chapters. The second one between Chapter 5 and Chapter 6, the final conceptual chapter.

Research outputs

Following is a list of the research outputs of this project and the relative outlets: the five research chapters have been published or are under revision in peer reviewed journals/books in the field of public management and health care management. Two chapters are single-authored, while three (Chapters 2, 4 and 6) are co-authored, and I made an essential contribution in all of them. In Chapter 2 action research and its interpretation was developed together with the two colleagues prof. Lega and dr. Prenestini; I performed the literature review, drew the theoretical framework and wrote the paper, and the other two authors revised it. In Chapter 4 I framed the theoretical background, performed data collection and analysis; prof. Noordegraaf supported the definition of the research design and the drawing of conclusions, while prof. Currie contributed with suggestions to the theoretical background and the conceptualization of the findings. I wrote the paper and co-authors revised it. Finally, in Chapter 6 the argumentative analysis derives from an overarching understanding of the findings of the research presented in the book, as well as a from a joint reflection based on applied research conducted first-hand by myself and the co-author. I performed the literature analysis and wrote the paper, while prof. Lega revised it and contributed to the

conclusions paragraph; as stated in Authors' contributions section of the journal, authors' order is alphabetical.

- Sartirana M., Prenestini A., Lega F. (2014) Medical Management: hostage to its own history? The case of Italian Clinical Directors, *The International Journal of Public Sector Management* 27(5), pp.417 - 429.
- Sartirana M. (2015) Opportunity does matter: supporting doctors-in-management in hospitals, in Pedersen, A., Waldorff, S., Ferlie E., Fitzgerald, L. (Eds.) *Managing change: from health policy to practice*, London: Palgrave.
- Sartirana M., Currie G., Noordegraaf M. (2019) Interactive identity work of doctors in management: a hospital case study, accepted for publication in *Public Management Review.*
- Sartirana M. (2019) Reconfiguring hospitals or reconfiguring medical management? Early evidence from Italy, under revision at a journal in the field of healthcare management.
- Lega F., Sartirana M. (2016) Making doctors manage, but how? Recent developments in the Italian NHS, *BMC Health Services Research* (16-2: 170).

Appendix: Brief note on medical management in Italy and The Netherlands

Italy

The Italian health-care system is a regionally based national health service that provides universal coverage largely free of charge[1]. Resources are collected through general taxation and are allocated from the central state to regions and from regions to Local Health Authorities, which operate owned hospitals and act as commissioners of services for independent public hospital private providers.

Overall, health expenditure is lower than the OECD average in relation to its GDP (9.2% in comparison to the OECD average of 9.3%). The system is largely public: 78% of overall healthcare costs are publicly funded, and 70% of hospital beds are public (Petracca and Ricci, 2015). Currently, the largest challenge facing the health system has been to achieve budgetary goals without reducing the provision of health services to patients. The number of acute beds has significantly reduced over the years, and in 2012 it reached 2.7 hospital beds per 1000 people, far below the 3.6 EU average, and occupancy rates grew to almost 80% (Ferrè et al., 2014).

Public healthcare providers, although subject to regional policies, maintain a degree of autonomy in issues such as strategy making, budgetary management or organization. However, many hospital organizational features, including e.g., structures of managerial responsibility, people management rules or the profile of the different professions, are defined at the central level through national laws or national labour collective agreements. Private hospitals, profit or non-profit, are usually accredited, undergo governmental regulations and most of their revenues come from public funding.

In terms of human resources, with 3.7 practising doctors per 1000 people, Italy is slightly above the EU average of 3.5, although it reduced over the last decade. The number of nurses is relatively low, at 6.3 per 1000 people, and the ratio of nurses to doctors is among the lowest in the EU (Ferrè et al., 2014). The vast majority of hospital doctors are salaried, and heads of units as well as clinical director need to work full time at the hospital, and their private practice is allowed with some restrictions.

With reference to medical management, specialty unit chiefs have traditionally been the pivotal role in hospital organizations, holding managerial and legal responsibilities over physical resources, medical and nursing staff and strategy making. Since 1992, when the so called "managerialization reform" of the system occurred, the clinical directorate organizational structure was made mandatory for public hospitals in all regions, and practicing physicians, selected among the unit chiefs, were appointed as clinical directors who were (formally) assigned responsibilities over directorate clinical governance, budgeting and strategic decision making (Cicchetti et al., 2009). In some cases directorates were also provided with dedicated budgets which were then divided among units, while more often resources were negotiated between the CEO and each unit chief.

[1] For a more detailed analysis of the Italian hospital sector and the history of medical involvement in management see Chapter 2 or Ferrè et al. (2014).

Clinical directors are part of the board of clinical directors, acting mostly as an advisory body for the CEO.

In terms of management training, doctors in the position of unit chiefs and above are required to undertake an accredited management course (about 12 days). On the contrary, no managerial education is provided in undergraduate or postgraduate curricula.

The Netherlands

The Dutch health system[2] provides universal coverage through mandatory registration to insurance programs or sickness funds. Most hospitals are private non-profit organisations, they undergo governmental regulations and are funded through contracts with insurance companies or funds. Over time the traditional central governance was weakened and stronger market mechanisms as well as forms of regulated competition among providers were introduced in order to promote efficiency and to improve access.

The system is among the most expensive in Europe (12.9 of GDP in comparison to the OECD average of 9.3%, although cost growth has slowed since 2012); yet it is also in the top five of best valued systems by its users in terms of quality. Unlike other countries the number of acute beds has been rising in recent years, though it remains below European averages (it is 3.3 per 1000 people in comparison to the EU average of 3.6) and with a significantly low occupancy rate (46%, more than 30% below the EU15 average). Acute inpatient care is offered in 85 general hospitals (of which 28 are top clinical centres) in 131 different locations, 8 university hospitals, and 65 specialized hospitals. These hospitals provide practically all forms of outpatient care as well as inpatient secondary care and, in most cases, 24-hour emergency wards.

As far as human resources are concerned, the number of physicians per head used to be relatively low in comparison to other EU countries, but has risen at 3.3 per 1000 people, nearing the EU average of 3.5. The number of nurses is in line with the average. Approximately 60% of medical specialists are self employed, and only in a few hospitals, especially university hospitals, they are salaried. For this reason historically there was a clear separation of financial interests and doctors' participation in management was more difficult. In the 1980s, as a consequence of the introduction of hospital budgeting systems, there were strong collisions between professionals and administrators, but they were followed by a progressive increase in doctors' participation in strategic management and decision-making power. Thanks to reforms in the last 15 years staff executive boards were introduced, including representatives of clinical specialties, with an increase in the overall strategic responsibilities assigned to medical professionals.

With reference to doctors' management involvement in the middle of the organization, for non teaching hospitals the picture varies across the country. In some hospitals traditional dual organizational forms survive, with management tucked in alongside the professional organisations, and partnerships or contractual arrangements are

[2] The paragraph is mostly based on Neogy and Kirkpatrick (2009) and Kroneman et al. (2016).

retained that keep doctors away from hospital governance. In other hospitals a model was adopted in which doctors are either wholly or partly salaried employees, with greater involvement in management. Finally, in other instances clinicians are given managerial responsibilities for running divisions, including their financial budgets, and a supervisory board has an advisory role regarding the hospital's strategic policy. Overall, in the Dutch system, if compared with the Italian one, doctors have lower levels of involvement in management, both in terms of formal roles and in terms of effective engagement of professionals in these roles. However, as anticipated, the situation is rather different for teaching hospitals, or University Medical Centers. In these hospitals, professors and other doctors are salaried employees, and are provided with relevant managerial roles. In particular, they are organized in autonomous divisions, led by doctors in management, provided with a decentralized administrative and managerial staff. Medical managers heading divisions are assigned financial responsibilities and strategic decision making power in the organization. Management training is provided by most hospitals to doctors in leadership roles, with great variability in terms of course contents and length. A short management course has been included into the curriculum for medical residents, and in the last decade the Canadian model of medical education (CanMEDS), fostering the development of organizational skills among medical students and residents, has gained momentum (Hartley, 2016).

CHAPTER II: MEDICAL MANAGEMENT HOSTAGE TO ITS OWN HISTORY? THE CASE OF ITALIAN CLINICAL DIRECTORS

This chapter was published in the following paper:

Sartirana M., Prenestini A., Lega F., (2014) Medical Management: hostage to its own history? The case of Italian Clinical Directors, The International Journal of Public Sector Management 27(5), pp.417 - 429 https://doi.org/10.1108/IJPSM-06-2012-0070.

Abstract

As a consequence of new public management reforms, leading professionals in public service organisations have increasingly been involved in management roles. The phenomenon of clinical directors in the healthcare sector is particularly representative of this, as this medical-manager role has been adopted in many countries around the world. However, professionals' managerial role taking still falls quite short of expectations. While most research has searched for the causes of this gap at the individual level by exploring the clash between management and professionalism, we argue that a contextualized understanding of the organizational antecedents, and particularly the existing medical management roles, provides a more thorough picture of the reality.

The chapter adopts an institutional perspective to study at the collective level the development of existing medical management roles and the rise of new ones (clinical directors). The analysis focuses on the case of Italy, a country with a tradition in medical management where, following the example of other countries, clinical director roles were introduced by law; yet they were not incisive. It is based on a review of the existing literature and extensive field research on Italian clinical directorates.

The chapter shows how in contexts in which doctors in management roles exist and are provided with legitimacy deriving from legal norms, historical settlements between professions and taken for granted arrangements, medical management becomes institutionalized, stability prevails and change towards new doctor-in-management roles is seriously hampered.

It contributes to existing knowledge on professionals' managerial role-taking, underlining the relevance of contextual and nation-specific factors on this process. It

provides implications for research and for policymaking in healthcare and other professional public services.

Introduction

One of the consequences of the new public management reforms in service sectors has been the managerialisation of professional roles. This has been particularly common in those health care systems where doctors have become increasingly involved in management work to meet the demand for greater control of resources and develop a deeper government of professional activities. A relevant example of this can be seen in the spread of the clinical directorate (CD) model in hospital care, according to which clinical units in hospitals are grouped in directorates (or departments) and led by a senior doctor who is in charge of resource management and clinical governance and supports the hospital top management in decision-making (Harrison and Miller, 1999). The clinical directorate trends in different countries demonstrate an international convergence of health policies and practices; however, there are variations both across and within countries, and the effective managerial role taking is not always achieved (Neogy and Kirkpatrick, 2009; Kirkpatrick et al., 2009; Ham and Dickinson, 2008). The attitudes and skills of candidates, and the dynamics occurring within the professional group do certainly have an impact on the process of doctors' management role taking, yet they do not to entirely explain this variability. Drawing from the concepts of legitimacy and institutionalization (Scott, 2001; Selznick, 1992) we argue that, when searching for the causes that determine this mismatch, greater attention should be given to the organizational context, and specifically to the stability and resilience of existing management roles, both medical and non medical. Therefore in the paper we use a broad concept of medical management roles, not restricted to clinical directors but including those doctors with managerial responsibilities "setting standards, reviewing performance, and exercising supervision and control" (Freidson 1985: 26).

For this purpose we analyse the Italian hospital sector, which is particularly significant as it is characterized by a long tradition in medical management, in which well established roles, professional groups and organizational structures were in place when, following the example of other countries, clinical director roles were introduced by law. After describing the roots of Italian traditional doctors-in-management roles, we show how their presence hampered the development of clinical director roles and their legitimation in the system. By drawing conclusions from the case of Italy, this article provides reflections for international comparison.

An institutional approach to medical management

Healthcare reforms involving changes in professional work have attracted interest from different fields, including public management, organisational studies, sociology and health services. Most of the research focusing on doctors involved in management has analyzed this phenomenon through frameworks developed in the field of sociology of professions, and clinical director roles have been considered as a prototypical object of analysis. According to this view, the effectiveness of doctors-in-management in their

roles lies in their capacity to redefine his professional role by overcoming the conflict between management and professionalism (Hoff and Mc Caffrey, 1996; Llewellyn, 2001; Thomas and Davies, 2005; Noordegraaf, 2007; Numerato et al, 2011) and to perform the managerial role without losing legitimacy and status within the professional community (Forbes et al., 2004; Witman et al., 2009). As a result clinical directors become effective hybrids, or "two way windows" (Llewellyn, 2001) finding a balance between the managerial and professional logics. This literature has often studied the phenomenon of clinical directors' managerial role taking at the personal level or looking at the relationships within the group of practicing physicians. Yet, as this process always takes place in complex organisations such as hospitals, in which contextual factors like formal and informal organizational rules, historical routines and conventions have a high relevance.

We develop this perspective by drawing from concepts of institutional theory, in particular from the notions of legitimacy and institutionalization. Legitimacy is defined as "a generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions" (Suchman, 1995). An organization's role, authority structure, order or power arrangement becomes an institution when it gains a relevant legitimacy, when it is "composed of cultured-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life" (Scott, 2001). Legitimacy can rest on a regulative basis, when there are rules and legal sanctions supporting the existing order; on a normative basis, when the order is coherent with shared moral values; or on a cognitive basis, when the order or way of action is considered meaningful and is therefore taken for granted (Scott, 2001). More recently Deephouse and Suchman (2008) have suggested to introduce a variant of normative legitimacy, namely professional legitimacy, to refer to legitimation provided by the congruence with the ethics and worldviews of a particular professional group, rather than by the congruence with general societal values. If a social order is highly institutionalized stability prevails, the existing norms and practices will not be questioned and change will be hampered. Or, as stated by Selznick (1992): "institutionalization constrains conduct in two main ways: by bringing it within a normative order and by making it hostage to its own history".

The institutionalization of medical groups and practices in the hospital sector has been a popular topic of research in the last years. For instance in his famous study Barley (1986) has analyzed the social structure (and the change process) of radiology departments of two US hospitals, while Kitchener (2000) has described the institutional forces which influenced inertia and change in professional roles when clinical directorates were introduced in UK hospitals. Hospital medical groups develop their own identities, belief systems and cognitive maps. And the settlement between professional groups, in terms of distribution of power over decision making, endowment of resources (people, technologies, beds, etc.) or the boundaries of professional practice areas, constitutes the main organizing principle for the hospital functioning. Change in this stable social order

can occur only if a "deinstitutionalization" process takes place in which, as a consequence of functional, political or social pressures (Oliver, 1992), existing groups or practices lose legitimacy, weaken and disappear, while new groups or organizational practices take their place. Change therefore can occur only when the regulative, normative or cognitive sources of legitimacy of a group or practice are undermined and existing arrangements are perceived unable to respond to the strong tensions which take place in hospitals. Although "traditional" professional groups have usually been considered as a subject of institutionalization, the same theoretical perspective has been adopted to understand the logics and dynamics of "hybrid" medical management roles and groups. For instance the acquisition of different types of legitimacy in healthcare organizations by emerging medical management groups has been studied by Hoff (1999) in the United States and Marnoch et al. (2000) in the UK NHS. Therefore the degree and type of legitimation of existing medical management roles and groups has a major influence over the change toward new forms of medical management. On this basis we argue that if organizational circumstances and medical management arrangements in place are highly institutionalized, and if the sources of their legitimacy are not compromised, new roles and groups aimed at further developing medical management can end up being entrapped by the very same systems they must improve.

Finally, as "patterns of accommodation between medicine and management are more nation-specific than is frequently acknowledged" (Kirkpatrick et al., 2009) it seems important to accompany the analysis of medical management arrangements and the sources of their legitimacy with the study of a nation's unique political, legal and historical context. This in-depth analysis is developed in this paper with reference to the case of Italy.

Methodology

The analysis that follows draws on both primary and secondary data sources. A review of the healthcare management literature was developed searching the electronic database EBSCO Business Source Complete Database for the following keywords: "clinical director" / "clinical directorate" / "hybrids" / "medical management" and "Italy". Papers published in the last 20 years were included. The volumes of key Italian journals in healthcare management[3] published after 2005 were screened manually, and a snowball strategy was adopted to collect previous literature. The results of independent studies on the development of clinical directorates based on surveys and documental analysis were analysed, as was national legislation on clinical directorates.

The paper also draws on previous research published by the authors (Lega 1999, 2002, 2008; Cantù and Lega, 2002; De Pietro and Prenestini, 2008; Lega and Prenestini, 2009; Poser and Prenestini, 2010) and on the findings of 10 action researches conducted by the

[3] Mecosan, Mondo Sanitario, Organizzazione Sanitaria, Politiche Sanitarie, Sanità Pubblica e Privata.

authors over the period 2002-2013[4] to support hospital independent trusts (3), general hospitals controlled by local health authorities (4) or teaching hospitals (3) in the design of clinical directorates or in the development of the effective engagement of doctors in the new managerial roles. The hospitals were based in eight different Italian regions, researches were developed on site and included interviews and group discussions with hospital top managers, clinical directors and other senior medical and non medical managers and unit chiefs. One action research was longitudinal (2002-2012) and allowed to analyze the dynamic nature of the process of professionals' managerial roletaking. The initial conceptualization of data was developed among the three authors, it was condensed, structured and theoretically contextualized by the first author and further discussed and enriched during feedback sessions with the co-authors.

The paper is organized as follows. Next section describes the features of the Italian system and their effects on the development of formal medical management roles. Following we describe the features of Italian medical management roles, and then the impact of traditional medical management forms on the development of clinical director roles. In the final paragraph conclusions are presented.

The Italian health system

This section describes the main features of the Italian National Health System (INHS) - and in particular its hospital sector –to understand how it potentially favoured the development of clinical director roles. According to the framework proposed by Kirkpatrick et al. (2012) to explain the development of medical management roles in a healthcare system, we first describe the general characteristics of the INHS, then the nature and process of public management reforms and finally the nature of organisational settlements with the medical profession.

[4] 2012: Assessment of the perceived directorates' effectiveness – LHA Bologna; 2010: Reconfiguration of the hospital network, Trento; 2009: Designing of the multi hospital network "A.O. Ospedale di Circolo" di Melegnano"; 2009: Reorganization of new hospital Niguarda of Milan according to "intensity of care" model; 2008-2009: Reorganization and development of clinical directorates at LHA of Bologna; 2008: Reorganization and clinical directorates development at orthopaedic teaching hospital I.O.R. in Bologna; 2008: Reorganization and development of clinical directorates at teaching hospital San Martino of Genoa; 2007: Reorganization and development of clinical directorates at teaching hospital of Udine; 2007: Reorganization of LHA of Udine; 2005-2006: Reorganization of the Foligno Hospital; 2004-2005: Reorganization of LHA of Bologna; 2003: Organizational development at Lucca LHA.

Table 2.1 The Italian health system

National population (2012)	Overall health spending, USD PPP per capita (2012)	Total expenditure on health as % of GDP (2012)	Public expenditure on health as % of total expenditure (2012)	Practicing physicians per 1000 population (2011)	Total hospital beds per 1000 population (2011)
59,118,000	2919.4	8.7	80.3	4.1	3.4

Source: OECD Health data 2013

The INHS grants universal access to a uniform level of care throughout Italy. It is a regionally based system such that the 21 regional governments are responsible for ensuring the delivery of healthcare services. Resources are collected through general taxation and are allocated from the central state to regions and from regions to Local Health Authorities (LHAs). LHAs operate owned hospitals and act as commissioners of services for Public Hospital Trusts (PHTs) and Private Accredited Providers (PAPs); funding is given to the LHAs based on capitation and a DRG system for PHTs and PAPs. Patients have the right to choose between public hospitals and PAPs throughout the country. In the last few years the cumulative effect of the growing strategic planning at the regional level, the strong financial pressures, the development of the commissioning activity of regions and LHAs, and some degree of competition have created a push toward hospital managerialisation (France and Taroni, 2005; Lega, 2005; Lo Scalzo et al., 2009; Anessi Pessina and Cantù, 2011). This push, in turn, has led to calls for improved governance of hospital healthcare services which has brought about a need for doctors to be more involved in management.

This trend was supported by the public sector reforms of the last 20 years, inspired by the values of the new public management movement. At the beginning of the 1990s, the INHS was reformed, bringing about most of the managerial innovations described above. One of the most relevant changes was the set up of hospital top management teams that were empowered with management responsibilities, substituting the traditional role of hospital administrators. These teams, composed of a general director or CEO, an administrative director and a medical director (a doctor by law), were given the task of reducing the autonomy of unit chiefs and dismantling the existing managerial style deeply connected with informal and political logics. In the same years, other, broader public sector reforms were passed and strongly affected public healthcare providers (in particular the so-called "privatisation" of the public employment relationship). In the late 1990s, regional governments also increased their legislative activity with reference to health policy and hospital organisation (introducing, among others, norms concerning the directorate structure).

Finally, the features of the medical profession in Italy, such as the fact that Italy is among the OECD countries with the most doctors per capita (4.1 per 1000 inhabitants: OECD data 2011) and that Italian doctors are hired and paid by the hospital and usually have open-ended contracts, seemed to facilitate the active involvement of doctors in management. Furthermore, the relatively marginal role - compared to other European countries - of medical bodies and societies, which do not have official decision-making roles in the system but rather lobby central and regional governments, hinders professional self-regulation which potentially might discourage doctors' involvement in management.

Medical-management in Italy: the old and the new

As anticipated, the involvement of doctors in management tasks has always characterised the history of the INHS, especially at the specialty unit level, which the first law on hospital organisation, passed in 1938 (RD 1631/1938), identified as the fundamental component of the organisational structure. Italian unit chiefs were not only experienced professionals but have also always been in charge of formal responsibilities concerning both the organisation of work and human resources (traditionally, doctors, nurses and healthcare assistants) and physical resources (beds, outpatient rooms, operating theatres, etc.). This responsibility has always been accompanied by the legal responsibility for monitoring, directly and indirectly, all of the clinical activities in the unit. After 1992 their role was enhanced with formal managerial responsibilities for achieving targets and controlling costs. In addition, the traditional wording *primario* (literally, primary physician) was substituted by *direttore di unità operativa* (unit chief).

Moreover, a second element characterising the INHS is represented by a class of doctors holding a specialisation in "Hospital hygiene and organisation", a medical discipline whose members have historically been in charge of the operational management responsibilities in hospitals. Their origin dates back to the first reform in 1938, when all Italian hospitals were required to have a medical director responsible for hospital management[5]. Over the years, this category of physicians (referred to as "hygienists") emerged as an independent medical specialisation, taking care of hospital hygiene, hospital organisation, medical archives, and epidemiological analysis. Many residential courses were introduced over time, and the discipline is taught today in 32 medical schools. Despite this, hygienists' professional legitimacy was not always acknowledged in organisations as some practicing doctors doubted the competency of colleagues who abandoned – or never began - clinical work. Hygienists today make up for most hospital medical directors, and comprise the large majority of the 50% of all CEOs with a medical background in Italy. They have also set up an active medical association (ANMDO) and, more recently, many of them contributed to the establishment of an association of medical managers (SIMM), modelled after the British Association of Medical Managers.

[5] The Italian expression used by the law is "curare il buon governo dell'ospedale".

In order to regain power and status this group has recently started acquiring new competencies in management fields as operations management, risk management, control of safety standards, implementation of EBM protocols and health technology assessment.

The healthcare reforms of the '90s also prescribed the introduction of the clinical director role in order to answer two perceived needs. First, the necessity to reduce top managers' span of control, as the number of clinical units in hospitals had grown significantly because the appointment as unit chief had been used as the only leverage to reward clinicians on their career path. The span of control had further increased over the previous 20 years due to hospital mergers. Secondly, the necessity to effectively reduce costs and introduce a model of care closer to needs of older, chronic, and more complex patients required a deeper clinical governance and a more incisive management of clinical services, which could only be performed by doctors on the shop floor able to manoeuvre within the "black box" of clinical processes. Clinical directors (labelled "department heads") were introduced as an intermediate hospital organisational level and were intended to embody a managerial role charged with fostering cooperation among different units in developing joint care pathways and evidence-based procedures and facilitate resource pooling to benefit from economies of scale and scope[6] (Lega, 1999, 2002; Lega and Prenestini, 2009). Therefore this role was also expected to take up some of the existing responsibilities of unit chiefs and hygienists, and also to contribute to top management activity by participating in hospital-wide strategy making. Italian clinical directors are defined by law as part-time roles, with doctors maintaining the leadership of the clinical units and usually some level of clinical activity. They are appointed by the CEO, often out of a shortlist of three candidates elected by the doctors who work in the directorate. They hierarchically report either to the CEO or the medical director and participate in the Council of Clinical Directors, which is expected to work as the executive committee supporting the top management on issues of strategic planning, management and clinical governance. The law does not prescribe the introduction of any support for the clinical director from administrative staff, nurses or general managers, although regional legislation and hospitals statutes are free to introduce administrative staff or nurse managers (Cantù and Lega, 2002).

However, the first directorates were not set up until 1995, and the diffusion took almost 15 years. In general terms, an early stage can be identified, lasting until the end of the 1990s, in which the development of CDs was slow: CDs were set up mainly in large independent hospitals, sometimes on an experimental basis, and the grouping of clinical units was often designed according to clinicians' preferences, most often on a specialty-based rationale, rather than according to organisational strategies of integration of care (Lega, 2008). To accelerate departmentalisation, law decree 229 of 1999 was passed, making the reorganisation according to the CD model compulsory for all hospitals. Yet

[6] Although the department (as we intended) were established only in 1992, the idea of grouping specialties in order to reduce the clinical and organizational fragmentation and costs had already been proposed - although never realized - in the previous reforms of 1968, 1976, 1978 and 1985.

most independent studies carried out between 2000 and 2004 (Senato della Repubblica, 2001; Cicchetti and Baraldi, 2001; Cantù and Lega, 2002; Bergamaschi and Fosti, 2002; ANAAO, 2004; Cicchetti et al., 2009) reported that, although the number of hospitals that had implemented departments increased dramatically in the following years, the development of clinical directorates and clinical director roles was far from being incisive in healthcare organisations. In most cases, these individuals were not managing directorate resources or acting as clinical unit coordinators accountable for achieving directorate targets (Bergamaschi and Fosti, 2002). Similar findings are provided by Poser and Prenestini (2010) and by a recent study by Morandi et al. (2011) based on a 2006 survey of over 1800 CDs, which reports that most of the directorates introduced after 1999 have not developed effective clinical governance tools, such as departmental guidelines, clinical pathways, telemedicine, systems for appraising clinical outcomes, departmental budgets and training programs.

Accounting for the reasons behind clinical director roles' poor development

This section explores the influence of existing doctors-in-management on the scarce engagement of Italian clinical directors in their role. First of all, the involvement of clinical unit chiefs in management turned out to be a major obstacle for the effective development of clinical director roles. Unit chiefs were accountable for the use of resources and were legally responsible for the organization of all clinical activities performed by the professionals working in the unit. Furthermore their role had even been strengthened during the healthcare reforms as they had been provided with new financial management responsibilities. Therefore their role was supported by a number of rules and coercive mechanisms, and they could manipulate rewards and sanctions to influence colleagues' behaviours. In short, using Scott's (2001) phrasing, they had a strong regulative legitimacy. But they also remained the "masters" of the hospital, with responsibility over training, knowledge transfer and professional development of their colleagues. They were highly respected professionals who deserved the followership of the doctors and nurses working in their units. As a consequence, they usually held a recognized professional legitimacy. Finally, Italian hospitals had always been based on clinical units, and unit chiefs had historically been provided with strong autonomy in clinical activity. The rules of accountability were clear and - to paraphrase the famous Griffiths report - if Florence Nightingale had carried her lamp through the corridors of the INHS she would have quickly found the people in charge. Many professionals considered this model comprehensible, as responsibilities were clearly defined, and meaningful, as it had always worked. As a consequence there was a good degree of agreement about the fact that the existing medical management model was an effective way to run the hospital, it had cognitive legitimacy.

Secondly, there was the medical specialty in hygiene and hospital organisation, the discipline that had historically developed a boundary-spanning role in dealing with

managerial and organisational issues from a medical perspective. They also had legitimacy in the system, from both a regulative, professional and cognitive perspective. This medical management group was a recognized medical specialty, and as the devolution of managerial power to clinical directors was seen in many cases as a threat to the future of the specialty, they often favoured inertia rather than change.

As a consequence, the Italian hospital sector historically had favoured the development of a strong medical management model. Such a model was highly institutionalized, as existing doctors-in-management roles were considered appropriate, usually had a powerful professional status and were backed by a regulative system. This model was stable and proved resilient to change when an alternative order (the clinical director model) was introduced. Resistance to clinical directors therefore did not come primarily from practicing physicians, but from professionals who were already medical managers. As a consequence clinical director roles, aiming at further developing medical management, became the object of what might be called an "institutional entrapment" due to the strong legitimation of those systems they were meant to improve.

Also, it must be added that the hospital top management itself was very cautious in setting up governance structures, incentives and management tools to support the effective involvement of clinical directors in their role (Lega, 2008). The delegation of functions to intermediate layers was seen by some CEOs as a danger to the legitimacy and effectiveness of their own role, and often top managers directly managed the relationships with unit chiefs, therefore delegitimising the formal authority of clinical directors. Furthermore, although the mandate of a CEO by law is 5 years, on average – according to most recent studies (Anessi Pessina and Cantù, 2011) – CEOs remain in the same hospital for an average of approximately 3 years, and this span of time has often been perceived by CEOs as too short to truly invest in building a class of clinical directors to delegate decision-making and responsibilities. Therefore, there was little "sharing of minds" between CEOs and clinical directors, and the top managers preferred to take autonomously strategic decisions leaving their implementation to hygienists or unit chiefs. As a consequence the stability of the existing medical management model was favoured also by non medical managers, and especially top managers. Rather than implementing the law by empowering and supporting clinical directors, they often supported the resilience of the existing order, preventing the institutional change.

Conclusions

"Of course, if they do not involve us in decision making we just ask for the latest "toy"… but if they did, we would be able to contribute to forging the vision, the positioning of this hospital".

Most research has searched for the causes the poor development of hybrid medical manager roles at the individual level, by exploring the clash between management and professionalism. Yet a contextualized understanding of the antecedents at the

organizational level, and particularly the behaviours of existing medical managers and non medical managers, provides a more thorough picture of the reality. This quote from a clinical director of a large Italian tertiary hospital shows only one of the many cases in which professionals are willing to engage in management, but the organization, namely top managers and existing medical managers, does not provide them, through delegation and involvement, the context to do it. And that explains why also doctors – and clinical directors - with a high managerial potential do not perform their hybrid role and just continue claiming the latest "toy" (i.e. the most recent, expensive technology).

By adopting an institutional perspective and studying doctors in management at a collective level, this paper shows that in contexts in which these roles exist and are provided with legitimacy deriving from legal norms, historical settlements between professions and taken for granted arrangements, medical management becomes institutionalized, stability prevails and the occurrence of change is extremely unlikely. As a consequence, the introduction of "modern" medical management roles in hospitals, which has been one of the component of most recent health policy reforms, should take into account the differences between contexts in which doctors-in-management did not exist and situations in which medical management arrangements flourished. These findings introduce a novel perspective which gives a contribution to the literature on hybrid roles not only by showing the relevance of the nation specific context in the development of doctors' engagement in the managerial role, but also pointing out that the development of new medical management roles such as clinical directors can be seriously hampered precisely in those systems in which medical management is already well established and benefits from strong legitimacy. Furthermore, also individuals that might be expected to support the engagement of clinical directors, i.e. the hospital CEOs, can contribute to this resilience.

Our research also answers the call to investigate the dynamic of "doctor subgroups which have gained status and power relative to other subgroups through recent reforms and reorganizations" (Numerato et al., 2011), and to deepen the understanding of the relationship between clinical directors and hospital top management (Marnoch et al., 2000; Hoff, 2001; Forbes et al., 2004; Mo, 2008). The findings can also contribute to broader research on hybrid roles in other professional public services. For instance similar problems in coping with professional and managerial different roles and identities have recently been found in academics who are appointed head of department (Floyd and Dimmock, 2011), and many professionals in schools or social services in most Western countries are struggling with comparable challenges (Kirkpatrick et al., 2005). The antecedents at the level of the individual and at the level of the professional group are important but should probably not be overemphasized. Rather than considering it only as a background control variable research should explore more the organizational context and its influence in providing (or not) the opportunity for professionals to effectively enter the new managerial roles.

This study has some limitations, mainly regarding the relatively scarcity of literature on the topic. Some of the findings might not apply to all Italian healthcare organisations or

regional contexts. Moreover, although the action researches in which they were involved exposed the authors to all key professional profiles (top management, clinical directors, unit chiefs, hygienists and nurses), hospital top managers were slightly over-represented, which might have partially affected the study results. Nevertheless, these initial findings may help develop more pertinent hypotheses and propositions for further inquiry using primary data sources.

The study also provides useful insights for health policy making and management in countries aiming at strengthening medical management. Policymakers should be careful in introducing hospital reorganizations and new standardized roles without considering if and how the individuals who should be the sponsors of change are going to engage in it. If hospitals' top managers do not believe in doctors-in-management, and are not willing to invest in them by delegating power and responsibilities and by supporting them with dedicated staff, doctors' managerial role taking will not occur. And if potentially competing professional groups of doctors in management already exist, a careful process of re-definition of their professional identity should be supported, and alternative development pathways and incentives should be provided to them.

Appendix: A methodological comment

As anticipated, the methodology section of the paper is in line with the requirements of the journal editor and the reviewers. It could be added that in the literature review I screened all the titles and abstracts resulting from the initial searches for "clinical director" / "clinical directorate" / "hybrids" / "medical management" and "Italy" on the electronic database EBSCO Business Source Complete Database for academic papers published in the period 1994-2013. After excluding articles that focused on professions others than doctors or that were not focusing on medical managerial role of clinical directors, I retrieved only five papers. Then I manually screened the paper titles of the five more prestigious Italian healthcare management journals (Mecosan, Mondo Sanitario, Organizzazione Sanitaria, Politiche Sanitarie, Sanità Pubblica e Privata) in the issues published after 2005, finding other five relevant papers. Following, to ensure coverage of other relevant studies, I included previous research published by the authors. Furthermore, I used a snowball sampling to identify articles that were cited as significant by one or more of the articles although not appearing as a result of the initial systematic searches, allowing to identify the relevant Italian articles published before 2005, grey literature, or results of independent studies on the development of clinical directorates. However, grey literature articles or reports that were normatively driven were not included. Thanks to this strategy the final number of papers retrieved was 20.

While reading and analysing the papers and comparing them with theory we found that institutional theory, and in particular the notions of legitimacy and institutionalization could explain the patterns emerging in the analysis. Potential antecedents explaining the development of clinical directors as medical managerial hybrids in the Italian health system were then identified. Particularly relevant was the contribution by Kirkpatrick et al. (2013), and their framework drawing from an institutional perspective which explains the development of medical management roles in healthcare systems, with specific reference to the nature and process of public management reforms and the nature of organisational settlements with the medical profession. Also, the initial conceptualization of the antecedents was developed in discussions among the authors in which we went back and forth from papers collected in the review on the Italian experience, other international literature on clinical directors (cited in the References) and evidence collected in the ten action research projects in which the authors had been involved. In these projects we worked in ten hospitals in the design of clinical directorates or in the development of the effective engagement of doctors in the new managerial roles. We had the chance to discuss with top managers and clinical directors, as well as with hygienists and medical unit chiefs, regarding the evolution of medical management and the conditions that hampered/supported doctors' engagement in managerial roles.

INTERMEZZO I

Chapter 2 presented a conceptual work based on a literature review, and looked at Italian professional-managerial hybrids from a macro perspective of analysis. It has shown, thanks to institutional lenses, the importance of contextual factors in explaining the development of medical managerial roles at the collective level. I now move to the empirical analysis, which I developed in Italian and Dutch contexts thanks to in depth case studies of two large hospital organizations. I asked myself which are the organizational dynamics (Chapter 3) and the interpersonal dynamics (Chapter 4) that impact on individual professionals' hybridization process, in order to possibly identify how this can be supported.

In Chapter 3 I make use of the AMO mode - drawn from the HR literature - which explains individuals' performance as an interplay of ability, motivation and opportunity. While the importance of individual motivation and ability has largely been acknowledged in the public administration and organization studies literature on hybrid managers, exploring the role of the opportunity to perform increases our understanding on the role of context in the hybridization. The chapter was published in a book for healthcare scholars and practitioners co-authored by influential academics in the field of organization studies applied to healthcare. It addressed the challenge of implementing reforms into organizational practices, and in particular the role of professionals in change processes. As anticipated, this is the reason why the chapter is shorter if compared with usual public administration publishing standards.

Chapter 4 makes a step forward and studies individual professionals' identity transition and the role of social interactions in this process. Theoretically, it makes use of institutional theory, and in particular it studies hybrids' identity work, the form of institutional work which takes place through the creation or transformation of established (professional) identities. It has been submitted and currently under revision in a public administration journal.

Then I went back to the research site described in Chapter 3 to deepen my understanding of contextual factors explaining professionals' hybridization, in particular organizational change over time. Chapter 4 describes this analysis, in which I also started encountering the development of "new" forms of medical management beyond the hybrid roles of unit chiefs and clinical director that had been the main focus of the analysis. Also Chapter 4 has been written for a healthcare audience and is currently under revision at a healthcare management journal, therefore it complies to the publishing standards of this research field.

CHAPTER III: OPPORTUNITY DOES MATTER: SUPPORTING DOCTORS-IN-MANAGEMENT IN HOSPITALS

This chapter was published in the following book chapter:

Sartirana M. (2015) Opportunity does matter: supporting doctors in management in hospitals, in Pedersen, A., Waldorff, S., Ferlie E., Fitzgerald, L. (Eds.) Managing change: from health policy to practice, London: Palgrave, and it is reproduced with permission of SCSC.

Abstract

This chapter discusses the (often underestimated) influence of the organizational context in shaping the process through which professionals take on managerial roles. It studies clinical directors (CDs), hospital doctors with relevant managerial responsibilities and explores the content of their work, their perceptions and the relationships with colleagues and the organization, in order to understand the conditions of possibility for the emergence of medical management. The analysis is guided by the concept of opportunity to perform, which is used to study how the organizational support interacts with individual skills and motivation in the process of professionals' managerial role taking. The empirical data, gathered by an in-depth case study in a large Italian tertiary hospital, show how a number of doctors are indeed capable and motivated to engage in management, but do not perform due to lack of opportunity provided by the organization, and in particular by non-medical managers.

Introduction

The introduction of professional–manager 'hybrid' roles has been seen as a solution to 'bridge the gap' between the two competing worlds of medicine and management (Freidson, 2001; Noordegraaf, 2007) at the organizational level. In particular, in a number of Western countries we observe doctors being involved in management as head of clinical directorates, which have become a popular object of analysis for management scholars (Fitzgerald and Dufour, 1998; Marnoch et al., 2000; Kitchener, 2000; Llewellyn, 2001; Kirkpatrick et al., 2009; Witman et al., 2011; McGivern et al., 2015). Clinical directorates are intermediate management units formed around either a broad medical specialty or a support service grouping a number of smaller specialties. They were introduced in order to increase the governance of clinical services, pool resources, favour inter-specialty integration and support the top management in the strategy making (Chantler, 1993; Kirkpatrick et al., 2013).

However, after the formal introduction of clinical directorates, doctors were not always effective in taking up management roles (Kitchener, 2000; Llewellyn, 2001; Lega, 2008, Neogy and Kirkpatrick, 2009; Numerato et al., 2011; Ham and Dickinson, 2012). This has raised the interest, among academics and practitioners, in understanding the determinants or antecedents of doctors' hybridization, which has been mainly explored with reference to the individual level, by looking at how professionals respond (and often resist) management logics. For instance, Forbes et al. (2004: 171) identify the personal attitudes of 'investors', defined as directors 'who came into management with a specific agenda… they saw themselves as natural leaders and innovators… for them management concepts were seen as being easily acquired'. On the other hand, they find the 'reluctants', those who 'felt pushed into accepting a clinical director role… the decision to accept the role either came from their reservations about being managed by someone they objected to or from a perceived need to defend their specialty… and felt no need to develop a managerial self'. Similar clusters were identified by McKee et al. (1999), Llewellyn (2001) and McGivern et al. (2015).

In this study, a complementary perspective is explored and looks at how organizational practices, such as management systems and the support provided by top (non medical) managers, by interacting with determinants at the individual level, influence the process of CDs' managerial role taking. This enables understanding of the complex managerial context of hospitals, organizations characterized by a continuous interplay of rational and political logics in between professional and managerial domains.

Theoretical framework

The role of the contextual factors at an organizational level, such as the hospital structure, management systems or the support provided by top (non medical) managers have rarely been addressed in the literature on professional–managerial hybrids, because they have often been considered as a control variable rather than a direct object of inquiry.

Only a few studies in the field of healthcare management have analysed how the opportunities to perform provided by the organizational context interact with professional logics to determine CDs' managerial role taking. A recent work by McGivern et al. (2015) argues that career paths and formal management training do not appear to have significant impact on hybridization, but hint at the role of peers and mentors in supporting the process of identity formation. Fitzgerald and Dufour (1998) found that the quality of relationships across professional boundaries facilitate the involvement of professionals in management and describe effective organizational arrangements supporting CDs. Hoff (2001) shows how elements of the work environment and situational factors, such as the socialization of CDs in the management role, favours the development of a positive dual commitment, both to the profession and to the organization. McKee et al. (1999) acknowledge the importance of facilitating factors like talented and experienced business managers and nurse managers, a proper design of directorates in terms of scale, nature of the business and presence of a clear strategic mandate, and finally the proactive support from the chief executives in terms of provision of review mechanisms, training initiatives and creation of managerial structures which draw CDs into the broader organization. Thorne (1997) highlights the role played by the organization in sustaining the individuals who struggle to perform this role, while Lega (2008), focusing on Italian CDs, also shows the relevance of contextual factors at the organizational level, like tenure, appointment process and directorate design.

In order to increase our understanding of how the hospital organizational context influences the behaviours of doctors in management, I make use of the conceptual framework of individual performance commonly referred to as 'ability-motivation-opportunity', or 'AMO' (Blumberg and Pringle, 1982; Boxall and Purcell, 2011). This comprehensive framework, which is grounded on the work of Peters and O'Connor (1980) on situational constraints, sheds light on the importance of the interaction between the opportunity provided by the context and the capacity and willingness of the individual, which do not stand in isolation but are embedded in a social order which might act as a hindrance or a facilitator of individual behaviour. Opportunity is defined as 'the particular configuration of the field of forces surrounding a person and his or her task that enables or constrains that person's task performance and that is beyond the person's direct control' (Blumberg and Pringle, 1982: 565). A broad range of variables, related to the features of the organizational environment and the actions of others, can be included in this construct, such as organizational procedures that favour information sharing and delegation, budgetary support or the interaction with supervisors and co-workers.

According to the interactive nature of the model, the lack of opportunity to perform inhibits personal motivation, as "early identification and removal of constraints might be a necessary, or at least desirable, first step for change programs aimed at affecting individual motivation, ability, or skill. To the extent that severe situational constraints

are present, therefore, any change program aimed at improving motivation or skill may not result in lasting desired performance improvements" (Peters and O'Connor, 1980).

The framework shows that when opportunity to perform is provided, ability and motivation can also develop and are further strengthened by the positive performance experienced personally. The model also explains that the interaction among these variables is not static but rather occurs in a process which develops over time. Furthermore, from this perspective, it can be understood why some types of opportunities might have different impacts on different groups of subjects as 'those highly able and highly motivated individuals predicted to have their performance most strongly affected by the presence of constraints will also be the most frustrated and dissatisfied under high constraint conditions' (Peters and O'Connor, 1980: 393). This comprehensive model has effectively been adopted by recent research in order to explain a wide array of behaviours including teamwork (Gould-Williams and Gatenby, 2010) and knowledge sharing (Siemsen et al., 2008).

I adopt these concepts developed in the HR literature applying them to the literature on professionals and especially medical managerial hybrids, which mainly draws from the fields of public administration and organization studies, and which has given little consideration to the AMO perspective (see also Currie at al., 2015). We have a great knowledge of the role of motivation and ability in the hybridization process, which are by and large based on individual/collective professional identity dynamics. However, the role of opportunity to perform, and the organizational support and HR practices that impact on it, have been overlooked. On the other side, also within the HR community the theoretical limitations of the AMO have been acknowledged (Boxall and Purcell, 2011). In particular, it has been claimed that it is necessary to avoid simplistic "best practices" approaches and rather bridge HR theory with institutional perspectives. This in order to increase the understanding of the interaction of HR practices with the institutional mechanisms which exist in organizations, including professional norms and values linked to individual professionals and their collectives (Boselie, 2009; Paauwe and Boselie, 2003).

Referring the AMO notions to the case of medical managerial hybrids allows to fully take into account the complexity of organizational contingencies which, by interacting with individual determinants and the determinants at a professional group level, impact the behaviour of doctors in management in hospitals. By doing this, the AMO model is applied in a way and with a methodological approach which differs from those contributions in the HRM field (Appelbaum et al., 2000; Boselie, 2010) which adopt a more positivist perspective to study and quantify the causal link between the three variables and the individual performance of line workers. Rather, I make use of its analytical categories for drawing a conceptual framework which, by describing how individual and organizational dynamics are intertwined, allows a more thorough understanding of the determinants of individual behaviours.

Methods

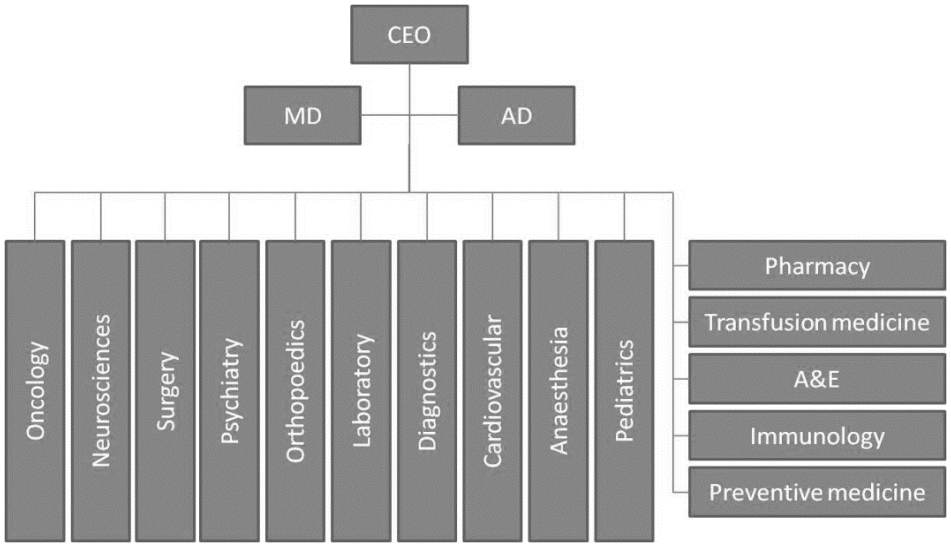
The study was designed to make sense of individual and collective experiences of CDs within their specific organizational context, with its non-formalized facets, tacit power arrangements and off-the-record information flows. For these reasons, the empirical evidence for this analysis was gathered through qualitative research and, in particular, through the case study methodology (Yin, 2009). This approach was adopted because, through accessing multiple sources of evidence, it allows us to capture the richness and diversity of professionals' sense making during the process of managerial role taking and to develop a deep comprehension of the complex social phenomena which take place in the hospital setting. For the same purposes, similar qualitative methodologies were successfully used by a number of previous studies on doctors in management (e.g. Kitchener, 2000; Marnoch et al., 2000; Witman et al., 2011).

Case study context

The case study was carried out in a large tertiary hospital in Italy. The Italian experience is particularly relevant as doctors have historically been involved in management in the Italian health system. Since the royal law on hospital organization of 1938, unit chiefs have been in charge of formal responsibilities over human resources and physical resources like operating rooms and beds; and, in the 1990s, they also became accountable for reaching production and financial targets. Moreover, there is a unit run by the so-called hygienists in every hospital, that is, doctors specialized in hospital organization taking care of operations management responsibilities. These factors also contributed to a limited presence, especially if compared with other systems like the NHS, of non-medical managers, who usually work in centralized offices (for instance, human resources, finance, budget and control, quality, ICT) rather than being based in directorates or clinical divisions. CD roles were introduced in all Italian hospitals at the end of the 1990s and were intended to participate in strategy making, foster clinical and organizational integration and pool resources. By law, CDs must be selected from among the units and work on a part-time basis, maintaining their role at the specialty unit level. They are appointed by the hospital CEO and take part in the 'council of directors' board meetings.

With its 1,000 inpatient beds, the hospital is one of the largest providers in its area; it offers both general services for the local population and highly specialized care. It employs almost 4,000 staff and has a budget of over €400 million. For the purpose of the study, it represents a critical case for two main reasons: (1) it is a hospital which has been exposed to relevant managerial reforms for the last 15 years and (2) it introduced CD roles back in 1998. At the time when the study was conducted, the organizational chart identified 11 'managerial' clinical directorates and 5 'support' clinical directorates (Figure 3.1). Each 'managerial' directorate included an average of five specialty units, ranging from a minimum of two to a maximum of ten.

Figure 3.1 Hospital clinical directorates



Source: Author's own.

In 2011, a new top management team (CEO, medical director and administrative director) was appointed which decided to increase the involvement of CDs in hospital management and decision making.

Data collection and analysis

The study, which took place in 2012, is based on direct interviews with the staff, observations of hospital board meetings over a six-month period and the analysis of archival material. Different categories of respondents were identified and multiple interviewees were selected in each category. The researcher had the unique opportunity to interview all CDs of the hospital[7], the hospital CEO and the other members of the top management team, the chief hygienist (operations manager) and the hospital chief nurse in depth. The presence of all hospital key informants afforded the gathering of valuable insights on CDs' actual managerial behaviours through the combination of a plurality of perspectives. The analysis was completed with the interview of the hygienists in charge of the budget negotiations and with two directorate nurse managers. In total 21 interviews were conducted, 16 with a medical background and five with a nursing or administrative background. Interviews were conducted with guarantees of anonymity and confidentiality, they took place on site and their average length was of one hour.

The interview protocol was prepared by the author analysing existing literature on doctors-in-management and was developed and fine-tuned after the discussion of the results of a pilot interview. The interviews were framed by a number of core question areas, including the content of the managerial activity; the reasons for moving into management and the attitudes towards the job; the relationship with non-medical managers and nurses and the interaction with the organization and how it changed over

[7] 13 clinical directors were interviewed out of 16 directorates (one directorate was vacant, one director was the pro tempore head of two directorates and the preventive medicine directorate was excluded as, due to the specific nature of its activity, it was considered not relevant for the analysis).

time (see also Appendix). Each theme was subdivided into specific interview topics; however, in order to empower respondents and increase their propensity to give narrative accounts, interviews were kept as open as possible. The question order was not rigid and follow-up questions were added if necessary. Interviews were conducted by the author, recorded and summarized in order to condense the most important meanings emerging from the answers (Weiss, 1994; Kvale and Brinkmann, 2009).

Participant observation took place at four monthly hospital board meetings, lasting about three hours each; the author observed the meetings in order to understand the most frequent topics of the discussions, the style of the hospital top managers, the verbal communication and non-verbal behaviours through which each CD participated in the discussion of performance management issues and/or strategic issues. Finally, the dataset was completed with the analysis of relevant hospital documents like the statute, the organizational charts and the résumés of all CDs.

The initial conceptualization of data was made through the analysis of theory, developing themes that were enriched by categories emerging from the words and ideas expressed by the interviewees. Identification of patterns for interpretation and understanding of causal relationships then took place in an iterative process from data to theory and from theory to data.

Findings

The vast majority of CDs were the 'natural' candidates for the position: highly influential clinicians, presidents of scientific societies, sitting on the editorial boards of international journals or pioneers of new techniques at a national level. They had the professional legitimacy to occupy the position and the respect from colleagues. They were also aware that in order to maintain that legitimacy, both within the directorate and in the medical community at large, they needed to continue their clinical practice. All of them had been unit chiefs for years and were used to solving operational management issues, managing resources and directing people. And they had been exposed to the notion of medical management for years, both directly – as many had worked in the United States in the early phases of their career – and indirectly, through personal international networks. However, CDs' engagement in management changed consistently, according to both the individual capacity and willingness to step into management and the degree of opportunity to perform provided by the hospital.

The old days: unsupported and unbacked

Although the hospital introduced clinical directorates back in the early 1990s, for a number of years CDs were not put in the position to really make a difference in managerial terms. The council of directors, initially presented to the organization as a management board, was summoned only four times a year and was intended as the place in which decisions were communicated one-way; discussions mostly took place with

reference to clinical issues, such as the adoption of accreditation criteria, guidelines or quality standards. An extensive system to assign targets and monitor the financial performance was indeed introduced, and the pharmacy started providing reports about the drug consumption and the planning of expenses, the hygienists supported doctors in operations management issues. However, CDs had limited power in managing the budgets of specialty units, and when problems arose, often unit chiefs knocked on the CEO door to be listened to (CD10) and they solved problems directly by bypassing CDs. Therefore, the opportunity to exercise managerial activities mostly came in terms of financial issues at the level of their own specialty unit.

Although in such context doctors' contribution to the hospital management was quite modest, different individual responses to management were present. A first group of CDs was composed of individuals who initially had the least interest in management, as they entered the role primarily with the hope to favour one's clinical group: 'I believed in my area of practice and I could not stand the risk of being governed by someone who did not care too much about it' (CD5); 'at the beginning, I wanted to be in a place to move my specialty forward' (CD4). They opted for conservative strategies; they continued to exercise their organizational power to access resources and managed to prevent the advent of undesired colleagues. They referred to the their managerial activities in the early years as a matter of controlling the achievement of financial targets, which required participation in setting the caps of the units and acting as supervisors in case of overspending: 'I understood that in order to be a good doctor you have to deal with financial management too' (CD4). Thanks to the exposure to monthly reports, frequent interactions with the staff of the CFO and discussions with the head of pharmacy, they had been acquiring competence in finance: 'it is really about administration, finance, and dealing with the pharmacy' (CD1). Accordingly, interactions with unit chiefs in the directorate were often focused on financial issues and took place on an occasional basis, and communication with the nursing staff was modest: meetings with the nurse directorate manager were non-frequent, often unscheduled and usually for administrative issues or small-scale operational problems: 'the only interactions were when we had to sign papers' (Nurse Manager (NM) 1).

The situation was rather different for a second group of CDs. They were those who entered the role with more of a positive attitude towards management, with the aim to make a difference and to change things. They had also been performing their role as budget controllers and had frequent exchanges with hospital accountants and pharmacists. At the same time, these directors reported being very much willing to address those few small-scale operational problems they were faced with: they held monthly directorate meetings with doctors and other professionals to foster discussion with colleagues and two-sided information sharing, and frequently mentioned the role of the nurse manager – with whom they held frequent interactions – as a key player in the directorate life. Apart from finance management they described their initial activity as a matter of fostering collaboration to share human or physical resources and clinical governance. Overall, they liked the managerial role, but they felt that their expectations

had been betrayed by the limited scope of their involvement, by limited power they were provided with: 'they pretended to involve us' was one of their comments.

The last two years: fostering the involvement and the emergence of the differences

Interviewees reported how in recent years a substantial change occurred in how their managerial role was supported by the hospital. In the managerial accounting system, some resources were pooled in order to be planned and managed collaboratively by the units under the director's supervision, and directors were asked to take active part in all the budget negotiations of the units. The new top management team asked unit chiefs to talk directly to CDs when organizational problems arose, therefore reinforcing their legitimacy. The council of directors became a monthly meeting, and the discussion of activity and performance data took the first place in its agenda: reports were analysed on a directorate basis, and directors had to openly respond to the CEO for gaps or missed goals, therefore increasing mutual control. Most importantly, the new CEO was openly sharing concerns and thoughts asking for suggestions and comments before taking final decisions.

This new approach had different impacts on CDs' behaviours on the basis of their degree of managerial ability and willingness. Those in the first group were indeed aware of the change: 'now we have to pay attention to the top management, and we are really responsible for the achievement of the directorate financial targets' (CD2), but were maintaining a conservative orientation, not taking possibly unpopular decisions which could compromise the status quo. The approach to managing organizational problems of the other units within their directorate could be described as 'live and let live'. When issues were openly raised, they tried to avoid tackling them directly and rather 'tossed the potato up' to the operations manager or the medical director. During the council of directors meetings, they rarely intervened and did not make proposals with long-term perspectives, or on issues related to the directorate or the hospital as a whole. They were not very interested in dealing with the new opportunities to engage in medical management that the organization was offering, and it was also clear to them that their main focus was the clinical work: 'that is the job I really like, where I really have fun' (CD4).

The second group of CDs, on the contrary, were making use of the new organizational space which had been provided and got involved in hospital-wide thinking on issues such as performance management, cross-directorate collaboration and service reorganization. During the directorate meetings, they were actively interacting with the top management team offering suggestions and proposals, for instance on the strategies to attract patients from abroad or to set up a district hospital network. Some of their comments were, 'Now they know what we think about things' and 'at the beginning the board was only a place to get to know each other, and to discuss problems of clinical quality, now it is different'. These directors greatly appreciated the new course of the events; and at the time of the interviews, they were willing to increase their engagement, to move from consulting to a decision making role and to broaden the scope of their

involvement by contributing to the development of partnerships with local institutions or to fund-raising initiatives. And they complained when the agenda of the council of directors meetings was driven by the discussion of short-term performance data: 'of course short term performance targets are important, but we should not talk only about these things, especially in the council of directors… we should discuss things like internationalisation, research strategies, strategic repositioning in our catchment area, criteria to select unit chiefs' (CD9).

Discussion

CDs' managerial behaviours emerged to be strongly influenced by the interaction between ability, motivation and the opportunity to perform provided by the organization. This situated account from a large Italian hospital shows how the poor engagement of doctors in management is not only a problem of scarce professionals' willingness to engage in management, but by and large it is due to lack of investment in these roles and by the lack of effective support from the top management.

This Italian case study confirms the findings of previous research on doctors in management as CDs, according to which managerial behaviours vary significantly on the basis of the ability of the individual in terms of people management competencies and strategic/entrepreneurial mindset. Also, the motivation to enter in the role, in terms of perceived congruence between professional and managerial values and culture, intention to make a difference and desire to achieve recognition, has a major impact on the dynamics and effectiveness of the role taking. Two types emerged: one of reluctant professionals who entered mainly for defensive reasons and did not want to engage in management; and a second group of enthusiastic doctors willing to take up the new managerial role, yielding similar results to the studies by McKee et al. (1999), and Forbes et al. (2004) and McGivern et al. (2015) on CDs in the NHS.

However, CDs' managerial behaviours were also strongly influenced by the role of the opportunity to perform provided by the organization. The group of doctors who reported interest and willingness to engage in management complained the most about the lack of involvement granted by the former top management team. Therefore, the analysis confirmed the value of the AMO framework to explain the behaviour of doctors in management: as claimed by Peters and O'Connor (1980) performance cannot be improved if the 'ceiling on potential performance' determined by severe constraints is not raised. When provided with greater support and higher degrees of freedom instead, they started performing the intended CD role and made a visible difference in managerial terms. The problems with medical management, therefore, not (only) are a matter of professional resistance but are also to an important extent due to the behaviour of non-medical managers, who resist delegation and involvement of doctors for fear of losing organizational control.

The analysis enabled the identification of two main organizational factors that offer doctors opportunities to perform in the managerial role: firstly, the support provided by the top management in the involvement in decision-making, for example in terms of frequency and content of board meetings, which gives the occasion to openly discuss hospital strategies but also represents a context for positive social control among professionals; secondly, the delegation of organizational power, the endowment with management leverages and effective backing, which strengthen CDs' authority in front of their former colleagues. This support is necessary to overcome the sources of resistance to medical management in the Italian NHS, which are due to a number of factors such as the short top management mandates, the scarce amount and quality of managerial support staff or the historical status and influence of unit chiefs (see Chapter 2). However, it seems plausible that similar dynamics can be found outside of Italy in other European systems, at either the institutional or organizational level. These findings are in line with the research on the models of clinical directorates and their impact on the effectiveness of clinical management. Fitzgerald and Dufour (1998) found that the presence of leadership trios or duos heading CDs, as those that are in place in the United Kingdom or Canada, increase professionals' involvement in management through inter-professional co-operation and mutual support. Hospitals in other countries might learn from these experiences and invest more in the quality of the staff which supports medical managers.

Finally, as stated by previous research on doctors in management, according to which managerial behaviours vary significantly on the basis of personal features, when motivation and ability are low, then performance will also be low, and an increase in the single dimension of opportunity to perform will have limited impact on doctors' managerial behaviours and therefore on the managerial performance. This was confirmed by the first group of directors, who self-reported an initial lack of interest for management and intended their role as a matter of understanding financial management and keeping costs under control. They were content with their role and not calling for greater involvement in management. And when the opportunity to perform a broader managerial activity was provided, to engage in more strategic, long-term and outward-oriented initiatives, they did not exploit it.

Limitations and conclusion

The research has limitations linked to the nature of the methods used. The case study methodology proved to be particularly effective in offering an in-depth understanding of political dynamics taking place in the hospital organizational context; however, the analysis has an explorative nature and uses cross-sectional information from a single organization. Therefore, future research could make use of multiple and/or longitudinal case studies.

Research on doctors in management has looked for the reasons of professionals' (un)willingness or (in)capacity to engage in management by exploring either the individual responses to the professional–managerial dilemma or by understanding how professionals can acquire and preserve the legitimacy to lead their peers. However, the time has probably come to look at the complex organizational settings in which these processes take place. The chapter, by bridging the literature on medical management hybrids with contributions from theories on the impact of the organizational context on individual performance, has shown how the different organizational support, which (non medical) managers offered to CDs, over time played a major role in determining the different managerial performance of those highly motivated and capable individuals.

Implications for policymaking and managerial practice are numerous. Firstly, if health policymakers in Western countries really want to increase professionals' involvement in management they should probably address top managers more than doctors. Secondly, if top managers are determined to assign CDs a strategic mandate, they should not fear to delegate and involve them in resource management and decision-making. Thirdly, organizational support to CDs' managerial role taking should be targeted to the needs of individuals: one size does not fit all. For the support to be effective in developing hybrid roles such as doctors-in-management, the amount and nature of training, involvement in decision-making and delegation of responsibilities should match the capacities and willingness of the different professionals. Accordingly, it is necessary to identify and understand the differences between a variety of forms of medical management, unveiling the multiple facets of a concept which, as argued by Glouberman and Mintzberg (2001: 57), 'is not one homogeneous process but several, usually quite distinct from one another'.

Appendix: A methodological comment

As anticipated the interviews were framed by a number of core question areas, which were aimed at understanding the role of the organizational context in the hybridization process and its interaction with individual factors. I asked about the reasons for moving into management and attitudes towards the new job, thanks to questions like "Why did you apply for the job?"; "Did your attitude toward the role change over time and as a consequence of what?"; "Are there aspects of your management job you find aligned / in contrast with your professional culture?"; "What are your future career intentions?"; "What are the greatest difficulties and the key challenges you encounter in your job? How do you deal with them?". Furthermore, I asked questions related to the relationship with others and the support received from the organization.

Observations were guided by theoretical frames of reference but, as anticipated, the existing healthcare and organizational studies literature did not offer much guidance on our understanding of role the organizational context in hybridization processes. However, while analysing empirical data I found that the conceptual tools provided by the AMO model were appropriate to make sense of the factors influencing the hybridization process, either motivations or competencies, and the organizational factors supporting/hampering it. Therefore, this HR model was used to guide the analysis and to frame the patterns emerging from data. Individual antecedents of the hybridization processes were grouped in motivational and competency-based factors, while the concept of opportunity to perform and support (or lack of opportunity and support) proved effective in explaining empirical data regarding hybrids' relationship with the organizational environment.

CHAPTER IV: INTERACTIVE IDENTITY WORK OF PROFESSIONALS IN MANAGEMENT: A HOSPITAL CASE STUDY

A paper based on a revised version of this chapter and co-authored with prof. Graeme Currie and prof. Mirko Noordegraaf has been accepted for publication in Public Management Review.

Abstract

Throughout the Western world, hybrid professional managers are expected to act as conduits for the introduction of management into public professional settings, but they appear less effective than policymakers and executives hope. To date, research has offered little understanding of professionals' identity transition challenge and the role of social interactions underpinning the hybridisation process. This chapter studies the identity work of hybrid doctors inside a large public healthcare organization, finding that it takes place through processes of *familiarising* with management, *rationalising* being a hybrid, and *legitimising* the new role-identity, which are enabled by organizational actors beyond the professional group. It contributes to the literature on the evolution of professional identities in organizations, by showing that identity work is distributed and supported by social interactions. Implications for policymakers and executives willing to consciously organize managerial role-taking are discussed.

Introduction

Understanding the evolutions of professionalism is one of the challenges for public management research and practice. Traditionally professionalism values autonomy and self-regulation, as well as institutionalised work routines, norms and values which are necessary to apply to complex real problems a body of knowledge acquired through higher education (Abbott, 1988; Freidson, 2001). However, public sector reforms introducing managerial supervision and budgetary control in of professional organizations, have put professionals under pressure calling for an evolution of the meaning of professionalism and the identity of individual professionals (Brock et al., 1999; De Bruijn, 2010; Noordegraaf and Steijn, 2013; Noordegraaf, 2015). This is especially true in the public sector of most Western countries, which on one hand underwent major budget cuts and cost containments, and on the other experienced an evolution of citizens' expectations in terms of quality and timing of services, accountability and performance disclosure, both requiring a change of professional work practices (Harrison and Pollit, 1994; Kirkpatrick et al., 2005). The development of hybrid roles is an important strategy that has been developed in these countries as a solution to 'bridge the gap' between professionalism and management (Kirkpatrick et al., 2005) Understanding the process of hybridisation is relevant as the involvement of professionals in management has not often yielded the expected results. Behaviours such as resistance towards, reluctance towards or circumvention of hybrid managerial roles are commonly reported, and effective professional-managerial hybridisation has not always been achieved (Numerato et al., 2011; Waring and Currie, 2009; Correia and Denis, 2016). As recent scholarship has shown, the effective enactment of hybrid roles is not only an issue of performing managerial actions and behaviours, but rather an issue (or problem) of inner values and identity (e.g. Doolin, 2002; McGivern et al., 2015; Croft et al., 2015; Reay et al., 2017). Therefore it is highly relevant, for both policymakers and executives in public organizations, to understand the process which underlies hybridisation, and the facilitators and constraints which may affect it, so that appropriate development and support can be provided for those individuals moving into managerial roles.

Existing research has greatly contributed to our knowledge of hybrids in the public sector (e.g. Byrkjeflot and Kragh Jespersen, 2014; Kirkpatrick and Noordegraaf, 2015; Schott et al., 2016). Yet, we still characterise most of the literature examining hybrid professional managers as based on a dualistic understanding where managerialism and professionalism are in conflict, and as telling us much about the problems associated with the implementation of hybrid roles. Yet, it offers little understanding of how the *process* of role-identity transition takes place and how this is or might be supported in organizational contexts (McGivern et al., 2015). In particular, research has looked at the role of interdependencies of hybrids within the professional community, which is important because professional legitimacy is necessary for hybrids to lead colleagues as "primus inter pares" (Llewellyn, 2001). However, we know relatively little about the

interaction of hybrids with other key organizational actors, when identities are (re)construed.

We address these gaps by examining how hybrid medical managers construe their managerial/professional selves through identity work, which has been defined as that "process by which people strive to shape relatively coherent and distinctive notions of their selves" (Brown and Toyoki 2013, 876). Our central research question, thus, is: *How does hospital medical managers' hybridization evolve and how are transitions enabled by social interactions in a wider organizational context?*

In this paper we use a case study as a basis for extending theory (Eisenhardt, 1989). We focus on the role-identity transition of clinical directors, i.e. doctors in charge of multiple clinical specialties, who are given managerial responsibilities, in a large Dutch public university medical centre. The paper identifies the micro-processes which take place in the construction of identities of hybrids, which make possible the evolution and reconfiguration of professionalism. We show how interactions with social actors play out in these processes, so that professionals' identity work is not so much the result of individual efforts, but rather is distributed.

The paper is organized as follows. We firstly provide a brief overview of the literature of hybrid professional managers, and the present theory on identity work, which we draw upon to study the dynamics of hybridization. Then we explain our focus on clinical directors and then describe the qualitative research methods used to collect and analyse empirical data. Next we illustrate our findings and discuss theoretical and practical implications for public management.

The challenge of bringing together professionalism and management

The evolution of professionalism and the blurring of professional and managerial domains is a lively area of organizational research, especially within the public administration field. Public sector reforms are continuously challenging existing professional boundaries, work practices, hierarchies and coordination mechanisms, values and identities of professionals at the collective and individual level (Noordegraaf, 2015). This was experienced in a number of public sector environments, including universities (Deem et al., 2007; Telkeen, 2015), education (Nordegraaf and De Wit, 2012) and, especially, healthcare (e.g. Forbes et al., 2004; Witman et al., 2011; Schott et al., 2016).

A first line of research has emphasised dualism and opposition between professionalism and management. With reference to healthcare, it has been shown how giving managerial responsibilities to medical professionals can increase their power, making it more difficult for government and executive management to challenge their work behaviours (Hunter, 1992). In some cases, doctors appointed to a management role openly resisted their new role and its strategic expectations, as they saw management and professionalism as incompatible (Griffiths and Hughes, 2000; Degeling et al., 2006). Such resistance has been open or, more often, subtle. And professionals selectively and

externally conformed to managerial practices, but without doing so substantially (Kitchener 2002). Rather than co-opted into managerial practice, they have been characterised as co-opting management to pursue self-interest (Waring and Currie, 2009). In these cases, doctors in management, meant to be a solution for effectively running healthcare in the New Public Management era (e.g. Ferlie et al., 1996), turned out to be a problem necessary of management, rather than a solution.

At the same time, research has increasingly reported multiple instances of professionals developing new and hybrid identities through the capacity to negotiate and merge professional and organizational/managerial cultures (e.g. Kurunmaki, 2004; Denis et al., 2015; Kirkpatrick and Noordegraaf, 2015; Schott et al., 2016). In that way, they develop a dual commitment to both the profession and the organization (Hoff 2001). Hybrids have the capacity to overcome the clash between pure professionalism and market based principles by developing new blended roles, routines and ways of working.

However, although most literature tells us much about the responses associated with hybrid roles, it offers little understanding of the dynamics of identity transition and their determinants. As argued by Denis, Ferlie, and Van Gestel (2015: 285), research needs to look beyond hybrids' response strategies and study "the agency and social interaction processes that shape these responses and consequently explore the hybridisation *process* in various public sectors". With a few notable exceptions (e.g. Pratt et al., 2006; Bevort and Suddaby, 2016) most authors study hybridisation as one among professionals' responses to complex institutional environments, but do not open the box of hybrid identity construction (Numerato et al., 2011).

Further, authors like Llewellyn (2001) or Witman et al. (2011) looked at the social dynamics taking place in the professional community, showing how managerial role-taking is facilitated when the hybrid has, and maintains, legitimacy within their group of peers. However, in these studies, hybridisation has been intended relatively independently of the broader social organizational order, and in particular has overlooked the relations with other key organizational actors, such as other professions and non-medical managers. Authors like Pratt et al. (2006) and McGivern et al. (2015) suggest antecedents of identity transition, but offer little evidence regarding this, relegating the importance of interaction between professionals and others to the background (Reay et al., 2017). Therefore in-depth qualitative research, bridging policy, management and organization studies (Currie et al., 2012) is needed to provide insight into this transition.

We claim this is a promising area for public management theory and practice, and it is subject to continuous evolution. Recent research on new hybrid forms (Postma et al., 2014; Martin et al., 2015; Noordegraaf, 2015) has underlined how environmental pressures and the evolution of professional work practices are determining the surge of hybrid forms that go beyond the mere blending or intertwining of competing logics. Rather, organizational values are becoming an intricate part of professional values, and organizing becomes embedded within professional action. At a system level, this is envisioned as the way for a rebirth of professionalism, not despite the power of

organizational logics and values but rather through constructive interaction with them (Martin et al., 2015). However, there is seminal evidence that reconfiguration of professionalism requires the redefinition and re-working of professionals' identities. As found for instance by McGivern et al. (2015) "disrupting traditional professionalism as outdated and unrealistic, [and] reconceptualizing professionalism in terms of delivering the best care for patients collectively" is possible through individual hybrids' identity work, and it is necessary to move from the macro to the individual level of analysis to fully understand the mechanisms through which macro changes unfold (Bevort and Suddaby, 2016). Building on this literature, within our work we study a situated account in which hybrids (re)work their identities while being exposed to a highly complex institutional environment, and surrounded by individuals that have potentially conflicting agendas and expectations. Previous research has reported on the role of individual agency and interaction in the construction of identities of professionals within a community of peers (e.g. Pratt et al., 2006; Bevort and Suddaby, 2016), we study if and how social actors beyond the professional group influence this process.

Constructing hybrid identities through identity work

Institutional theory offers a powerful perspective to study the processes that take place in complex professional service organizations including modern hospitals (e.g. Greenwood et al., 2011; Lockett et al., 2012). Professionals have been described as powerful 'institutional agents' (Scott 2008), and hybrids, who are exposed to the contradictions of medicine and management, are in a social position to engage in the continuous reshaping of existing institutions and in the creation of new ones.

In particular, we examine hybrids' *identity work* as a form of institutional work. The notion of institutional work underlines the role of actors continuously engaged in creating, maintain and disrupting institutions (Lawrence et al., 2013). Identity work is that form of institutional work which takes place through the creation or transformation of established identities (Lawrence and Suddaby, 2006). Identity work is manifold as it involves the "forming, repairing, maintaining, strengthening or revising" of the components of the self (Sveningsson and Alvesson, 2003: 1165). Such work has both an internal and external dimension, since new identities are established when an external and socially prescribed role becomes internalised (Leung et al., 2014). Identity work has increasingly been considered an important form of institutional work (McGivern et al., 2015), as the taken-for-grantedness of values and practices is strongly affected by the construction of identities.

The identity perspective on hybridity is highly relevant to study how professionals in complex public organizations deal with managerial role-taking, as it provides a richer understanding of the consequences, for groups and individuals, of macro- and meso-level interventions in the public sector (Denis et al., 2015). Thanks to this approach it is possible to identify the dynamics which make professionals capable to solve the apparent contradictions of professionalism and management and eventually become

capable to embed management and organizing within professional action (Noordegraaf et al., 2015; Noordegraaf, 2015).

The concept of identity work is useful in understanding professionals' identity transition as it emphasises the dynamics of identity construction and its intrinsically processual nature, as well as the fact that identity construction is "more interactive and more problematic than the relatively straightforward adoption of a role or category" (Pratt et al., 2006: 237). By bridging institutional theory and identity theory it provides the theoretical tools to understand how social groups and other individuals actively interact with individual agency in shaping or maintenance of identities (Bevort and Suddaby, 2016). However, the latter remains a promising area for future studies, and Leung and colleagues (2014) have made a call for research on *how* enabling collectives allow individuals to conduct identity work.

Research on individual professionals' identity development has largely focused on the process of construction of professional selves as part of natural career transitions, and if it has analysed the role of interactions in this process has done so by looking at those taking place within the professional group. Ibarra (1999) studies how professionals understand how to evolve to more senior roles by observing role models and experimenting provisional selves. While Pratt et al. (2006) study how young professionals in training take on their professional group identity, showing how this is a dynamic process encompassing identity customization, performed to solve the mismatch between personal identity and actual work demands, and social validation within the professional group. They find that interactions with senior colleagues and peers are relevant in the social validation of professional identity changes. Similar findings regarding how interaction enables professionals' role change through exposure to different perspectives and social validation of the new identity are reported by Chreim et al. (2007). Creed et al. (2010) provide a rich analysis of the processes through which professional actors trigger institutional change through identity work. However, they study the heroic agency of marginalized professionals acting individually against the professional group and its institutions.

Therefore, in most cases scholarship has studied the role of professional peers as enabling collectives in the identity development process. However, the relations of professionals with diverse social actors in the development of *hybrid* individual identities has remained vastly on the background. In particular, we lack a clear understanding of how professionals working in complex institutional environments - where they interact with actors embodying apparently conflicting logics - perform identity work and develop hybrid identities. McGivern et al. (2015) do explore the processes of hybrid identity construction in this kind of settings, i.e. medical managers in modern healthcare organizations. – They show that while "incidental hybrids" maintain and protect their traditional identity, professionals willing to take up hybrid roles are capable to reconstruct their professional identity . However, although acknowledging the formative work related to action of mentors or role models, their analysis provides limited evidence regarding the relational dimensions of identity processes, and

empirically studies hybrids but does not explore the social contexts where the processes of identity change take place. To our knowledge, the only study which has directly tackled the topic is the recent work by Reay and colleagues (2017), showing how open and/or private relational spaces facilitate social interaction across the stages of *collective* hybrids' identity construction. Within our work we study a situated account in which hybrids, exposed to multiple and heterogeneous interactions beyond their professional group, dynamically construct their *individual* identity through identity work. We do this by studying hybrid medical managers, i.e. professionals appointed to managerial roles. And we study medical hybrids working in hospitals, complex institutional environments where traditional professionalism is challenged by new managerial values and practices embodied by a number of diverse organizational actors surrounding hybrid professionals.

Case selection: clinical directors

We focus on clinical directors as a relevant example of hybrid professional managers. Pioneered at John Hopkins Hospital in the 1970s, these roles dispersed in North America and then in the National Health Service of the United Kingdom (Chantler, 1993; Kitchener, 2000). The UK example was followed by Australia and multiple countries in continental Europe, including: The Netherlands, Norway, Denmark, Italy and France (Neogy and Kirkpatrick, 2009), where clinical directorates (labelled divisions, departments, *poles de gestion*, etc.) were introduced. Clinical directors' hybrid role should give them the opportunity to effectively perform activities in between management and professionalism, such as the promotion of clinical governance, the development of multi-disciplinary and inter-professional collaboration, the achievement of cost savings, but without compromising the quality of care (Braithwaite et al., 2005). Furthermore, clinical directors are also in between hospital top management and front line managers, and they can contribute to the implementation of organizational policies and to the reduction of the disciplinary fragmentation typical of professional organizations.

However, while these results were achieved in a number of instances, in many other cases clinical directors were unwilling or incapable to take up managerial roles (Waring and Currie, 2009; Croft et al., 2015; Correia and Denis, 2016). Other times they were not supported by non-medical managers or by pre-existing medical manager roles, as shown in Chapter 2. For these reasons policymakers and hospital executives, called to foster the implementation of the management reforms at the organizational level, have faced a dilemma. It might be too demanding for executives in terms of investments of time and resources to support re-alignment of medical responsibilities. Under what conditions it is worthwhile to promote clinical directors, by involving them in strategy making, delegating responsibilities and supporting the development of managerial skills?

The identity transition of clinical directors is therefore a challenge for professionals, but also for policymakers and executives. It is important to have a deep understanding of process of managerial role-taking, and the *conditions* which underpin it, in particular the

role played by social interactions, especially between clinical directors and other organizational actors. In the following paragraphs, after illustrating our research approach and methods, we present the three micro-processes of identity construction we found in clinical directors' hybridization, and how interactions with managers, nurses and external staff supported it.

Research design and methods

We conducted a case study in a large university public hospital with the aim to extend theory (Eisenhardt, 1989; Yin, 2009). The use of a multiple sources of evidence, and in depth analysis of our case, was suitable for the goal of understanding the organizational interactions and the complex dynamics taking place in a hospital. Furthermore, the same methodology had been successfully used by previous studies on hybrid roles of professionals in management in healthcare (e.g. Kitchener, 2000; Forbeset al., 2004; Witman et al., 2011). We gathered our data through the selection of doctors in management and respondents of different professional groups, namely administrators and nurses, and at different management levels. We based our understanding and interpretation of identity work around interactive processes, inducing from data and the frames of understanding presented by the respondents themselves. We recursively cycled among data and emerging theory in order to build our theoretical framework.

Study context

The hospital is located in the Netherlands, thus empirically extending geographical coverage of studies of hybrid medical management roles, mostly developed in Anglo-American contexts (Numerato et al., 2011). From the 1980s, as a consequence of the introduction of hospital budgeting systems, in the Netherlands there was a progressive increase in management participation in strategic management and decision-making power (Kuhlmann et al., 2013; Kroneman et al., 2016). Thanks to reforms in the last 15 years executive boards were introduced, including representatives of clinical specialties, with overall strategic responsibilities. This particularly the case in Teaching Hospitals, or University Medical Centers, were doctors are salaried and not self-employed, as it happens in non-teaching hospitals.

The hospital we studied has an integrated structure, bringing together service delivery through a teaching hospital, and research and education, through a medical faculty, both governed by one board of directors. It is organized in ten clinical divisions, headed by a clinical director, who is a professor of a specialty and was selected among department heads. Each clinical director is part of a division management team, composed of a medical manager (the clinical director), a care manager (most often a nurse), a financial manager and a research manager, which together report to one of the hospital board members. Management team members are formally on the same hierarchical level, with the medical manager acting as the chair of the team.

The hospital introduced the clinical directorate (division) organizational structure in the early '90s. Divisions were delegated decision making over strategy, organization and human resource management, and the formerly unified corporate staff body was largely decentralised. This push toward divisions' autonomy, together with their size both in terms of turnover and personnel, required significant involvement of clinical directors' in management, and it is what makes the hospital a representative case (Yin, 2009) suitable to study the processes of hybridisation of (medical) professionals in managerialised public service organizations.

Data collection, analysis and interpretation

We obtained access to the site thanks to a research partnership established between the hospital and the university employing two of the authors. Data was collected in 2012 through semi-structured interviews and document analysis. The first interviewees were clinical directors identified by the partnership contact point, a clinical director herself, with the aim to let us interview both successful and less successful hybrids. Subsequently the selection of respondents took place through purposeful sampling based on the progressive analysis of data. For instance we interviewed respondents that were openly referred to as relevant actors, as in the case of the former hospital CEO or the former director of one of the divisions.

We conducted a total of 29 interviews with a multi-actor and multi-level approach (Table 4.1). They included seven representatives from the executive management team and the hospital central HR staff, including two former clinical directors who moved to full time management jobs; 15 members of the division management teams, among which were 7 clinical directors, with an average of 4.5 years in the position; and seven frontline managers. About one third of interviewees were women, and respondents represented 9 out 11 divisions (the two missing divisions were non clinical ones, providing diagnostic services or research). Interviews were conducted with guarantees of anonymity, they lasted 40-70 minutes, were recorded and transcribed, accounting for about 500 pages of transcripts. They were complemented by notes taken during the course, and at the end, of each interview in order to capture the interviewer's feelings and impressions. Interviews were conducted on site and by a single researcher, which reduced variability in data collection.

Table 4.1: Profile of the respondents by role and professional background

	Doctors	**Nurses**	**Administrators**
Executive management and HR	2		5
Division management team	7	3	5
Frontline management	5	2	
	14	5	10

One interview protocol was used for clinical directors, which was structured in three parts: (a) content of clinical directors' work; (b) how they experienced being a professional in management; (c) which factors affected the managerial role-taking (see also the Appendix). For the other respondents, a different and more open protocol was used, as they were asked to report their experience with (a) clinical directors' roles, (b) the nature of the interactions they had with them, and (c) the evolution of both. The interviewees told us about the different occasions, including formal and informal meetings and interactions, in which discussions took place regarding clinical directors' bridging of professionalism and management. To increase credibility of data, we encouraged interviewees to provide illustrations and concrete examples, and this also contributed to our confidence in understanding the trustworthiness of respondents' statements (Weiss, 1994). As data gathering and analysis were intertwined, the emerging themes served as the basis for focusing and fine-tuning the questions. The interviews were complemented by the analysis of divisional organizational charts and respondents' resumes.

Data were first analysed through close reading of the transcripts. Coding was then performed by one of the authors with the support of Atlas.ti software. The process took place in multiple waves. We developed a first order analysis of all transcripts, using in vivo coding (Strauss and Corbin 1998) whenever possible to give voice to informants' own words and to the concepts they used to describe and make sense of personal experiences. We then went back and forth from data, emerging theory and literature, as we looked for patterns and idiosyncrasies across respondents, in particular comparing the answers provided by clinical directors with those given by other informants. Through this process we identified our emerging themes and tested their appropriateness (Braun and Clarke, 2006; Saldana, 2012). While performing the analysis we saw that identity was emerging as a key issue and chose to make use of the concept of identity work in order to understand the process of hybridisation. We then collapsed related themes into broader explanatory categories, which allowed us to make sense of the data and achieve increasing levels of theoretical abstraction. On the basis of our empirical data, we identified three micro-processes of identity construction and how interactions played out in such processes. We refer to them as: *familiarising oneself with management*; *rationalising being a hybrid;* and *legitimising the new role-identity.* For instance narratives related to professionals' attempts at seeing the division wellbeing as a whole were associated the theme "bringing the focus away from one's own specialty". This theme, together with "experiencing issues at a higher level" were consolidated in the category "familiarising with management". While passages in which interviewees referred to the discovery and development of new competencies were associated with "elaborating a new self-description". This theme, with "giving meaning to management" was condensed in the category "rationalising being a hybrid". At the same time, we identified the interaction mechanisms which accompanied each of the three micro-processes, enabling and supporting identity change through: *developing managerial capacity*; *role modelling and coaching*; *increasing space for action*. This process of analytic generalisation (Yin 2009) led to the conceptual framework presented in this paper.

Findings

In the following paragraph we illustrate our findings on hybrids' identity change, presenting the three micro-processes of identity construction and how social interactions with key organizational actors like managers, nurses and external staff were associated with them. Of course professionals varied in their degree of hybridization and some social actors were more engaged than others in supporting professionals' identity transition. However, except for the one case described below, all clinical directors reported significant changes in their professional identities.

Familiarising oneself with management

A first way in which doctors worked on their identity was through the connection and reconciliation of medical and managerial activities. This happened when clinical directors, some months after their appointment, started changing the daily way of working and experiencing issues at a higher level:

> "There is much more pressure, because you have always to be sharp, you have always to be there, you have always to read everything […] is a big big difference, it is much broader, it is much more interconnected. And I have direct contact with the board of directors, almost every day" (#26, Clinical Director).

Clinical directors enjoyed increased knowledge and confidence from practicing managerial tasks, and this reduced their resistance apparent when first appointed, allowing the building of local bridges between the worlds of medicine and management in areas like inter-professional collaboration and division-wide strategy making.

This process occurred through the continuous interactions with the members of the division management team, as these exchanges helped professionals in understanding management and in seeing the complementarities between their clinical and the managerial work. For instance, care managers (nurses) helped doctors to better understand how to deal with patient centred pathways and to work together with non-medical professionals. Meanwhile, discussions with the finance managers represented occasions for hybrid medical managers to gain a deeper understanding of reporting instruments, reimbursement mechanisms, ICT innovations. Therefore, interactions represented an occasion for developing managerial capacity with doctors learning the "what" and "how" of managerial practices. Both formal team meetings, and informal interactions, such as morning conversations around the coffee machine, represented other arenas through which hybrid medical managers familiarised themselves with the new management role:

> "You get a lot of input. Basically I can tell you that 90 per cent of what I learned from managing the department I learned from the other managers. I just ask a lot and I basically copy-paste what I like from others [...] Also when, for instance, I have a very complicated discussion [...] I ask one of the other managers to join me in that discussion, and then after that I ask feedback: what would you say, how would you do that?". (#17, Clinical Director)

The provision of this type of feedback was key for hybrid medical managers to reflectively identify effective (and ineffective) managerial practices and styles. During the management team meetings, clinical directors were commonly asked to address managerial issues, whose scope was far beyond the level of their expertise gleaned from longstanding clinical activity. As a consequence they gained an opportunity to derive a broader strategic picture of the organization. So they progressively abandoned short term, tactical and specialty oriented approaches to management, which might have come from a position as heads of one of the clinical units. This was helped significantly by the open climate in which strategic choices were discussed within the divisional management team, with specific reference to investments, resource allocation and business development opportunities. The practice of disclosing these decisions transparently within and across the organization not only prevented the emergence of opportunistic behaviours around self-interest, but also forced a progressive shift in the mindset and behaviours of many medical managers:

> "Being very transparent, sharing all information related to budgets, changes in budgets, deficits, problems with budgets, everything was shared in the division […] there was no secrecy" (#16, Executive Manager, former Clinical Director)

Feedback provision supported the strategic enactment of the managerial role for clinical directors and the progressive reconciliation of medicine and management. Sometimes the process was rather smooth, in other cases it involved open discussions:

> "We had some very big discussions [...] he also had some serious talks with the chief of our board of directors [...] and that helped […]. So now a year passed by, and we are happily surprised, my colleague and I, about the way he developed himself" (#24, Nurse Manager).

Rationalising being a hybrid

A further component of the process of hybridisation was doctors' internalisation and self-reflection over the evolution of their professional identity. This allowed them to progressively elaborate new convincing self-descriptions, and to avoid seeing the internal divide between medicine and management as an insuperable obstacle.

> "I think my strengths are inspiration and motivation [...] I can inspire and motivate people to do it like that and I'm very result-driven [...] a lot of people are good doctors and in my opinion there were a lot of people who were as good as researchers as I was I am especially good in the things I told you [listening to people and reorganizing things] […] and if you do that well, it's fun and you get recognition for it." (#20, Clinical director)

Such rationalisation of potential conflicting identities helped in assimilating what medical management was, and what was not, and which were its immediate and ultimate goals. Those doctors who had performed a deeper reconstruction of their professional self were those who referred prospectively at their managerial and professional career, locating their efforts in changing their identity within a longer term frame of personal development.

> "The question is, why do you want to be a manager, because you want to have more power, or […][because] you are looking for an answer on the question 'how can I improve patient care'?" (#22, Frontline medical manager)

Medical managers started understanding management as "being in a position where we connect things" or "combining the interests of people and bringing that together", or:

> "Keeping everybody on board, because [...] everybody has his own way of thinking about things and you all have to bring that together. So mainly it's doing that, working on strategic issues, trying to get everybody on board." (#26, Clinical Director)

This was helped by a growing shared understanding that the way professional their work was carried out needed to change because society outside was calling for that:

> "This is not changing the culture because I want to, but because we have to, society is changing, the chances are changing, our hospital nowadays is not the same as 10 or 20 years ago […] what we regard a top professional these days is not the same as what one regarded a top professional 20 years ago". (#17, Clinical Director)

We heard about different types of interactions associated with this evolution, always in one-on-one settings. Most medical managers reported the importance of having other people who helped to deal with the identity struggles of the new situation they faced in their managerial role. For instance some mentioned conversations with executive managers, especially those who had been practicing doctors and had experienced similar challenges in the course of their career. One doctor found it particularly useful to have periodical talks with the former head of the division, who was a respected clinician:

> "What worked well for me, is to get feedback from people I respect [...] I have some people who either had my position before and are now retired - one of the divisional heads is a personal friend - and now I ask him sometimes: what would you do?" (#26, Clinical director)

Interactions also provided the space and time for deepening the reflection on professional/managerial values and identity transition. For instance, some clinical directors benefited from discussions with external professional coaches to reflect upon enactment of the hybrid managerial role:

> "I had this coach and this coach told me, after half a year, I should go away for a week. Stop working, go home, think [laughs], and that's what I did [...] Because before that time you just work, work, work and run around like an idiot, and you don't see anything anymore. That was very helpful." (#6, Clinical director)

Legitimising the role-identity

From previous research we already know that, in order to become a hybrid in a professional organization like a hospital, it is necessary to be recognised by peers, to have and maintain a high level of professional legitimacy (Llewellyn, 2001), and this was the case also in the hospital we studied:

> "[The Clinical director] makes clear that he knows what goes on, so he is a professional, [although] not involved in actual patient care. It's just the fact that he is known to be interested and involved in the way people deliver the care […] that gives him an enormous credit." (#10, Frontline medical manager)

Yet, within our study, another key element in the construction of the new identity turned out to be the progressive development of *organizational* legitimacy, or social acceptability outside the clinical domain. This involved making the new managerial side of these professionals visible and acknowledgeable, openly showing the sensibility and the added value of the new hybrid profile across the organization, providing and reinforcing the status of medical managers, as key for hybridisation. This activity consisted in the effort to obtain the respect and the resources associated to the Clinical Director role. As a position not yet fully recognised within the professional community, it was not endowed with social and cultural capital, and therefore doctors in management strived to accumulate these resources.

> "You have to be respected and people have to recognise that you have influence [...] A lot of people are very much respected, because they are the top in research, or the top clinical doctor [...] I'm top in fixing things and innovating the whole process of doing our job here […]: that's respected. I don't say I'm the best specialist or the best researcher here. I don't seek for respect on that". (#20, Clinical Director)

> "In my time - but I am not so old - you were regarded a top doctor if you published in a huge impact journal […] Basically what I am trying to do is getting some of the respect that people gave to top scientists […] distributing the admiration a little bit better". (#17, Clinical Director)

This process occurred through the interaction with actors others than specialist professional peers, in particular executive managers, who supported and enabled the legitimisation process. The first months after appointment were reported as particularly critical for some medical hybrid managers, even more when newly appointed clinical directors were not the "obvious" candidates with high seniority, but younger and talented professionals; i.e. not necessarily 'first amongst equals', as in the following case:

> "At the beginning people were looking like, you know, is he a top professional? [...] This was very recognisable. Of course we discussed that and we said: ok, we can imagine there are better professionals, but we're also looking for someone who can be a manager, someone who is really able to take the problems at a higher level". (#16, Executive Manager)

Openly backing clinical directors' most delicate decisions, which might, for example, adversely impact their specialist clinical peers, proved crucial to legitimise their role.

> "If then the Board doesn't support you for 100 per cent you're not going to be successful. They have to back you up with the difficult decisions and they have to go all the way in supporting you with these difficult decisions. And in the implementation of the decisions." (#14, Clinical Director).

On the contrary, when support and "space" for action was not guaranteed – as it had happened in the past, with executive managers bypassing clinical directors in order to solve problems - hybrids' capacity to enact their role was deeply compromised.

> "From the old days and from the old professors, there was still a way, a bypass, I mean: the chief of [surgical specialty x], if he had a complaint about not getting enough theatre time, he just went straight ahead to the chairman of the board and said: listen guys, I am a famous professor and I want this and that." (#2, Executive Manager)

In particular, for those clinical directors who needed a drastic reduction of involvement in clinical practice so they could enact their hybrid managerial role, their legitimacy was buttressed through appointment to positions which provided high professional visibility within the hospital and outside; e.g. appointment as director of medical students' training or as member of an important national committee.

In-between identity transformation and maintenance

The familiarisation with management tasks, the personal rationalisation upon enacting the new role and the development of organizational legitimacy represented three micro-processes for construction of the new hybrid identity, which moved hybrid medical managers beyond a reluctant stance. These individuals experienced an evolution of the self towards a hybrid professional-managerial identity that, although at different degrees, was rather stable and meaningful.

However, we should not assume this was always the case. For one doctor we interviewed, the work of maintenance of the pre-existing identity clearly prevailed. He entered the role reluctantly and was not able to reconcile the two identities, always referring to his identity retrospectively, talking about his professional original blueprint. Even after years of involvement in management, he had not internalised the strategic demands of the hybrid medical manager role: the mismatch between the managerial role and the personal identity remained. Since he had been offered the same type of support provided to other doctors in management, this different outcome was arguably due to rooted personal traits and values. He was incapable to deeply engage in management, irrespectively to the influences of the social environment. And he had firmly decided that he would have stepped back to the profession after a limited number of years as clinical director.

> "I am a little bit different than most of the other clinical directors, in the sense that I have always retained a lot of clinical activity [...] I think in being a little bit more managerial, you can take care of patients too, only on a more abstract level. But my inspiration is taking care of patients and doing good patient care, my inspiration is not being a manager or being an administrator [...]. I don't think you should do that your whole life [...] then you become an administrator, but you're not truly a doctor anymore". (#4, Clinical Director)

Although this was the only reluctant clinical director we interviewed, this attitude was not considered not an isolated case within the group of unit chiefs at the hospital. Many professionals were indeed not motivated to take up a relevant management role.

> "[In] management I tried to my best, but it's not my talent, it will not give me energy and it will never be my attitude […]I think there's quite a reluctance to go into management despite the fact that there are financial gains. There's more reluctance than a trend to do it." (#10, Frontline medical manager)

> "It's not a job many people would like to have, so there's not much about a fight. Because for many people it's not what they choose for when they started to be a doctor." (#22, Frontline medical manager)

Accordingly, training opportunities and careful selection processes – comprising interviews and assessment sessions – are in place at the hospital in order to identify those candidates with the willingness and potential to become medical managers:

> "This is a difficult model. How do you find them? I said: we have about 130 professors here, we have about 600 medical professionals, the country has 6000 academic medical professionals, I only have to find 11, that must be possible". (#2, Executive Manager)

Discussion

Our aim was to understand how hospital medical managers' hybridization evolves and how transitions are enabled by social interactions in a wider organizational context. Drawing from a healthcare context we investigated the interactive construction of identities of professionals in management in an organizational environment. We found that hybrids' identity construction is a dynamic and articulated process, which takes place in different ways and does not stand in isolation but rather is institutionally sensitive and is made possible by social interactions. The three micro-processes through which hybrid identity is shaped are:
(1) Familiarising: acquiring practical knowledge to fill the (apparent) gap between professional and managerial practices;

(2) Rationalising: increasing the awareness of the changing identity, elaborating new meanings given to the professional self;

(3) Legitimising: developing social and cultural capital enabling hybrids to be authoritative and credible in the role.

Medical professionals we interviewed changed their way of daily working by bringing focus away from their own specialty and experiencing an interconnected activity and decision making at a higher level. Then they made sense of managerial practices in a way compatible with patients' demands and other traditional professional motivations, such as visibility, innovation and research, therefore "storying" their identity transition in a

personally meaningful and convincing way. Further, they obtained validation within the organizational context thanks to work of legitimisation, encompassing the achievement of influence, credibility and respect within the professional group. The hybridisation process was not intended as the unnatural juxtaposition of two clashing sets of practices and values, but rather as a sensible – although not always easy – evolution of traditional professionalism. When such work is performed these professionals can learn to *be* hybrids rather than just *do* management reluctantly (McGivern et al., 2015).

The three micro-processes have a strong relational dimension, and they were associated with different dynamics of interaction with key organizational actors (see Table 4.1). We found that familiarisation with management was especially accompanied by learning through feedback exchange and observation of co-workers, while the rationalisation of the new identity was supported by private interactions with role models and mentors, capable to touch the most inner dimensions of self. Finally, the legitimising process was enabled by the back/up and support provided within the organization. Interaction therefore favours professionals' identity work by supporting their capacity and willingness, as well as by providing sources of legitimacy. In our hospital case the actors that played a key role in these processes were non-medical managers with different professional backgrounds, senior medical management or external coaches, and hospital executives. Therefore, it emerged that the construction of new identities is affected not only by individual traits, but it is more fundamentally influenced by relations and surroundings. In Table 4.2 we summarize the three identity process, the specific social interactions that facilitated these processes, and the mechanisms that affected identity formation and change.

Table 4.2: Hybrids' identity processes and social interactions

Identity process	**Social interaction**	**Mechanism**
Familiarizing	• Receiving feedback in one-by-one and group discussions • Observing co-workers' managerial practices	• Developing managerial capacity
Rationalizing	• Discussing about self with senior hybrids and external professionals	• Role modelling/coaching
Legitimizing	• Receiving back up and opportunity to perform from executive managers	• Increasing space for action

Such approach allowed us to turn the attention from the outcomes of identity transition to the mechanisms which underlie them, and contribute to answer the call by Sveningsson and Alvesson (2003: 1190) for the development of research giving a "better feeling for the contexts, complexities and processes of identity construction", overcoming the limits of a literature which "emphasised the individual level of analysis and perhaps included organizational context as a constraint" (Chreim et al., 2007: 1516). And our in depth qualitative methodology proved appropriate to grasp an understanding of individual responses to the role taking and the complex system of interactions occurring in a professional organization.

These findings contribute to our knowledge of hybrids' identity work in multiple ways. In organizations where a context for interaction and effective support are provided hybrids' identity work can be something different from juxtaposing incompatible logics, or incorporating managerial values and practices in the professional world. Rather, it can be a process where professionals partially reframe the very notion of professionalism, broadening the scope for professional action and redefining patients' interests from individual to collective (McGivern et al., 2015). Most of the hybrids we studied understood new societal demands and in order to maintain credibility in front of society they accepted the challenge to co-evolve and reconfigure traditional identities (Martin et al., 2015). In our case, professionals reframed their value sets and started seeing management as a way to take care of patients at a higher level, and therefore envisioned the managerial identity not as alien, but as in line with professional tradition (Noordegraaf et al., 2015). However, this is not a straightforward process. Medical professionalism can indeed be redefined and reconfigured, but only if individual professionals are provided the support to engage in processes of identity work. The purposeful action of others – in our case managers, nurses and external professionals – facilitate identity change.

Accordingly, as far as the debate on the role of agency/structure on the identity construction of professionals is concerned, we claim that hybrids in complex institutional environments do not act as heroic individuals who are called to reconcile autonomously alternative logics (Bevort and Suddaby, 2016). Nor they are necessarily passively subject to the influence of the dominant professional mindset or the pressures of imposed organizational/managerial logics. Rather there is space for a constructive interplay between individual action and the complex network of relationships in which the professionals participate. Therefore, identity work through which professional identities can be reconfigured is not concentrated to the individual professional, but rather is *distributed*, as it arises through the interaction with other relevant actors.

Our findings support what found by Pratt et al. (2006) and McGivern et al. (2015) on the role of interactions in identity construction. However, in our case of hybrids exposed to institutional contradictions, we found first of all that relevant interactions involve actors that lie beyond the limited and homogenous boundaries of the profession, in particular nonmedical managers and other professions. By embodying different logics and sets of values these actors allow the springboard of novel identities, and through this interaction

individual agency is supported and fostered. The frequency and quality of forms of interaction we found in our analysis probably explains the high number of professionals who reconfigured their professional identity. Secondly, interactions play a role not only in the ex post social validation of identity (e.g. Pratt et al., 2006) but in the entire process of the identity shaping. This is in line with the recent work by Reay et al. (2017) showing that professional role identities can change thanks to the collective efforts of others.

Like most of the literature on hybrids our study shows some, albeit limited, variation, with at least one of our role holders remaining aligned to his traditional clinical self, being incapable to hybridize and thinking and talking about his identity retrospectively (Bevort and Suddaby, 2016). Therefore, we cannot expect all doctors to engage in identity work to support their transition into a hybrid medical management role, even if requisite support is provided. Individual willingness, values and capacities do maintain a significant role in explaining doctors' hybrid identity construction. As shown in Chapter 3 in the study of Italian hybrid managers, although the opportunity to perform in the role provided by the organization is a key element for effective hybridization, individual ability and motivation do maintain high relevance in the process.

Coming to the implications for policy and management, we acknowledge that hybridisation does indeed imply a challenge not only for hybrids but for policy makers and executives. It implies the risk of losing the leadership in the organization, of fuelling opportunistic behaviours, of empowering organizational antagonists (see Chapter 2). However, through examining interactions associated with identity work in taking up and enacting (medical) manager roles, we provided insight into how the transition might be supported. The study by McGivern et al. (2015) hints at antecedents of effective identity transition, but provide littles information regarding this. Our study highlights the importance of those around hybrid managers, beyond their peer group, for providing support to the familiarisation, rationalisation and legitimisation processes. Even though clinical directors are less likely to hybridise compared to other executive medical management roles (McGivern et al., 2015) we found that such process can take place, at least when clinical directors are properly selected, when the role is provided with autonomy, status and effective support.

Practices that can be explicitly or implicitly enacted by organizational actors include, first of all, solutions to develop hybrids' managerial capacity, through the presence of trained and empowered non-medical managers and support staff capable to provide applied managerial knowledge, and an organizational culture - supported by the purposeful actions of key organizational players – valuing transparency and feedback provision. Secondly, the adoption of formal (or informal) coaching and mentoring programmes, favouring role modelling and discussions over the evolution pf the professional self, necessary to accompany uneasy identity changes. Training activities, such as MBAs or formal management programmes, outdoor directorate strategy making session, team building initiatives, can represent fruitful occasions for self reflection and growth. Finally, the capacity of executives to delegate and back hybrid managers, providing resources, autonomy, decision making power, overcoming the fear of a loss of power

and control. And this set of organizational practices should be tailored to match the different needs of professionals, targeted at their primary gaps in terms of either bridging of management and professionalism, personal reflection or legitimacy in the new role. As a consequence, policymakers and executive managers pursuing implementation of hybrid roles, should understand that the process of becoming a hybrid is by and large shaped by the organization. These findings can provide relevant insights for public executives and policymakers dealing with professionals other than doctors, such as nurses, teachers, professors and researchers in different public professional organizations. Hybrid professionalism is not only about hybrids, rather it is about how hybrids are managed.

Conclusions

Professionals in management have become a common phenomenon, but this does not mean that taking up managerial roles has become common. Professionals, specifically those with a medical background, have often been seen to buffer their professional peers from managerial intrusion, rather than enact a strategic organizational role. This has been characterised as an identity transition challenge, but extant research has offered little understanding of how such transition to management takes place, and how it is influenced by the relations outside the professional group.

As a single case study of professional managerial hybrids in a Dutch hospital, our study may have limited empirical generalisability. However, this paper offers theoretical and practical insights for understanding how the combination of professionalism and management generates hybrid situations, not only in terms of principles and structures, but also in terms of identity. This takes much effort, and our case shows that performing professional manager roles calls for relational and organizational support. Many others are important for becoming a hybrid. In that sense, institutional identity work is primarily interactive, and hybridisation is not so much concentrated work, but distributed.

Accordingly, our research brings new perspectives from professionals in management in continental Europe, showed that public managers should invest in consciously organizing managerial role-taking, which they can shape by supporting the hybridisation processes we traced: familiarising, rationalising and legitimising. Instead of stressing classic managerial/professional dichotomies, this fits a more contemporary focus on organizational practices in which managerial-professional connections are reconfigured.

Appendix: Interview protocol for clinical directors

I - Introduction:

- Introduction of the interviewer and the research project
- Short description of the content of the interview
- Introduction of the interviewee: background and brief description of the current position

II - Content of work:

- Tell me about your typical working day. How much time do you devote to clinical activity, management of the unit and management of the directorate?
- What does your activity as a clinical director consist of?
- What are the directorate activities?
- Who do you work with as a clinical director?
- What main differences did you experience between being a unit chief and a clinical director?
- What is the goal of the clinical director role in this hospital?

III – Becoming a professional in management:

- Why did you apply for the job?
- Did your attitude toward the role change over time? As a consequence of what?
- Do you like your role? What do you like in your role?
- To what degree do you want to continue practicing (or doing other kinds of professional work)?
- Did you relationship with colleagues changed?
- What are your future career intentions?
- What do you consider your greatest achievement in the management of the directorate? And the biggest failure?
- What are the greatest difficulties and the key challenges you encounter in your job? How do you deal with them?
- What are your future plans for the directorate?

IV – Which factors affect the managerial role-taking:

- Tell me about the management team meetings. What do you talk about? Do you sometimes have diverging opinions? How do you deal with that?
- Tell me about your relation with the directorate nurse. What do you talk about with her? What was the topic of the last meeting?
- Tell me about your relation with the finance manager. What do you talk about with them? What was the topic of the last meeting?

- When do you talk to the top managers? What are the contents of the conversations? What was the topic of the last meeting?
- What kind of management training did you receive? What is your opinion of its effectiveness?
- Did you have a coach? What is your opinion on it?
- Do you feel supported by your organization in the role?

CHAPTER V: ENABLING HYBRID PROFESSIONALISM? EVIDENCE FROM THE HOSPITAL SECTOR

A single authored paper based on this chapter is under review in a primary international journal in the field of healthcare management.

Abstract

Hybrid medical managerial roles seem to be the solution to reducing the friction between traditional professionalism and "modern" organizational paradigms. However, professionals responded in different ways to these conflicting demands, and we need to better understand the contextual factors that explain such variation.

This chapter studies hybrid professionals in a hospital characterized by numerous organizational changes. The site is located in Italy, a country in which, despite management practices are now embedded in healthcare organization, the degree to which professionals embraced new hybrid roles is still limited. A longitudinal case study was performed that involved gathering data through multiple sources of evidence to understand the complex organizational dynamics that take place in the hospital.

A group of professionals willing to become hybrids engaged in strategy making and performance management, and this was enabled by hospital top managers. A second group of doctors, initially more reluctant towards medical management, proved capable of interiorizing organizational values and practices in a reconfigured way; distinctive contextual factors, which offered space for interaction with colleagues *within* the professional domains but beyond disciplinary boundaries, had a key importance in supporting this evolution.

This study provides evidence for scholars and practitioners willing to understand how medical management is evolving and how this transition can be supported. I contribute to the literature on hybrid managers by showing how contexts facilitating social interactions enable professionals' hybridization.

Introduction

A number of today's healthcare challenges require professionals with the capacity to reconcile apparently contrasting values and priorities. The provision of the best quality of care and the use of the latest technologies for all patients has to face the pressure of cost containment, requiring taking efficiency in the use of scarce resources into consideration. The increase of chronic illness and co-morbidities, calling for multidisciplinary and patient centered organizations, clashes with the traditional specialization of healthcare organizations, where service provision is organized according to rigid disciplinary boundaries. The spread of evidence-based medicine and accountability for results calls for transparent measuring and reporting of results, in contrast with traditional performance management and people management systems based on informal relationship within the professional group (Dwyer, 2010; Spehar et al., 2012; Lega and Calciolari, 2012; Kirkpatrick et al., 2016).

To face these and other challenges a number of health systems have fostered the development of medical-managerial "hybrids" , i.e. medical professionals engaged in managing professional work, colleagues, and other organizational resources (Fitzgerald and Dufour, 1998; Montgomery, 2001; Numerato et al., 2011), which have diffused among health systems globally, from the US to the UK, Canada, New Zealand and Australia, to other countries in Northern, Central and Southern Europe (e.g. Hoff, 2001; Denis et al., 2001; Doolin, 2002, Neogy and Kirkpatrick, 2009). These roles have been seen as a way to reduce the friction between traditional professional values and new organizational paradigms. On one side professionalism, described as based on the autonomy granted to professionals in order to apply their specialized knowledge to treat complex cases, while their behavior is collectively supervised and controlled within their professional group (Abbott, 1988; Freidson, 2001). On the other hand management logics, which emphasize values like efficiency, cost-effectiveness, and accountability to patients and the public (Noordegraaf, 2015).

Research has shown that professionals taking up managerial roles responded to these conflicting demands in different ways. While some of them formally took on management roles without substantially performing management practices (Forbes et al., 2005; Von Knorring et al., 2010; Correia and Denis, 2016), many others fully enacted their hybrid roles as they succeeded in finding meaningful combinations of professional and managerial values (Noordegraaf, 2007). However, the antecedents of developing hybrid roles require further research (Hoff, 2001) and scholars should look beyond hybrids' response strategies and study "the agency and social interaction processes that shape these responses" (Denis et al., 2015: 285).

Therefore, the aim of this study is to achieve a better understanding of the conditions and contextual factors at the organizational level that have an impact on hybridization, i.e. the process through which professionals take up hybrid roles-identities. This is particularly relevant in the hospital sector context, which is undergoing a number of rapid changes that are questioning the traditional organization of professional work

(Lega and Calciolari, 2012), and in which "our understanding of the nature and impact of reforms and how they are re-shaping the relationship between medicine and management remains limited" (Kirkpatrck et al., 2016). This is a relevant topic not only in theory but also in practice, as healthcare managers and policymakers, who are struggling with the engagement of professionals in management, are interested in understanding the reconfigurations of medical management and if and how it can be enhanced. As a recent study by Kuhlmann and colleagues (2016) has pointed out, creating supportive organizational environments for medical managers remains a challenge.

The paper studies hybrid roles outside the Anglo-Saxon and the Scandinavian world, since I wished to study medical management in a country which has "imported" NPM reform templates from abroad (Dent, 2003). As a matter of facts, a number of European countries are facing distinctive challenges related to political and cultural resistances in implementing health reforms that support medical management (Neogy and Kirkpatrick, 2009). Unlike countries like the UK, in Italy doctors have traditionally been involved in managerial positions within organizations, which has increased resistance to change, and the implementation of management reform processes has suffered from the lack of skills and financial resources, as shown in Chapter 2. As a consequence there is evidence that despite that management practices are now embedded in healthcare organization the degree to which professionals have embraced new hybrid roles and identities is still limited (Lega, 2008; Liberati et al., 2015). Findings from the Italian context can provide insight for other European health systems which have shown mixed evidence with reference to the responses to hybrid management innovation. For instance in France it has been found that doctors heading the newly introduced "medical poles" struggle to achieve legitimacy by leveraging pre-existing professionals networks (Vinot, 2014). In Germany the new hybrid model is confronted by existing (sedimented) practices, as senior doctors feel their ascendancy threatened (Bode and Maerker, 2014).

This qualitative longitudinal study in a hospital environment characterized by continuous organizational changes provides an ideal setting to gain an in-depth understanding of professional hybrids and their relationship with others within a complex organizational context. The site is a large tertiary hospital, which underwent healthcare sector reforms in the 1990s that introduced performance management systems, favored the involvement of doctors on the hospital board and introduced intermediate organizational layers (clinical directorates) headed by professionals responsible for the use of resources. More recently, the hospital witnessed the introduction of patient-centered logics and a new layout design. This analysis bridges health services research and health policy with organizational studies, responding to the calls (Currie et al., 2012; Kirkpatrick et al., 2016) to develop research with a stronger engagement between the three approaches The paper is organized as follows: after presenting the theoretical background of the study, the research context and the methodology, results are illustrated and discussed, and implications for healthcare policy and management are drawn.

Theoretical background: the evolution of healthcare professionalism and the missing role of context

The relationship between management and professionalism in healthcare is a rich and dynamic field of study, following the continuous evolution of professional practices and professional organizations worldwide. Initially, research anchored in the sociological tradition pictured managerial reforms as a process in which professional culture was subjugated by managerial hegemony; alternatively, it argued that professionals were capable of resisting managerial dominance by open or subtle opposition strategies (Numerato et al., 2011). Professionals often externally conformed to managerial practices, but without doing so substantially (Kitchener, 2002), and rather than co-opted into managerial practice, they have been described as co-opting management to pursue self-interest (Waring and Currie, 2009).

Over time, research has progressively overcome this hegemony-resistance framework shifting to the study of hybrid professionalism and hybrid professionals, and the strategies used to juxtapose and eventually blend the different values, logics and practices (Noordegraaf, 2015). Professionals in hybrid roles, usually working as part time practitioners and part time managers of their colleagues, in the position of a primus inter pares, were found capable to mediate managerial and clinical demands. They have been asked to contribute to hospital wide strategy making, management of resources and coordination of care linking professional practice with organizational objectives, and this was described as the mediation or blending of alternative logics (Pache and Santos, 2013), the creation of "two-way window" roles (Llewellyn, 2001), or the capacity to be simultaneously loyal to the organization and the profession (De Wit, 2013). Accordingly, hybrid professionalism has been described as the co-product of clinical and organizational values (Schott et al., 2016). Of course, staying in hybrid roles is not easy, and individual responses as well as professionals' level of engagement may vary. McGivern et al. (2015), in line with other scholarship from different Western countries (Forbes et al., 2005; Von Knorring et al., 2010) distinguish between incidental or reluctant hybrids, professionals who maintain a more passive and reactive attitude, looking at management as something which "needs to be done"; and willing hybrids, doctors who are enthusiastic about and take an entrepreneurial approach toward the managerial role, willing to redefine their professional identity and challenging traditional professional practices.

Recently, scholarship has suggested going one step further, observing that some hybrid organizational activities are increasingly both managerial *and* professional. The reorganization of clinical practice or the planned efforts to increase service quality are activities that are developed in order to respond to professional rather than to managerial values, acknowledging the evolution of patients needs, and societal and cultural changes. While the notion of hybridity reflects the juxtaposition and combination of different values, there has been a move *beyond* hybridity (Noordegraaf,

2015), in which organizing becomes an intricate part of professional work and managerial and professional discourses overlap (Olakivi and Niska, 2017).

Yet, although this rich literature thoroughly covers the different responses of professionals to management, our understanding of the condition explaining such variation remains limited (Kirkpatrick et al., 2016), and existing studies hint at antecedents of effective hybridization (McGivern et al., 2015), but provide littles information regarding this. In particular, despite Noordegraaf (2007) suggested to explore the relational dimension of professionalism, and its links with the outside world, organizational rationales and other professions, we know relatively little with reference to the role of the social/organizational context on these individual dynamics. As argued by Denis et al. (2015), there is a need to look beyond hybrids' responses and rather study how these are shaped by agency and social interactions.

Existing research shows how the development of professional identities and roles is inherently relational, yet most studies in the medical field tend to look at contexts in which interactions take place within the professional community. It is the case of Pratt (2006) who has analyzed the importance of socialization and role modelling in the development of young doctors' identities, while other authors have studied hybrids and the construction of their role among colleagues and their legitimization as "primus inter pares" (Llewellyn, 2001; Witman et al., 2011). In contrast to this literature, the recent work by Reay et al. (2017) showed the potential for change to be orchestrated by *others*, i.e. business managers, who supported doctors in incorporating managerial values. This work is extremely interesting but it studied (general) practitioners, who are professionals without major managerial responsibilities and working outside complex organized settings. This work aims to fill this gap by giving empirical attention to the dynamics of medical managers' hybridization and the influence of the organized context in which they take place, in order to understand how these transitions can be supported. Therefore, the research question of this study can be synthesized as "*how do medical managers hybridize over time, and if and how this evolution is influenced by the social/organizational context in which professionals work*?"

I do this by studying hybrids in an evolving hospital organization. Modern hospitals are a suitable environment to study the impact of context on medical professionalism as they are complex and institutionalized environments in which professional work and roles are affected by managerial reforms (Byrkjeflot and Kragh Jespersen, 2014), which are continuously exposing professionals to new types of interactions with colleagues and non medical managers. Among the various existing forms of professionals-in-management, this paper focuses on clinical directors, i.e. medical management roles heading intermediate management structures and coordinating multiple medical specialties, in a hospital characterized by managerialization reforms in the last 20 years with the aim to increase clinical governance, control costs, and develop care integration and patient centeredness.

Study context and methods

Medical management in the Italian hospital sector

The Italian hospital sector has a long history of hybrid medical management, as unit chiefs have traditionally been accountable for unit level managerial responsibilities, and doctors working in hygiene departments have offered executives support for a number of hospital management and organizational issues (see also Chapter 2). The healthcare sector reforms of the 1990s made the clinical directorate model compulsory in public hospitals of all regional health systems (Cicchetti et al., 2009), with the aim to increase accountability for results and favoring clinical governance collaboration within directorates. Clinical directors (CDs) can now be found in every organization, although with different degrees of engagement in the role as, in a number of cases, the implementation process was poor and doctors took on the role formally rather than substantially (Lega, 2008). Increasingly in recent years, in addition to the new organizational structure, process management logics aimed at favoring the sharing of resources and transversal collaborations beyond the directorate boundaries have been present in regional healthcare policy guidelines (see also Chapter 6). Clinical pathways spread in all hospitals for the care of major diseases, and new organizational forms characterized by multidisciplinary departments and wards grouped according to patient care needs are now common (Tozzi et al., 2014). Indeed, the impact of these reforms has been questioned (Liberati et al., 2015); while some professionals appear enthusiastic of new patient-centered approaches and its focus on quality, others blame the reforms for looser systems of responsibility, de-specialization and further impoverishment of the medical status.

Managerialization reforms at the hospital

The hospital I studied is a critical case to study the evolution of medical management in the Italian NHS. It is located in Northern Italy and with almost 1000 beds and 4000 employees and a yearly budget of over 400 million euros, it is one of the largest in the area. It is in one of the Regions that, in recent years, has invested the most in the managerialization of the healthcare system. It has been exposed to management practices for the last 20 years and has undergone a relevant development and empowerment of clinical director roles as well as clinical pathways in recent years. Also, while conducting the study, the hospital relocated from the old pavilion-based physical structure to a newly built site, designed to favour inter-unit collaboration and care integration. The following is description of the history of managerialization at the hospital before 2012 when the study began (for details see also Chapter 3) and a synthesis of the main organizational changes that took place during the study.

For many years after the introduction of clinical directorates, dating back to the late 1990s, every unit director preserved "his own kingdom". Specialty unit directors maintained a pivotal role in the organization and governed according to professional, rather than managerial, logics. This was strengthened by a traditional pavilion physical layout dating back to the 1930s, where wards, outpatient services, and operating rooms

were fragmented. CDs' managerial activity largely consisted of cost management, and CDs were rarely active in strategy making or in the promotion of collaboration initiatives within the directorate or hospital-wide programs, proving unable to overcome conflict of interests or think beyond the boundaries of their specialty. A minority of CDs were willing to take on more managerial responsibilities, but encountered the resistance of specialty unit directors, who were defensive and did not want to be governed by a peer. Furthermore, they faced opposition from hospital executives, who were prudent in delegating responsibilities and involvement in strategy making; for instance, the hospital board (a council of all CDs together with the top management team) was summoned only four times a year and never became a decision-making body. Also, the central unit of doctors specialized in hospital organization (the so called "hygienists") took care of hygiene and some operations management responsibilities, further reducing the need for professionals' involvement in hybrid roles.

In more recent years, a number of changes have taken place. Firstly, clinical pathways were introduced, with the support and supervision of non-medical managers. Not only in transplant services, which had historically required inter-unit coordination, but also in cancer care or trauma care and for a number of other major diseases. Then, after the arrival of a new top management team in 2011, CDs were strongly empowered and transformed into an effective organizational structure. They were made accountable for the financial performance of the directorate and became increasingly involved in strategy making; the hospital board began having monthly meetings, and executives started fostering CDs' active participation in the decision-making process. For example, they were involved in planning the future hospital relocation, and actively consulted on the design of the organizational structure, decisions concerning technological investments, the physical layout, and the relocation schedule. Finally, in 2013 the hospital was relocated from the historical pavilion structure to a newly-built site designed according to modern architectural logics, including: the integration of facilities and the optimization of logistics and patient flow according to process management logics. Medical offices for different units were placed side by side, with common meeting rooms. Operating theaters and outpatient services were concentrated and shared among different departments, and different clinical specialties started sharing the same nursing staff and, in some cases, the same beds.

Methods

I conducted a case study (Eisenhardt, 1989; Yin, 2009) with a goal to develop theory on hybrid professionalism in organized contexts. This longitudinal in-depth analysis, allowed by qualitative methodologies and multiple sources of evidence, was meant to increase the understanding of the complex organizational dynamics taking place in the hospital. Similar research approaches were adopted by a number of previous studies on the topic (e.g. Witman et al, 2011; Correia and Denis, 2016). Collecting data over time allowed to take into consideration the impact of the changes to the work context determined by the hospital relocation.

I gathered data over time from three different types of sources: 1) semi-structured interviews with hospital senior medical and top managers; 2) observation at board meetings; 3) archival data. The researcher had the unique opportunity to interview, at least once, all CDs of the hospital[a], doctors who had part-time involvement in management while maintaining clinical activity and the direction of a specialty unit. Therefore, interviewees were able to report on their experience of bridging medicine and management at different levels, ranging from clinical practice, to specialty unit management to clinical directorate management. I also interviewed the hospital's top management team, including the CEO, administrative and medical directors, the chief nurse, the chief hygienist and three hygienists on his team. Two CDs retired during the study period and were substituted while all other interviewees maintained their roles. In total, 30 interviews were conducted from May 2012 to July 2014. Nine interviews, with the two newly appointed CDs and with a selection of CDs and hygienists for a second round of interviews, took place after the relocation.

The research approach allowed to combine a plurality of perspectives and gather in-depth insights on how doctors struggled to bridge medicine and management over time. A constant comparison technique was employed, repeatedly comparing data across informants and over time. Anonymity was guaranteed, interviews were held in Italian and the average length was of one hour. The author prepared the interview protocol, based on existing literature on medical managers. The topic list for interviews with CDs, and fine-tuned after a pilot interview, included open questions on the content of their managerial activity, the hybrid role, the contextual influences on performing the role and if/how this changed over time. Other respondents were asked to report on their experience with CDs' roles, the nature of the interactions they had with them, and the evolution of both. Interviews were conducted on site by the author, digitally recorded and summarized in order to condense the most relevant findings emerging from respondents (Weiss et al., 1994).

Interview data were triangulated with the analysis of old and new organizational charts, strategic plans and the résumés of interviewees, as well as observation at hospital strategic meetings. The researcher observed four 3-hour board meetings in 2012, with the aim to gain deeper knowledge of the hospital executives' management styles, the nature of the contribution of different CDs to discussions, and explicit and non-verbal reactions to managerial decisions. Further evidence was collected by the author who, in 2014, participated in two 2-hour meetings about the development of care pathways with top management and a selection of CDs.

The qualitative data analysis was developed by identifying relevant concepts in the empirical material, grouping them into categories emerging from the words and ideas expressed by informants, and using the insiders' point of views as the starting point of the analysis. Statements of findings were made when corroborated across multiple informants or data sources. The interpretation was then developed in an iterative process commuting between data and existing organizational theory on medical managerial hybrids. Data was organized according to the distinction between willing and incidental

medical hybrids found by previous literature (Forbes et al., 2005; Von Knorring et al., 2010; McGivern et al., 2015) .

Findings

Willing hybrids and the support from executives

All CDs at the hospital were highly influential clinicians, with the professional legitimacy to occupy the position. All of them had been unit chiefs for years, had served as presidents of scientific societies, and were members of editorial boards of international journals. However, while talking with them about their hybrid role and the nature of their professional-managerial commitment, a small group of CDs emerged (about one in three CDs interviewed) who saw their role as providing an opportunity to initiate change, set a direction, or contribute to the strategy of the hospital. These professionals were willing to perform as hybrids, aiming at setting a direction to the directorate and coordinating the activity of other specialties as primus inter pares. When their interactions were observed at board meetings, they showed confidence in using managerial tools, in talking about directorate planning, and contributing to strategy making. They were comfortable in their roles, finding a meaningful professional mission in the new position, and did not experience relevant dilemmas between professional and managerial values, as underlined by the following quotes:

> "I think I started to behave like a clinical director the day after my graduation, that's why I do not find any difference… it is just a responsibility at a higher level - more nurses, more doctors, more organization, more people coming to me with problems." (CD16)

> "My mission is to motivate people to achieve difficult goals, to have people that come to work every day and think, "what can I do for patients *and* the hospital?"". (CD9)

All of them reported that in order to fully enter their role the relationship with top managers and the support provided by them had a key importance. In the past they had had few interactions with executives, had been scarcely involved in hospital decision making and had been frequently bypassed by top managers, which undermined their legitimacy in front of peers:

> "In the past unit chiefs knocked directly on the CEO door to be listened to" (CD8)

However, they greatly appreciated the effective responsibilities attributed to CDs by the new top management team, and the fact that board meetings had become an opportunity to share problems and communicate with the CEO, as this represented the chance to fully enter their position as CDs. They started receiving backing from executives in making complex decisions, and real delegation of responsibilities, which allowed them to fully enter their roles.

> "At the beginning the board was only a place to get to know each other, and to discuss problems of clinical quality, now it is different… we have the responsibility over administrative and financial matters, and this has increased a lot our relationship with the top managers." (CD4)

"In the past the council of directors was useless. Executives pretended to involve us. Now they really want to do it, they want to listen to our opinions." (CD8)All of them acknowledged the importance of the new forms of interaction with colleagues favored by the introduction of clinical pathways or by the new layout. However none of them reported these elements as major factors in explaining the evolution of their medical role. As a matter of facts, in many instances they had pioneered multidisciplinary projects years before, therefore they perceived that these features had always been part of their way of intending their professional practice:

> "Medical education, quality management, patient centeredness initiatives…these are things that have always been dealt with in our directorate." (CD14)

Incidental hybrids and spaces for professional interaction

In line with previous literature, a second larger group of CDs appeared more reluctant towards the hybrid managerial role. Most of them preferred clinical practice to management activities, and felt uneasy in dealing with strategy making and in contributing to complex decision making during board meetings. They expressed a more prudent attitude, viewing their role as keeping good relations with other unit chiefs and merely channeling information. And despite the backing and involvement from the top management they had been provided with, their attitude had not changed over time, as they appeared mostly bound to their original specialty, and maintained a professional mindset with a limited capacity to take on major responsibilities in front of colleagues.

> "At the beginning it is new and unknown, it is a challenge… but then you realize that it interferes with your clinical activity… it is a difficult choice for those who have clinical activity, sometimes I think that I'd have more fun doing other things." (CD5)

> "I spend most of my time in clinical work, because that is what I like. I was afraid that they would ask me to leave the clinical practice, and in that case I would have resigned… it is that management clashes with my mentality a bit" (CD10)

> "[Some CDs] have problems in managing resources; some are not capable, some are afraid of conflicts, others are purists and do not want to get dirty with money because they say it is not their role." (Top Manager 2)

However, these professionals also experienced a change in the way in which they organized service provisions, and they referred to the adoption of practices like collaboration, resource pooling, programming, standardization of work or stakeholder management. For instance, a CD in a directorate meeting reported with competence and satisfaction the initiatives he had put in place to favor communication and integration between hospital and primary care professionals in the provision of cancer care. The very professionals that were unwilling to engage in the strategy making and finance

responsibilities associated with the role, were indeed performing organizational work practices that were referred to as a having an intrinsic professional nature:

> "There are management activities that are part of the clinical work because they are about reorganizing and rationalizing clinical activity." (CD11)

> "If I have bad relationships with a City Council, that means not only that I have an economic problem, but that the patients who live in that area will be treated poorly. […] Building visibility and establishing pathways in collaboration with society is something necessary today…it is part of clinical work." (CD13)

These professionals commented on how change was favored by a number of factors, which included the importance of working together within clinical pathways, initially developed by the hospital in transplants and then extended to in the care of other illnesses, which resulted in work cross-boundary work and in an interdisciplinary way in providing clinical care. Further, they reported the interaction with other organizational professionals, as the hygienists, the quality office, or the pharmacists offering a tutoring activity.

> "Now I have quality people within the directorate… and the activities are now linked with the quality system. Before when a clinical director mad a decision... it was rarely translated into practice, now it is different". (CD2)

The new physical layout had also progressively, sometimes coercively, redefined their way of working favoring frequent interactions with colleagues. The following quotes, from the second round of interviews, show the impact of the new physical layout on hybrids' behaviors:

> "Now it is easier not to be schizophrenic, I mean divided between the part [i.e. the specialty] and the whole, and rather think in a unitary way…. For instance, having a multidisciplinary organization in trauma care, as well as the new spaces, facilitate a unitary vision, not bond to the specialty." (CD5)

> "Before every one was in a different pavilion and had his own kingdom. Now we have common spaces, shared operating rooms … and we can dialogue on a daily basis." (CD7)

Of course, some variation was found across areas of the hospital. For instance, surgical CDs proved to be more resistant to the reshaping of work practices than other professionals. As shown in the following quotes, although some new work processes and shared standards were introduced, the traditional autonomy and self-regulation proved hard to dismantle.

> "For us surgeons it is more difficult… in operating rooms change takes more time… going from everyone having their own treasure to a situation where the treasure is common and shared on the basis of need is more difficult." (CD5)

Discussion

The evidence that was collected highlights the taking up of hybrid managerial roles as enabled by a number of interrelated features of the social/organizational context. The analysis confirmed the existence of alternative individual responses to hybrid roles, but found that different types of hybrids respond differently to the interactions taking place in the organizational context.

On one side, willing medical managers are professionals with the capacity and motivation to embrace strategic managerial responsibilities and run reorganizations at the operational level. They were fully engaged in their hybrid role, which was made possible not only by individual features but also thanks to the support provided they received in the organization, in line with what was found by the recent work by Reay et al. (2017). Interaction with top managers, involvement in decision making and backing in difficult decisions were the features of a context providing opportunity for managerial action, which was a key condition for the full engagement over time of these professionals in their hybrid roles.

On the other side, incidental hybrids were mostly bond to the traditional professional mindset and values, they were not motivated or capable enough to fully take up the decision making responsibilities over finance and hospital wide planning, even despite the support they received within the organization. However, doctors in this second group showed the capacity to effectively engage in others forms of management and organizational commitment over time. Rather than activities like strategy making and values of efficiency or monitoring, these professionals engaged in quality initiatives, service reorganization, staff empowerment or accountability to patients. . For these doctors, a different type of factors played a key role, in particular a social and organizational context providing space for interaction with other professionals from different specialties. This included: occasions to come in contact with other organizational professionals like pharmacists, hygienists, or quality staff; the involvement in pathways and multidisciplinary forms of organizing; the collaboration among disciplines required as consequence of the pooling of resources and the redefinition of working spaces. In contrast to previous literature that suggests that changes of professional identities are driven by the professional group (Pratt et al., 2006) or by interaction with business managers (Reay et al., 2017) , this study shows that these evolutions can also be enabled by the interaction with other professionals beyond the disciplinary boundaries. These findings develop what Noordegraaf (2015) hinted at when he argued that redefined post-hybrid medical managers are not primarily collaborating with executives but rather establish connections with other colleagues, patients and external stakeholders *within* their professional domains.

Furthermore, the study has shown that while relevant shares of professionals resisted to this involvement in management, reconfigured forms of professionalism incorporating values like collaboration, quality or accountability to patients appear more easily accessible to doctors, and not only to an elite group of professionals capable of getting

and willing to get involved in strategy making and performance management. Therefore, the potential of new professionalism - in which the processes of clinical management become embedded within professional action - exists and is not merely an issue of academic commentators. However, in order to favor this evolution, "romanticized appeals to professionalism", as argued by Martin et al. (2015) are not enough. Rather, professionals need to be surrounded by contexts purposefully designed by managers to support interaction, and in which change in work processes is enabled or - in some cases - even coerced. Further examination of the precise mechanisms through which these organizational and social elements function represents a fruitful avenue for future research.

The paper provides an in-depth analysis of a case, which is representative of the changes that are progressively being experienced in the Italian hospital system and builds on this experience which differs from most of the that reported in Anglo-Saxon and Scandinavian countries. This direction of change towards a reconfigured form of medical management looks promising for the numerous hospitals that have been struggling with the introduction of CD roles and are currently undergoing policy-driven organizational reconfigurations. This is why studying an Italian hospital is interesting and the findings from the Italian experience can be generalized, especially in in other Southern and Central European countries experiencing professional resistance to the introduction of managerial values and structures in hospitals (Kuhlmann et al., 2013).Indeed, variation emerged as some professionals of surgical directorates showed resistant behaviors. This proves that the evolution of professionalism is not a straightforward process, as some forms in which medical professionalism is intended offer less opportunities for embedding organizational values and practices, as can be seen with surgeons, as also found by Correia and Denis (2016). Combinations of professional and managerial principles risk remaining uneasy; progress to reconfigured professionalism is not a straightforward evolution and requires time and long-lasting efforts.

Conclusions

By focusing on a hospital case study in the Italian NHS, this study has illustrated that different processes of hybridization are in place, and that this evolution is enabled by different forms of interactions with multiple actors beyond the professional group. In particular, I have shown how also incidental hybrids, if properly supported, can take up organizational principles, which are not seen by doctors as "alien" with respect to professional practice, but rather as both professional *and* organizational (Noordegraaf, 2015).

Understanding such dynamics is relevant not only for executives and organizational scholars, but also for healthcare policymakers interested in the outcomes and implementation challenges of reforms in a number of European countries. This was the reason behind the intent to combine the different but complementary approaches of health services research and organizational studies, capable to provide a richer view of

what management actually is and overcoming oversimplification and myths of command and control approaches more common in traditional sociological approaches. Of course, the study has limitations linked to the nature of the methods used; although the case study proved effective in offering a deep understanding of the hospital organizational context, the analysis has an explorative nature and uses information from a single organization. Thus, future research could benefit from multiple case studies. Furthermore, comparative international evidence would allow to shed light on the effects on medical management models in other countries. Also, the examination of the effectiveness of the different forms of hybrid medical managers on organizational or clinical outcomes represents a necessary path for future research willing to guide policymaking and management.

I believe these areas of research are relevant since, as evidenced by the number of managerial skills frameworks developed by Departments of Health, Ministries of Higher Education and medical societies, medical management is a global priority and it has the capacity to find solutions to face the challenges of care innovation for multimorbidities and chronic diseases, increasing patients' expectations and the need for accountability on quality and efficiency (Lega et al., 2013). However, as argued by Glouberman and Mintzberg (2001: 57), medical management "is not one homogeneous process but several, usually quite distinct from one another", and it calls for careful implementation capable to enable the reconfiguration of doctors' professionalism.

INTERMEZZO II

After the three empirical chapters studying individual hybrids and their interactions with the organizational and interpersonal dynamics, Chapter 6 will get back to the macro and collective level. This conceptual paper completes the analysis presented in Chapter 2 on the Italian experience with medical management, reflecting on what emerged in the research up to now, especially in the longitudinal case study.

It also was developed after personal exposure to the early effects of recent health policy reforms (which brought in the Italian NHS new organizational models, clinical pathways and patient centered organizational forms), which I experienced directly or indirectly through research projects conducted for the observatory on the managerialization of the INHS (OASI) of Bocconi University. As pointed out in previous chapter, these changes are relevant as they are depicting forms of involvement of professionals in management which differ from the traditional hierarchical hybrid roles of unit chiefs or clinical directors.

Further, next chapter arose after reading recent theoretical contributions, like those of Martin et al. (2015b), or Noordegraaf (2015) and other contributions published in the recent Journal of Professions and Organizations, which envision a progressive move beyond hybridity, with the possibility to reconfigure professionalism in a way which is not only the juxtaposition of contrasting logics but, in some way, a synthesis of medicine and management.

Therefore this last contribution, while confirming the importance of context in hybridization, discusses if and how it is possible to go beyond traditional hybrid forms, shifting the focus of attention from formal roles to processes, and from concentrated to dispersed medical management. As anticipated, it was also meant for a healthcare audience and has been published in a health services research journal.

CHAPTER VI: MAKING DOCTORS MANAGE… BUT HOW? RECENT DEVELOPMENTS IN THE ITALIAN NHS

This chapter was published in the following paper:

Lega F., Sartirana M. (2016) Making doctors manage, but how? Recent developments in the Italian NHS, *BMC Health Services Research*, 16(Suppl 2):170 [8]

Abstract

Involving doctors in management has been intended as one of the strategies to spread organizational principles in healthcare settings. However, professionals often resist taking on relevant managerial responsibility, and the question concerning by which means to engage doctors in management in a manner that best fit the challenges encountered by different health systems remains open to debate. This chapter analyses the different forms of medical management experienced over time in the Italian NHS, a relevant "lab" to study the evolution of the involvement of doctors in management, and provides a framework for disentangling different dimensions of medical management. It shows how new means to engage frontline professionals in management spread, without deliberate planning, as a consequence of the innovations in service provision that are introduced to respond to the changes in the healthcare sector. This trend is promising because such means of performing medical management appear to be more easily compatible with professional logics; therefore, this could facilitate the engagement of a large proportion of professionals rather than the currently limited number of doctors who are "forced" or willing to take formal management roles.

[8] As anticipated, authors order is alphabetical.

Introduction

In the health systems of Western countries, clinical management has been intended as one of the strategies to spread New Public Management principles in healthcare settings. Managerial vocabularies became the norm in health policy making, and organizational arrangements that assign relevant leadership responsibilities to doctors, such as the clinical directorate model of hospital organization, were translated in different health systems across the globe (Braithwaite et al., 2005; Ham and Dickinson, 2008; Kirkpatrick et al., 2013).

This change was not (only) a political fashion, but it was an attempt to respond to current epidemiological and societal changes for which traditional modes of care provision proved inadequate (Helay and McKee, 2002; Lega and De Pietro, 2005; Lega and Calciolari, 2012). Cost containment needs required the competence and the tools to carefully select investments and to monitor the spending and the use of resources. The progressive rise of chronic diseases and multimorbidities made the hospital organizational model based on disciplinary fragmentation unsuitable for the new challenges and called for an increase in coordination across specialties and professions. Raising patients' expectations in terms of service quality and timing of care involved service reorganization and a departure from the traditional paternalistic and doctor-centered relationship with patients. Last, the increasing call for accountability required hospitals to provide data on performance, quality, safety, and the efficiency of their operations and to focus increasingly on "value" (effectiveness and appropriateness) in the use of public money. This call determined an evolution from informal and tacit performance management systems, typical of traditional professional organizations, to more explicit and structured procedures to collect, compare and manage data in hospitals, which required a change in doctors' mode of working with colleagues and administrators (Helay and McKee, 2002; Lega and Calciolari, 2012).

These are some of the factors that contributed to the diffusion of medical management, which provides managerial responsibilities to doctors to make them "hybrids" that are capable of bridging the worlds of medicine and management (Noordegraaf, 2007). However, although there is evidence that clinical management is beneficial for healthcare organizations (Goodall, 2011; Lega et al., 2013), critics argue that it has not yielded the expected results. As findings across Europe, UK, Sweden, Netherlands, Italy, show, lights and shades characterize the role of doctors as managers: many doctors took managerial roles reluctantly, and few pursued management as an opportunity to develop their professional roles (Forbes et al., 2005; Vlastarakos and Nikopoulos, 2007; Lega, 2008a; Lega, 2008b). After years of trials, medical management continues to encounter resistance from some medical professionals, and sceptics in different Western countries question whether it is really worth it. Additionally, it was shown that "patterns of accommodation between medicine and management are more nation-specific than is frequently acknowledged" and that existing knowledge of how the processes of doctors' participation in management "are unfolding across different national systems remains

limited" (Kirkpatrick et al., 2009: 643). Therefore, the question concerning by which means to engage doctors in management in a manner that best fit the contexts and challenges encountered by different countries remains open to debate.

This work's objective is to contribute to this discussion by highlighting the Italian experience of hybridization and by analyzing alternative solutions experimented to involve doctors in management over time. We will show how new forms of medical management are arising in response to innovations in service provision, following a pathway of development which was largely unplanned, although quite effective. This trend is in accordance with the international attempts to redefine medical professionalism towards a hybrid model capable to encompass managerial values and practices. This paper is structured as follows. We first present research on the different forms of medical management and the contradictions that underlie this concept. Then, we report the illustrative case of the Italian NHS to show the state of the art doctors-in-management roles in hospitals in the last two decades, as well as the recent developments that provide the opportunity for rethinking doctors' managerial engagement. The results are discussed, and implications for policy and management in Italy and in other health systems are presented.

Background

In accordance with the healthcare reforms of the last 25 years, a vast body of the scientific and grey literature in the field of healthcare management has investigated doctors in management and their effectiveness (Lega et al., 2013). However, medical management has been applied in a heterogeneous set of situations in different healthcare organizational contexts and at different levels within the organization. Therefore, to support effective policy making, it is important to shed some light on the differences which lie within this overarching, but somewhat blurred, concept.

On the one side, we find medical management expressed by physician executives, those hospital CEOs who originate from the ranks of the medical group, as capable of maintaining a dual commitment to the profession and the organization (Hoff, 2001; Montgomery, 2001). It was shown how the presence of a doctor as a CEO does have a positive and significant impact on hospital performance (Goodall, 2011; Bloom et al., 2013). Clinicians can also be involved in the strategic governance of hospitals, and research has shown a positive association between the presence of doctors on hospital boards and hospital effectiveness, in terms of the engagement in quality improvement (Weiner et al., 1997) or perceived quality (Veronesi et al., 2013).

Medical management has also been introduced at the middle tier of healthcare organizations, in particular hospitals, particularly with clinical directors, i.e., the medical leads who head large divisions that group different specialties (Braithwaite et al., 2005; Lega, 2008). We found studies that analyze the forms and benefits of this experience in a number of different countries because this model has spread worldwide in recent

decades (Kirkpatrick et al., 2013; Neogy and Kirkpatrick, 2009; Bode and Maerker, 2014; Vinot, 2014). More critical views, which originate from the literature rooted in organization studies and the sociology of professions, have emphasized the problematic sides of this process, notably the resistance from doctors, the subtle co-optation of managerial logics to pursue self or professional interests, the gap between the formal introduction of role and effective managerial role taking, the limits determined by the ambiguity of clinical leader roles as "two way windows", and the side-effects of contingent managerial authority experienced by doctors-in-management (Llewellyn, 2001; Waring and Currie, 2009; Numerato et al., 2011). Certain authors have shifted the attention from the individual medical manager to the medical management team, in which competencies are pooled together in a group. This pooling may occur when clinical directorates are led by leadership duos or trios of a clinical director, a nurse manager and an administrative manager. Fitzgerald and Dufour (1998), as well as previous Chapters 3 and 4 showed how these arrangements may reduce doctors' resistance towards management, making it possible for them to maintain a clinical practice and/or to focus on clinical governance issues.

A different form of medical management is that performed by frontline professionals, who are increasingly called to engage with improvement initiatives, exerting a leadership that is therefore shared and distributed across the whole organization rather than concentrated at the top management level (King's Fund, 2011; Martin et al., 2015a). This finding is in accordance with the recent studies on medical engagement, i.e., the contribution of all professionals to the enhancement of organizational performance (Spurgeon et al., 2011). Achieving a higher engagement of staff was found to have a positive impact on a number of dimensions of organizational outcomes (Spurgeon et al., 2015). However, research has shown that the compatibility between formal clinical management structures and a shared leadership approach, in which lower tiers are empowered and managerial responsibilities are distributed, remains puzzling (Buchanan et al., 2007). Furthermore, it was shown that although in principle distributed leadership appeals to professional values and doctors' desire to be re-empowered, in practice it is not straightforward to effectively engage frontline practitioners with it (Martin et al., 2015b). The rhetoric of engagement is often strong in the conversation between administrators and doctors-in-management; the practice is much less.

This variety shows how health policymakers and executives continuously attempted to identify specific solutions to bring management to healthcare organizations. Occasionally, solutions were identified through intentional policy interventions, whereas many other times at the organizational level, in search of more effective responses to professional claims, pressures from patients or other stakeholders, and technological innovations. Therefore, medical management is a multifaceted construct, "not one homogeneous process but several, usually very distinct from one another" (Dwyer, 2010: 57), and medical management arrangements are not static but fluid and may evolve over time. This finding calls for an understanding of how schemes of medical management are experimented with to orient research, policymaking and doctors'

training programs. Furthermore, it is important to study experiences outside Anglo-Saxon contexts, where most analysis are still developed. In particular, we analyze the recent developments of medical management of the acute hospital sector in the Italian NHS. The Italian case is theoretically interesting because twenty years ago the country introduced New Public Management reforms aimed at fostering medical management through clinical directorates, as it happened in many other Western health systems. However, over time, and especially in recent years, it has experienced alternative solutions to engage doctors in management, developed at the organizational level rather than in response to system-wide reforms.

We review Italian literature on medical management. The following analysis is also based on the research conducted first-hand by the authors and their colleagues for the observatory on the managerialization of the INHS (OASI), which has been run by Bocconi University since 2000. Every year, a specific report is produced, and the topic of management roles and engagement of doctors has been in the agenda of the observatory since its inception.

Findings from the Italian NHS

Italy has a regionally based National Health Service that provides universal coverage free of charge. Regional governments are responsible for the delivery of primary, secondary and tertiary care services through Local Health Authorities, Public Hospital Trusts and private accredited hospitals. The system is largely public: 78 % of healthcare costs (which, in total, represent 9.1% of GDP) are publicly funded, and 70 % of hospital beds are public (Armeni et al., 2015; Petracca and Ricci, 2015). Regional governments allocate resources to health organizations and have significant degrees of autonomy in organizing the provision of care in terms of health planning, monitoring, determining the number and vocation of health providers, and the cooperation/competition dynamics (Ferrè et al., 2014). Providers, although subject to regional policies, maintain a degree of autonomy in issues such as strategy making, budgetary management or organization. However, many hospital organizational features, including e.g., structures of managerial responsibility, people management rules or the profile of the different professions, are defined at the central level through national laws or national labor collective agreements.

With reference to medical management, specialty unit chiefs have traditionally been the pivotal role in hospital organizations, holding managerial and legal responsibilities over physical resources, medical and nursing staff and strategy making. Since 1992, when the so called "managerialization reform" of the system occurred, the clinical directorate organizational structure was made mandatory for public hospitals in all regions, and practicing physicians, selected among the unit chiefs, were appointed as clinical directors who were (formally) assigned responsibilities over directorate clinical governance, budgeting and strategic decision making (Lega, 2008; Cicchetti et al., 2009). Furthermore, specific managerial education was required for doctors in the position of unit chiefs and

above, and general healthcare management training schemes began being promoted by regional governments, as the reform gambled on the further involvement of unit chiefs as doctors in management. The head count and competency level of non-clinical managers was not increased to any significant extent. In the system, a professional group of doctors devoted to hospital hygiene and organization has also been operating for decades. These professionals usually work in a team that supports the hospital Medical Director (who, with the CEO and the Administrative Director, form the top management team). Most Medical Directors originate from the ranks of these hygienists, as well as nearly half of CEOs (Fattore et al., 2013).

Despite the isomorphic adoption of clinical directorate organizational structures, the effective hybridization of doctors was far from being effective in most public Italian hospitals. Only a share of professionals embraced management and effectively changed the manner of working to assimilate managerial logics. The majority resisted such processes, formally accepting clinical director roles but not enacting them in practice according to power vested or expectations attached to the role [28]. Unit chiefs, who had always been clinicians more than managers and who had always advocated the interests of their specialty, proved incapable or unwilling to have strategic and hospital-wide responsibilities. A number of contextual factors contributed to this behavior. For instance, hygienists maintained their traditional pivotal role in addressing hospital organizational matters, and this worked as a "safety net", which made the engagement of practicing doctors in management less urgent. Additionally, at least in certain cases, hygienists were also directly opposing the spread of medical management, which was viewed as a threat to the previously uncontested turf, as shown in Chapter 2. Furthermore, the processes of doctors' hybridization were hampered by the poor support that hospitals provided to clinical directors. In most cases, a part-time nurse manager was paired with the doctor, and eventually a part time secretary. Minimal decentralized support personnel such as operations managers or a finance manager were assigned, and centralized offices (including, for instance, human resources, operations management and logistics, and finance) were composed of personnel with experience in administrative tasks and bureaucratic processes, with minimal competence in management. Therefore, doctors were not exposed to professionals capable of transferring to them a managerial mind-set, and they were required to be involved in small scale problem solving or budgeting analysis, which caused frustration or resistance to management practices. Additionally, there was a lack of delegation from hospital executives; in many hospitals, clinical directors were bypassed and the council of clinical directors never became a real decision making body (Lega, 2008; Cicchetti et al., 2009) as also put in evidence in Chapter 3. Consequently, as described in Chapter 2 the in-class managerial training that most doctors undertook was rarely followed by specific opportunities to engage in hospital strategy making.

However, in recent years, the Italian NHS has experienced a number of new forms of engagement of doctors in management involving frontline doctors and professionals with middle seniority levels. This change was not the consequence of a policy discourse

over healthcare leadership, as the one which took place in the United Kingdom. Instead, it was favored by the introduction of process based organizational structures or innovative hospital layouts, as a number of new hospitals have been re-designed with the aim to pool resources such as operating theatres, wards or outpatient facilities, to favor patient flows and to encourage interdisciplinary collaboration around clinical processes (Villa et al., 2009; Lega and Calciolari, 2012). Because the legally binding structure of responsibilities in hospitals remains strongly centered round unit chiefs and clinical directors, different hospitals autonomously pioneered solutions for the (re)distribution of managerial responsibilities across organizational layers and professions. New responsibilities have been created, such as the direction of clinical pathways which introduce matrix-like organizational forms, or the coordination of clinical network within and across organizations (Tozzi et al., 2014; Pirola et al., 2015). A number of healthcare organizations are shifting the strategic focus from traditional "vertical" directorates to "horizontal" clinical processes. Pathway coordinators are now provided with goals, responsibilities and budget autonomy, because they often are leading multidisciplinary teams with performance and result-based responsibilities. In other organizations, directors of transversal "centers" are being introduced with the objective of grouping specialties around core product lines, such as care of cancer, women's health, and trauma (Cazzaniga and Fischer, 2014). Engaging doctors, including those who are relatively young and without formal hierarchical roles, with these management responsibilities has become a means to train them on the job in management skills, including collaboration, strategy making, goal setting, and performance review. Additionally, engaging doctors has begun to be used as an effective assessment of leadership competencies to be used when formal hierarchical positions are open.

Such major reorganizations have also been accompanied by the conferment of new managerial responsibilities to professionals others than doctors. New roles such as nurse bed managers have been introduced; ward nurse managers have been provided increasing levels of responsibility over technologies and human resources (Pirola et al., 2015). Responsibilities over operation management and logistics, regarding the management of theatres or patient flows, have been transferred to process engineers or properly trained hygienists, and some have envisioned this as an opportunity to redefine and qualify the vocation of the specialty (Fantini et al, 2015). These developments have had different outcomes on existing medical management roles, such as unit chiefs and clinical directors. They were a major opportunity to reduce the burden of operational tasks and allow top professionals to engage in more qualified managerial activities, particularly strategy creation and clinical governance. However, these changes are being perceived by some as a new attack on medical dominance, the endpoint of a progressive impoverishment of the traditional pivotal role of the unit director (Liberati et al., 2015).

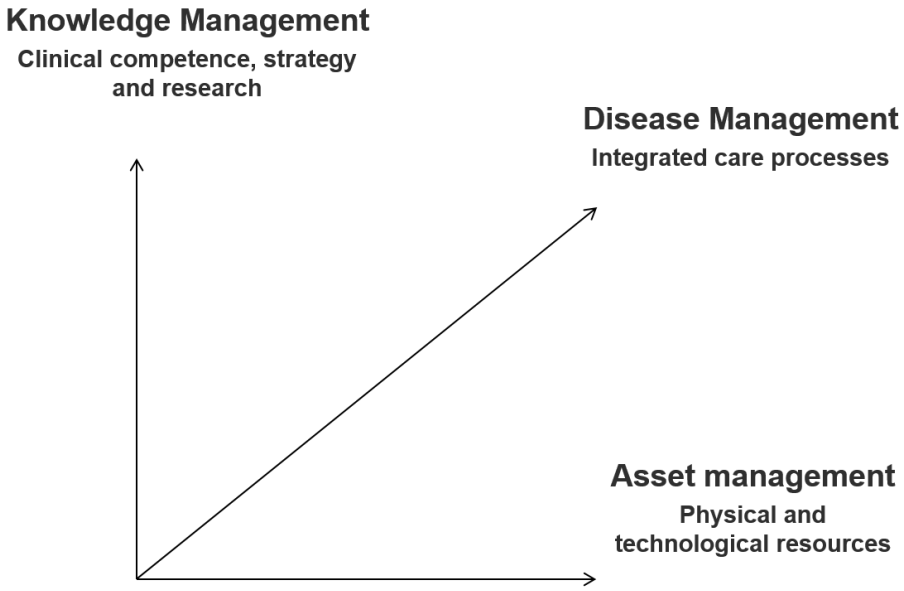
Discussion

The involvement of doctors in management as clinical directors in the Italian NHS encountered resistance, and did not produce as effective result as expected. A number of doctors proved willing and capable to hybridize, yielding very positive results. However, the majority, years after the introduction of clinical directorates, continue to struggle in the new role. We derived a new understanding of how management competencies are being developed and distributed among different hybrid roles and non-clinical staff. The main trigger for this has been the increase of new forms of medical management that involve frontline professionals and unit chiefs in activities such as decision making over hospital-wide issues, design and management of interdisciplinary and interprofessional care processes, service quality improvement, and the development of clinical networks.

Although traditionally unit chiefs, and to some extent clinical directors, were in full control of staff, physical and financial resources and disciplinary strategy making, a progressive separation of managerial responsibilities is occurring, which can be depicted as in Figure 6.1. The knowledge management activities, which is the strategy making over the development of medical disciplines, the nurturing of clinical competence, and the planning of research, remains under the control of unit chiefs, senior and respected professionals endowed with status and legitimacy within the medical group. However, the activities related to the establishment, running and improvement of coordinated care processes that provide high quality clinical care to patients, referred to as disease management, is increasingly developing and is becoming a responsibility assigned partly to unit chiefs but mainly to frontline doctors, primarily those who are young ad emergent, or certain senior high-caliber consultants. Last, resources such as wards, beds, outpatient services, operating theatres, and technologies, are increasingly shared by a number of different specialties and managed in a coordinated manner. The same applies to non-medical staff, such as nurses or other health staff, which are no longer managed by unit chiefs but are self-governed and work with different medical units. Therefore, the asset management is controlled by operation manager roles, an arising group of professionals within the Italian NHS with various backgrounds including engineering, management, nursing and particularly the doctors who specialize in hygiene and hospital organization.

The conceptual framework illustrated by Figure 6.1 provides an understanding of new management roles and responsibilities developed in the Italian NHS, and may offer to international scholars new insights regarding how the different dimensions of medical management can be distributed.

Figure 6.1 - Three axes of responsibility



Source: Adapted from Lega (2012)

Further reflections can be derived from the analysis of the Italian experience, which contributes to the international debate about hybrids and may offer insights to policymakers and practitioners.

Developing clinical management does not necessarily mean to involve professionals in middle or top management roles. New forms of medical management, which we called disease management, related to the capacity to understand the functioning of the hospital as a whole, to work and collaborate across disciplines and professional boundaries, to care for the overall performance and quality of the services provided to patients, can be developed. Therefore, management competencies, rather than in the hands of a small group of senior professionals, can be dispersed throughout the organizations. This phenomenon was neither determined by system-level reforms nor accompanied by an explicit narrative on "shared leadership" or "medical engagement"; instead, it emerged as the consequence of the changing work practices and organizational arrangements in healthcare organizations.

We also showed how the professionals engaged in these new roles have a high potential to resolve the contradictions between clinical and managerial logics and understand that clinical leadership does not necessarily regard dismantling professionalism, but rather regards reshaping it. This is in accordance with the work, e.g., of Martin et al. (2015b) who claim the development of a "new professionalism" characterized by the engagement of clinicians and a focus on coordination, quality improvement and accountability to patient while performing their clinical work. Kirkpatrick and Noordegraaf (2015) show how a "reconfigured" professionalism does not compromise

traditional values but makes the profession responsive to a wider network of accountability and at the service of the new expectations of patients and society. It is not straightforward for doctors to understand and interiorize this evolution, and this process may be opposed by professionals, as it happened in Italy with unit chiefs, who view this as a new menace to the power of the profession. However, this evolution also has the potential to "rehabilitate professionalism as a force for good, and thus rescue it from the persistent and damaging accusation that it is primarily a self-interested claim aimed at obtaining monopoly rents and other privileges. […] a reinvigorated 'new professionalism' […] may embody the best of the professional ethic and secure its place at the heart of service delivery" (Martin et al., 2015b: 378-379). Furthermore, this type of development could offer, as it happened in Italy, interesting opportunities to provide visibility and status to a new rank of doctors that has less career development opportunities than in the past due to the economic crisis and reconfiguration processes.

Another interesting remark from the Italian experience concerns the importance of providing organizational support to medical managers. We have seen how a (limited) group of leading professionals can perform effectively in middle or even top management roles. Therefore, such doctors should be identified and provided with adequate training, administrative staff and delegation of responsibilities from executives, as suggested in chapter 2 and 3. Further, these doctors should be paired with nurse managers and other non clinical managers, in order to help them to focus on strategic management and clinical governance issues without jeopardizing their precious time for clinical practice. However, it appears important to develop means to support the development of management competencies for doctors not only when they are close to taking on a formal management role but also since the early stages of their professional career. Despite the popularity of competency models, such as CanMEDS or similar ones, the training of management skills remains underdeveloped (Wallenburg et al., 2012). This does not mean to teach a full spectrum of management tools or techniques, such as accounting, financial management or health technology assessment. Instead, the issue is supporting the development of distributed forms of management and leadership, which include taking initiative, understanding how the organization works and feeling a sense of ownership and responsibility for the overall service provided to the patient (Blumenthal, 2012). The seminal work by Noordegraaf et al. (2015) describes a case study that proves the effectiveness of involving medical residents in quality improvement sessions and calls for the development of healthcare research in this area. Interestingly, the study acknowledges that training does not transform all doctors into medical leaders, but that those doctors that "discover they have little affinity with leadership and management […] may acknowledge the importance and difficulties of leading and managing service delivery" (Noordegraaf et al., 2015: 21), therefore reducing the resistance to the introduction of managerial logics and principles. This appears to be an interesting path.

Additionally, we found how this evolution in Italy benefited from the support of other professions, particularly nursing but also the discipline of hygienists, who envisioned it

as an opportunity for qualification and development. The Italian case shows the benefits that can derive from having a professional class of doctors specialized in hospital hygiene and organization. Although they have contributed to slowing the process of development of clinical directors, there is evidence of the great contributions they can provide to the efficiency and effectiveness of clinical activities (Fantini et al., 2015). This is something which other health systems could examine.

Conclusions

This paper has analyzed the developments of hybrid medical management roles focusing on the Italian experience, showing new forms of involvement of doctors in leadership and management activities that are emerging, often without deliberate planning, as a consequence of the innovations in service provision introduced to respond to the changes in the healthcare sector.

We conceptualize this process through a framework that disentangles three axes of management responsibility in healthcare organizations, which may support research and drive the future design of medical managerial roles. We showed that this evolution is promising because these new forms of medical management, especially what we defined as disease management, seems by and large compatible with redefined professional logics. Therefore, medical management appears to be achievable by a large proportion of professionals and not only by a limited number of entrepreneurial doctors willing to take on formal management roles. Furthermore, based on the recent Italian experience, clear directions to improve doctors' training schemes emerge as well: "When the going gets tough, the tough need to get going."

Finally, we must acknowledge that this paper has certain limitations. First, after fifteen years of research, there remains a relative scarcity of literature on the topic. Second, in the literature review and in the field experience of the authors there is an overrepresentation of hospitals with higher degrees of managerialization, often located in Northern and Central Italian Regions. Therefore, certain findings may not be equally representative of all Italian regional contexts or healthcare organizations.

CHAPTER VII: CONCLUSIONS AND DISCUSSION

Introduction

Explaining the influence of the context on hybrid managers was largely a puzzle for both theory and practice. With this study I had the chance to delve into an inspiring literature and to develop in depth field research which allowed me to shed some light on this topic. Therefore, at the end of this book it is now possible to answer the research question of the work, i.e. *How the rise of hybrid medical managers and the hybridization process are affected by social/organizational conditions?* In this final chapter I look backward, connecting the dots of this research work, as well as I try to look forward, at the future of research on hybrids in light of recent practical and theoretical development. I provide first a summary of the main finings of each chapter and then I develop the overarching theoretical considerations. Following I discuss my methodological choices and practical implications, and I conclude with presenting limitations and future research directions.

Summary of the main findings

While most of existing research had looked at hybrids' resistance or alternative response strategies, the goal of this work was to increase our knowledge of (medical) hybrid managers and the process of hybridization, with a particular focus on the role of context. I wished to develop an understanding of the role of the social context in which hybridization processes take place, in order to know more about why hybrids develop and the enabling conditions for their realization. Following is a synthesis of the major contributions of the different chapters, and then a discussion on the overall messages of this research work.

First of all, in Chapter 2 I looked at hybrids at the collective level showing, drawing evidence from the Italian case, that the rise of hybrids is largely path dependent – i.e. influenced by historical circumstances and decisions made in the past – and affected by the institutional surroundings with their formal rules, established power arrangements, taken-for-granted norms of conduct. New medical managers cannot develop if they do not have, or are provided with, legitimacy within the system, a legitimacy which arises from the presence and alignment of regulative, normative and cognitive forces. Accordingly, the development of new medical management roles such as clinical directors can be seriously hampered precisely in those systems in which medical management is already well established and benefits from strong legitimacy. This is a

relevant finding as it contrasts the "standardization" of medical management policies internationally, which strive to implement NPM inspired reforms with similar hospital organizational structures and managerial roles across (sometimes very) different countries. Change, and especially change in complex public professional organizations, cannot be achieved only through reforms, but requires careful and contextualized implementation processes.

Then in Chapter 3 I moved to the empirical study of hybrids at the individual level, providing new understanding to the literature on hybrids, as up to now limited attention had been paid to the influence of the institutional and organizational context on the hybridization process. I show how situational constraints can hamper hybridization, also in cases in which professionals are entrepreneurial and willing to embrace hybrid roles. Organizational support and opportunity to perform, in terms of involvement in decision-making, delegation of organizational power, endowment with management leverages and effective backing, have a key role for explaining the realization of hybridization. And organizational actors beyond the medical peer group, especially executives and non medical managers (including nurses) are extremely relevant under this respect. Therefore, many time behind professionals' resistance to management, rather than an incapable or unwilling doctor lies an authoritarian general manager or poor support staff.

In Chapter 4, looking at the hybridization process through the lenses of identity work, I have studied "the agency and social interaction processes that shape [hybrids'] responses" (Denis et al., 2015: 285) putting in evidence that hybrid doctors' identity is – at least to a certain extent – dynamic and interactive. Focusing on a Dutch case I showed that becoming a hybrid requires engaging in the three processes of familiarization, rationalization and legitimation, and that this identity work is distributed and interactive, rather than concentrated and individualistic. The purposeful agency of relevant organizational actors beyond the professional group, and in particular non medical managers and executives, play a key role in the co-creation of hybrid role identities.

In Chapter 5 I went to back to the site studied in Chapter 3 to study longitudinally which elements of the social/organizational context enable hybrids' engagement in management. I found that doctors willing to become hybrids engaged in strategy making and performance management, and this was enabled by hospital top managers. Most importantly, also reluctant hybrids proved capable of interiorizing over time organizational values and practices but in a reconfigured way, and this was favored by a social and organizational context providing space for interaction with other professionals from different specialties and beyond the disciplinary boundaries. These interactions were facilitated, among other factors, by the new physical layout which coercively redefined hybrid managers their way of working.

Finally, in the argumentative Chapter 6 I return to the collective level of analysis and I make sense of some of the research results, in light of the recent developments of medical

management in the Italian NHS and theoretical advancements in the literature on hybrids. Firstly, I show how, as a consequence of innovations in service provision, a new trend of medical management arose which appears to be more easily compatible with professional logics, therefore potentially facilitating the managerial engagement of a large proportion of professionals. Secondly, I reflect on the fact that medical management is not a homogenous concept but rather a multifaceted construct, as it may be applied to different organizational levels, from executive positions to middle management to frontline roles, and can have different contents, ranging from the govern of resources to the organization of care pathway to the strategic development of knowledge. Disentangling the different levels and dimensions of medical management is key to understand the phenomenon and provide specific guidance to professionals and administrators.

Conclusions: looking beyond hybrids

Grounding on the evidence which was collected and reported in the different chapters it is now possible to draw the overall conclusions of this work, answering the overarching research question of this book, which was: *How the rise of hybrid medical managers and the hybridization process are affected by social/organizational conditions?*

The most important finding of this research is that it is necessary to look *beyond* hybrids, at the environment surrounding them, in order to understand their rise and realization. The degree of development of new collectives of hybrid mangers in healthcare systems is not only dependant upon the strength/weakness of "traditional" values within the professional community. Seemingly, whether doctors hybridize and craft new identities or not is not simply related to personal capacities or attachment to a conventional professional mindset. Rather, context matters for hybrid managers, at both the collective and individual level, as nation specific factors, the relation with other professions, organizational support and interaction with other professionals and non medical managers determine why hybrid roles rise and how individual hybridization processes unfold. Hybrid roles and collectives develop on the basis of trajectories which are path dependant, and that are influenced by the legacy of existing medical management arrangements. At the individual level, the shaping of hybrids' identities is deeply affected by the institutional structure in which they are embedded and the complex network of relationships in which they participate.

In the following sections of this paragraph these themes will be addressed while answering the three specific subquestions.

Accounting for path dependency in the rise of hybrids

With reference to the first specific subquestion, I identified those antecedents explaining the rise of a collective of healthcare hybrid managers. First of all, I found that medical management is largely path dependent, that is: history matters. Kirkpatrick et al. (2012),

identified three dimensions that impact on the development of medical-manager roles: governance of the hospital sector; nature of organizational settlement with key professions and nature and process of public management reforms. I support this framework but I show the relevance of a fourth dimension, i.e. the level of institutionalization of the pre-existing forms of medical management.

This is a key point to understand the specificities of most European systems if compared to Anglo-Saxon countries, where most of the literature on hybrid was developed. As argued by Kirkpatrick et al. (2009: 652) "medicine in the UK still reflects an archetypal 'liberal profession', which fought hard to maintain its independence from the state […] even in the modern era, the dominant 'strategy' of medicine has been focused on independence, the ideals of self-employment and relative detachment from administration". On the contrary, in Italy as well in many European systems professionals, as highlighted by the recent studies by Bode and Maerker (2014) or Correia and Denis (2016), clinicians have consistently been interested in filling management positions. If medical managers are already institutionalized, and if the trajectories of managerialization reforms suffer from inadequate endowment of resources and competences, new hybrid managers in formal roles strive to achieve legitimacy and power. This contextualized understanding of hybrids makes it possible to overcome the focus on professionals and their responses, common in the traditional sociological literature, which tend to explain implementation problems in health organizations as a matter of professional resistance to management.

This has also significant implications, as policy making and expected outcomes are not correlated as it might be assumed, and stability and maintenance of existing arrangements may easily prevail. It provides empirical evidence to develop the findings of Kirkpatrick et al. (2013) when they argue that the institutional context plays a key role in explaining different outcomes when translating similar management ideas and models. This understanding allows to avoid managerialistic perspectives in health policy, in some cases supported by the action of consulting firms or international agencies, favoring the standardization of organizational structures and managerial tools irrespectively of local contexts.

Understanding the impact of organizational context in hybridization

The second research question wished to explore if and how the organizational context supports (or hampers) the development of individual hybrid managers. Existing literature has seen professionals as passively influenced, in an overly deterministic way, by the dominant professional mindset (Griffiths and Huges, 2000), with its strong institutionalized pressures of normative socialization (Abbott, 1988). In this scenario, individual professionals in hybrid roles are called to exert agency acting as "heroic" individuals in a lonely strive to reconcile alternative logics (Creed et al., 2010), and they can succeed or not. However, I show that a constructive interplay between individual action and the institutional structure can take place, as structure can enhance and not only prevent professionals' hybridization by providing sources of agency which stir

identity change. I demonstrate that an organizational context providing *opportunity* for engagement in management is necessary for enabling hybrids' capacity and willingness towards the reshaping of individual identities. On the other hand, the agency of entrepreneurial professionals willing to embrace hybrid roles can suffer from pressures and constraints determined by the managerial structure, rather than the professional world.

Therefore, we need to look *beyond* hybrids at the organizational context in which hybridization processes are embedded. This is in line with the recent work by Martin et al. (2017) studying what enables or constrains actors in contexts characterized by institutional change, and calling for more studies addressing the meso-level mediators of agency, as well as with the work by Bevort and Suddaby (2016) on "inhabited" institutions.

My approach, which bridged the literature of hybrids and identities with the notions of the AMO framework offered a complementary perspective on how the interplay between the individual agency and the institutional structure takes place. The analysis highlights a number of interrelated features of the organizational context which act at as *opportunity-enhancing* practices (Lepak et al., 2006; Jiang et al., 2012) which enable hybridization by empowering individuals to use their capacities and motivation. In particular, among these features I found the presence of management and governance systems delegating power to hybrids, work practices which guarantee backing in difficult decision and involvement in decision making. Professionals willing and capable to perform in managerial roles call for organizational contexts in which their agency can unfold. On the other side, organizational environments can also discourage individual action, acting as "opportunity-hindering" structures and practices.

I believe these findings are relevant considering the highly institutionalized settings of healthcare and hospitals where change of established values and practices has been considered extremely difficult.

Understanding the impact of the social context in hybridization

In addition to the organizational aspects of the context, I highlight the significance of relational and social dimensions in hybridization. The construction of professionals' hybrid identity is not individualistic, but a distributed process to which many actors participate, including managers and other professions, and which takes place in different forms. Existing research on professional identity had looked at the role of interdependencies of hybrids within the professional community (Llewellyn, 2001; Pratt et al., 2006; Witman et al., 2011). However, we knew relatively little about the interaction of hybrids with other relevant actors in professional organizations beyond the disciplinary group. I have shown that others contribute to shape hybrid identities, in particular other professionals, non medical managers and executives. They facilitate the interiorization of the new hybrid identity and the legitimization of the new role. Similar findings are reached by the recent paper by Reay et al. (2017), who, although focusing on a different group of professionals (general practitioners, who lack major managerial

responsibilities and do not work in large professional organizations) shows the importance of the interactions between professionals and business managers and the role of "relational spaces" in the creation of medical-managerial identities. They found that interactions occurring in private "safe" spaces facilitate the questioning of the old professional self and stimulates identity change. While interactions with colleagues in public spaces support the co-creation of a new shared professional identity.

Further, I show that a context facilitating social interactions within the professional group among doctors of different specialties is relevant for engaging in management also those professionals that initially appeared more reluctant towards hybrid roles. When organizational structures and work practices deliberately crafted by top management to favour these types of interaction are in place (e.g. meetings with pharmacists, hygienists, or quality staff; the involvement in pathways and multidisciplinary forms of organizing; the collaboration among disciplines required as consequence of the pooling of resources and the redefinition of working spaces) a reconfiguration of professional identities towards new organizational values is enabled. Therefore, also professionals who can be considered "incidental" hybrids, not willing to engage in strategy making or performance management, can develop the capacity to engage in medical management in other forms. They start building connections across disciplinary boundaries contributing to care pathways or other forms of forms care integration, establish linkages with actors outside the organizations (e.g. GPs) and external stakeholders, and engage in quality or safety initiatives solving the trade-offs between standardization and professional autonomy.

Overall, trying to give some indication regarding the puzzle of professional managerial hybrids - theoretically an opportunity but more often a challenge for healthcare policy and management - this study draws attention to *other* individuals, i.e. those actors surrounding hybrids in their organizational contexts apart from the professional group. I found that their role in in changing hybrid professional identities is much stronger role than had previously been considered.

The need to go beyond hybrid professionalism

This work also contributes to the literature on professionalism suggesting to go beyond hybrids in a second sense, as we need to overcome the notion of hybrid in our understanding of the evolution of medical management. This conclusion was not expected at the beginning of this research journey, and it was determined by two reasons.

On one hand, while developing research on clinical directors as hybrid managers I was puzzled by numerous clinical directors who, although struggling with some aspects of management, like strategy making or performance management, were willing to embrace a number of other organizational values. As a matter of facts in the last six years, especially in Italy, a number of hospitals started introducing reforms towards process based and patient centered structures, as well as resource sharing, that were welcome by doctors in management and clinical directors more than vertical managerial approaches typical pf previous years. Also favoured by new hospital layouts, new forms of medical

management, which I referred to as *disease management*, are now present in daily work processes including – but not limited to – quality management, safety procedures, multidisciplinary work, patient centered work design. On the other hand, as anticipated, international scholars started to suggest theoretical development to the notion of hybridity. In the last two years the contributions of Noordegraaf (2015), Martin et al. (2015) or Olakivi and Niska (2017) have been picturing a different view of hybridity, which I found appropriate to make sense of the findings I was gathering while interviewing "incidental" clinical directors.

Therefore, in order to understand hybrids it is necessary to explore the new forms in which management and professionalism are accommodating, which privilege connectivity within the organization, engagement with stakeholder as well as adherence to standards of practice. Accordingly, hybridity itself is not a homogenous concept, but rather multiple hybridities exist. In the past the focus – in theory and practice - had been placed on hybrid roles, filled by hybrid managers provided with resources and responsibilities. Increasingly, the focus is shifting towards hybrid processes and hybrid work practices, in which organizational and professional action not only coexist but coincide. I add to the nascent literature on "organizing professionalism" (Noordegraaf, 2015) evidence on the role of the organizational context to support the reconfiguration of professional practice. In line with Martin et al. (2015) I confirm that "romanticized appeals to professionalism" are not enough, as professionals need to be surrounded by contexts purposefully designed to change work processes and enable - sometimes even coercively - interaction.

While I started this PhD project talking about hybrid managers, I ended talking about (hybrid) professionals, as this form of bringing organizing in medicine and professionalism is – to some extent – at the reach of all professionals, not only those in formal managerial positions as clinical directors. Of course, senior doctors in leading roles maintain a greater responsibility in engaging in the reconfiguration of care processes in line with organizational principles, as with their behaviors and decisions influence colleagues and large portions of the clinical activity. Of course, there is no reason why the diffusion of the new model of "organizing professionalism" cannot be compatible with the "traditional" medical hybrid roles and their managerial responsibilities - including finance and strategy making - which will always be necessary, since formal hierarchical structures are in place and hybrid managers remain best suited to lead colleagues than non medical managers.

Methodological reflections

An interdisciplinary and qualitative approach

In this work I have brought together organization studies literature, in particular about institutional theory and identity theory, as well as human resource management and health care management literature. The goal was to produce a contextualised research

capable to make (theoretical and practical) contributions for different fields and for different audiences. The public administration approach provided an understanding of the politics of change in organizations; the organization studies perspective was useful to study the micro dynamics of change; the healthcare management perspective makes it possible to understand the policy context and the practical implications of hybrids and hybridization. Further, this interdisciplinary approach provides value as it helped to explore the connections between different levels, from the macro societal level to the micro interpersonal one. I made use of a qualitative multimethod research approach. Someone has asked me whether it is still necessary to study hybrids through qualitative methodologies, since they are not any more a new topic in public administration or healthcare research. Furthermore, most journals in the field of healthcare management, especially when based in the US, tend to prefer quantitative methodologies. Indeed I did not decided to adopt qualitative methods to surface a brand new phenomenon. Rather, I did it because I wished to develop a fieldwork in which I could be exposed to the complex organizational dynamics that take place in hospitals in order to answer my research question about the processes and context of hybridization. I wished to describe processes grasping situational details, and to understand people's views and interpretation of the complex reality which they experience. In this, it proved very interesting to interview multiple actors in each organization, with different professional backgrounds and with positions from the top management to the frontline. This was true for the Italian case study, but first and foremost for the Dutch case study, which was the occasion to dive into the organizational and professional dynamics of a hospital in a foreign country. At the same time, serving as a researcher in the Italian hospital also required finding solutions to avoid the risk of getting involved in political processes, as hospital executives or professionals might have tried to use answers to research questions to achieve organizational objectives.

Furthermore, hearing how interviewees described the situation they experienced helped me to discover new aspects of medical management, to which I would have probably paid less attention, for instance the development of new professionalism and the importance of hybrid process and not only roles, as illustrated in Chapters 5 and 6. Further, due to my interest in applied research, I did not want to limit to a description representing actors' interpretations and sensemaking, but also to develop research capable to identify avenues of action in order to provide guidance for health policy makers and practitioners. This is what I had the luck to experience, and it is the reason why I think that qualitative methods were the appropriate choice.

As far as the organization of the work is concerned, I have greatly appreciated the decision to structure the dissertation around a bundle of articles. I have already acknowledged the limitations of this approach, in terms of lack of depth in the literature analysis or methodology sections, or in the reduced readability. Indeed it was a necessity, as in 2012 I received some funding for the research project from the Lombardy Region – Directorate General for Education, and it made necessary to deliver part of the research outputs before the end of the PhD. At the same time, it allowed me to gain experience in

writing since the very beginning of my project, and to receive valuable feedback from colleagues and reviewers on early versions of the papers. Further, it was important from a personal viewpoint, as having research outputs ready soon provided confidence and motivation, as well as clear scheduling of work. This was particularly relevant being an external PhD student, not benefiting from a salary related to PhD project and developing most of my research while being physically located in Italy and travelling periodically to The Netherlands. Of course, it also made possible to have most of the work already published in international journals prior the viva, and provided me visibility as a researcher in the field of medical management hybrid and professionalism. Finally, it allowed to guarantee flexibility in the organization of work. For instance, initially Chapter 6 was not programmed, but reflecting on the evidence collected and the evolution of the Italian context I decided to write a final argumentative paper on the development of Italian medical management.

Some comparative considerations

Since in this work I talk a lot about context, I wish to present a few ideas regarding the comparison of Italy and the Netherlands, even though - as anticipated - the study was not designed as a comparative research. Both countries introduced medical management reforms at the beginning of the nineties, and – a least in teaching hospitals – the Dutch organizational structures and contractual arrangements resemble the Italian ones. Also, in the two countries we found relatively similar attitudes of professionals towards medical management roles. Initially most doctors resisted management, as they were not necessarily willing to redefine their professional self. Most of them passively accepted the new managerial work, or undertook it for instrumental purposes, for instance in order to oppose some undesired candidate, which might have compromised the future development of their own specialty. When they entered the role, their established professional identity was indeed dominant and in most cases the managerial choice was seen as a "sacrifice", as it meant to leave aside one's professional interests and sources of "inspiration", not to feel fully part of the professional group anymore. Management was seen instrumentally as the tool to achieve and administer power according to opportunistic interests, as those in hybrid medical manager roles continued to orientate towards their specialist peers. Yet, over time, a process of personal change ensued, supported by the interaction of medical managers with other organizational actors. Hybridization began to take place, even though at different paces.

However, I did find interesting differences, confirming what was reported earlier by Kirkpatrick et al. (2009: 643) while studying England and Denmark, i.e. that "patterns of accommodation between medicine and management are more path dependent than is frequently acknowledged". In the Dutch case the change process appeared faster and more meaningful for professionals on the basis of a number of contextual differences. They include the greater financial and strategic autonomy provided to clinical divisions; the professional quality and amount of non-medical management staff; the stability at the top of hospital executive providing direction and continuity; the overall availability of financial resources and staff which allowed to provide e.g. relevant training

opportunities, individual coaching, support and administrative personnel, etc. Many of these solutions, which greatly increase the opportunity to perform provided to professionals in management, might be introduced in Italy as well as in other countries struggling with the development of medical management. Another interesting comparison relates to the development of competency based training systems for medical students and residents in the Netherlands, valuing soft skills and organizational capabilities. Although these systems have only recently and partially been introduced, this experience appears highly relevant and might also be exported elsewhere.

As anticipated in Chapter 5, my work studies hybrid roles outside the Anglo-Saxon and the Scandinavian world, since I wished to study medical management in countries which had "imported" NPM reform templates from abroad (Dent, 2003). For this reason, I hope that the findings collected in this book can be of interest for readers from a number of European countries which are facing distinctive challenges related to political and cultural resistances in implementing health reforms that support medical management (Neogy and Kirkpatrick, 2009). For instance in France doctors heading "medical poles" were described as leveraging pre-existing professionals networks in order to achieve legitimacy in the new role (Vinot, 2014), in Germany new hybrid roles are confronted by existing practices and powers (Bode and Maerker, 2014) while in Portugal hybrids were found as reconfiguring managerial criteria according to specific interests and reinforcing medical autonomy (Correia and Denis, 2016). This is why findings from the Italian and Dutch context can provide insight for other European health systems which have shown mixed evidence with reference to the responses to hybrid roles.

Finally, my analysis focuses on healthcare, and in particular on doctors in the hospital sector. However, many of the findings reported above can offer material for reflection for other public professionals group working in organized contexts, including nurses, academics, judges, school professors or the police, which share with medical doctors most of the challenges of hybrid professional-managerial forms. Existing research comparing public professionals in different sectors is extremely interesting (e.g. Currie et al., 2016) but scarce, and it would be important to develop further comparative work on hybrids.

Practical implications: reforming professionalism and supporting hybrids

My empirical research was developed after a critical confrontation with existing literature and provided some original contributions to the scholarly debate. However, the other relevant goal of the articles bundled in this work was to draw implications for health policy and practice on how professionalism can be reformed and hybrid managers supported.

Implications for professionals and professional associations

I should firstly say that although medical management is well developed worldwide, still doctors – and most notably their organized groups – tend to see managerialization as a threat. A cultural shift should be done thanks to the understanding that medical management is not about dismantling professionalism, but rather about reconfiguring it. In particular issues like safety, quality or patient centeredness, can be seen as *both* managerial *and* professional problems. Finding new work processes capable to (effectively, not bureaucratically) address these issues, can become a relevant issue in the agenda of all doctors.

This can be done in many different ways. First of all, health education reforms should introduce training of management and organizational capabilities in medical school and residency programs. This responds to the professional need of aligning medical education with the shifting health needs and socio-economic demands. The spread of CanMEDS or other mechanisms, favouring training over time and at all levels, through tools like mentoring, visiting experiences, courses, 360° feedback, etc., should be encouraged and sponsored, in particular management training initiatives that make use of existing professional frames and traditions (Hartley, 2016). On one side, it is necessary to favour the development of educational training programs capable to develop soft skills, teamworking, interprofessional collaboration. Under this respect, programs using the wording of "medical leadership" as a substitute for "medical management" might result more effective, as offering doctors a more attractive self-narrative.

At the same time, it is necessary to foster an "organizational" sensitivity, supporting medical students in the development of an understanding of the overall process of patient care, interdisciplinary and not necessarily hospital based. An interesting avenue, as also suggested by Plochg et al. (2011), is to favour in formal training programmes the incorporation of "values" from the field of public health in the conventional set of professional values of hospital doctors. This would require to move from disease-oriented services to person-oriented services, and to think at new forms of organizing health services that consider multimorbidity rather than individual diseases and disciplines.

Training on-the-job in organizational issues is also extremely relevant, and it is an interesting area for educational innovation. Effective experiences should be spread, like the one reported by Noordegraaf et al. (2015) in which medical residents of different specialties within a hospital meet periodically to report organizational problems and discuss possible solutions. Doctors in early career stages, especially those with higher leadership potential, should be provided opportunities to engage in management of people and resources. For instance, they could be assigned responsibilities over teams, pathways, projects, in order to train them on-the-job and at the same time evaluate their managerial capacities and identify future career trajectories. Also, they could be offered the opportunity to participate in mentoring programs with (carefully selected) senior colleagues on organizational and not only clinical issues.

Implications for hospital executives

A number of interventions in hospitals' organizational structure and management systems can vastly favour the development of organizational capabilities. It is the case of proper design of physical layouts and the organizational structures, as hospitals in which outpatient services, wards and operating theatres are shared, spaces are designed to favour interdisciplinary and interprofessional encounters, horizontal pathways or care centres are formalized, multidisciplinary teams meet regularly, greatly support the early nurturing of organizational competencies among doctors. Also, the presence of quality programs and standards of practice, as well as the availability of clinical indicators and patient satisfaction data, makes evident the alignment between (at least part of) managerial decisions and professional priorities.

Appropriate selection mechanisms should be in place to identify candidates for formal managerial positions. Assessment schemes, appraising not only clinical competence but also managerial experiences and capacities should be used. Also, job interviews might include a presentation of a strategic plan for the directorate/division, in order to appraise managerial competencies and identify clear performance indicators for the mandate. At the same time, as shown multiple times in previous chapters, appropriate support for formal doctors-in-management roles should be provided. Too often non-medical staff working in hospitals and supporting doctors have inadequate professional background, with an administrative education but without the managerial capabilities and the diverse professional experiences necessary to govern the large endowments of resources which exist in hospitals. The presence of management teams supporting hybrid roles, providing them support, feedback, as well as operational assistance, has a paramount importance. Open feedback provision is greatly favoured by hospital cultures, where the value of different professions is acknowledged, i.e. where nurses or administrative staff are provided with the legitimacy to interact with doctors at the same level, and where new ideas as well as problems can be openly reported and discussed.

Formal training programs in management for high calibre professionals, which are already in place in multiple countries, can also be effective for providing knowledge of managerial tools, time for thinking on professional practice as well as exchange of experiences with colleagues. However, coaching and mentoring programs permitting deeper personal reflection and sensemaking appear even more effective to accompany professionals in their identity transition over time.

Hospital top managers should also be willing to invest in hybrid professional-managerial roles, delegating some of the leverages of power to intermediate organizational layers. Although this entails taking up the risk of slowing down processes or being exposed to opportunistic professional behaviours. However, having direct communication channels, providing professionals with autonomy, human and financial resources, as well as support and backing in "uneasy" decisions, appears necessary for favouring an effective hybridization and legitimizing new roles within the professional group and the organization.

At the same time, it is necessary to create alternative career trajectories for those high value professionals who are incapable or unwilling to take up a managerial position. In many health systems managerial roles are the only career steps which can provide doctors with adequate financial reward and status. It is necessary to devise professional career advancements, provided with internal and external visibility, as well as salary increase, available for those professionals that are not suited to become managers. The experience of the Research Manager in the Division Management Team of the hospital described in Chapter 4 is an interesting example under this respect.

The presence of medical doctors with expertise in hospital organization could also be fostered. The significant Italian experience of "hygienists", as reported in Chapter 2, has lights and shades but could provide interesting reflections for other countries, where some professionals (often trained as Public Health doctors) have similar responsibilities.

Implications for health policymakers

To conclude with some implications for health policymaking I should say that, although this has not been the focus of my work, I think it can easily be argued that in those systems where hospital doctors are not salaried by the organization but work as contracted professionals the development of real hybrid forms of medical management appears unlikely. This work shows how, in order to achieve change, it is necessary to understand the dynamics of reform implementation at the organizational level. Numerous hospital systems have been struggling with the introduction of clinical director roles as it not possible to foster managerial change by imposing standardized practices by law. On one side it is necessary to take care of the different contexts, which include the organizational cultures, existing managerial roles, top management styles, resource endowment, etc. On the other, reforms should intervene at different levels, for instance it is probably poorly effective to demand managerial competencies to senior doctors if the training and educational system stresses the professional-managerial divide.

Limitations and future directions for research

With reference to the limitations of this work, each chapter has specific limitations which have already been reported. Some limitations of the overall research design are the lack of a multiple case study approach; lack of fully crafted nested case studies (e.g. at the clinical directorate level) within each organization; lack of international comparisons; lack of quantitative or mixed methods approach; focus on hybrids in the medical profession, not including other healthcare professions, e.g. nursing. It would be extremely interesting to develop the current work by address one or more of these issues. Now I wish to briefly identify other areas for further work, which build on some of the suggestions for future research identified in the single chapters.

This thesis shows that professional work is changing and that the challenge of hybridity is now common for both medical managers and frontline professionals. However, the concept can be interpreted in different ways, privileging either formal roles or processes. Future research might examine how the "organizing professionalism" model, as an evolution of the controlled professionalism approach (Noordegraaf, 2015) can be sustained. Not only for professionals at large but specifically for that group of hybrids who are called to exercise managerial roles authority in healthcare organizations. And comparisons with healthcare professions other than doctors would provide further theoretical insights. The work by Currie et al. (2016), studying nurse managers and showing the differences between hybridization forms in high versus low performing organizations, is an interesting direction.

The lens of institutional theory can be used with the aim of broadening existing understanding of hybrid professionalism across different countries and health systems. More comparative studies can be develop to explore convergence and divergence in the adoption of medical management models and the ways in which similar organizational structures and roles are translated, becoming "dis-embedded from their original context and re-embedded in the context of adoption" (Kirkpatrick et al., 2013). Future research may investigate these arguments also in other domains within healthcare, e.g. non hospital doctors and nurses, and in other public sector areas, studying professionals in education, police, justice or social work.

Another avenue of research regards deepening our knowledge of the microprocesses of identity transition of hybrid professionals, especially underlining the impact of social interactions beyond the professional group. This research is promising and developing, as confirmed by the recent work by Reay et al. (2017) on the role of interaction between professionals and managers to reinterpret and rearrange the institutional logics that produce collective professional role identities.

Further, the study of hybridization "in context" might benefit from more interactions between the literatures on professionalism and identity with leadership research, and especially the studies on plural leadership and co-leadership in contexts characterized by institutional complexities. There is recent promising research developed by Gibeau et al. (2015; 2016) on medical-managerial co-leadership, hinting at logics combining professionalism and managerialism which echo the concepts of reconfigured and redefined professional work used in other literatures.

It would also be interesting to see more attempts at developing studies bridging professionalism theories and research on human resource management practices. We still know very little about the impact of HRM in professional organizations, characterized by status hierarchies and power, and the role of legitimacy and occupational status as a constraint or a source of motivation has not been studied in the context of the AMO perspective. In this work, together with opportunity-enhancing work environments, I only implicitly hint at skill-enhancing and motivation-enhancing practices that can support professionals in taking up the managerial hybrid role. The

work by Currie and colleagues (2015) represents a stand alone example under this respect. It would be extremely interesting to dispose of more research studying the impact of practices like training systems, talent management, incentives as well as career development systems, in supporting professionals, both in the early experiences with managerial engagement as well as when they take up hybrid managerial roles. Of course, this requires an approach to human resource management capable to take into consideration the context and to balance methodological rigour with relevance.

Finally, it is necessary to tackle one of the major flaws of the literature on hybrids, i.e. the issue of the effect of medical managerial roles and practices. While this work contributed to the knowledge of the why and how hybrids arise and develop, I have not addressed the outcomes and effectiveness in terms of either financial performance, clinical results or patient or staff satisfaction. There is some evidence that hospitals with clinically qualified managers exhibit better management practices which are linked with positive clinical and financial outcomes (Bloom, 2010), and Goodall (2009) showed that the in the US having a doctor as CEO was correlated with greater financial performance. Also, research has shown a positive association between the presence of doctors on hospital boards and hospital effectiveness, in terms of the engagement in quality improvement (Weiner et al., 1997) or perceived quality (Veronesi et al., 2013). However, we know very little regarding the benefits of hybrid managers within organizations and research needs to address this gap in order to be credible and inspire policymaking and management.

Final remarks

In this work I have offered new understanding on how hybrids rise and how hybridization unfolds by looking at the role of the social and organizational context. I did it through qualitative analysis, which allowed to delve into the complexities of the hospital organization and to look at the relational dynamics of hybrids with other key organizational actors. The reader now has new awareness of the reasons *behind* the development of hybrid managers and their role-taking, and has discovered that the answer lies *beyond* hybrids, at social and organizational contexts which enable and support the crafting of hybrid role-identities.

The academic field in which this piece of research is nested is rich and vital. Future achievements will provide evidence and theoretical awareness not only about hybrids, but about the reform of professionalism itself. With the aim to find a meaning of "who (medical) professionals are" which is convincing for today's world and capable to be the foundation for effective, sustainable and responsive healthcare systems.

REFERENCES

Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labor*. Chicago, IL: Chicago Press.

Ackroyd, S. (1996). Organization contra organizations: professions and organizational change in the United Kingdom. *Organization Studies*, 17, 599–621.

ANAAO. (2004). Indagine ANAAO Assomed sullo stato di attuazione dei dipartimenti gestionali e collegi di direzione, *Iniziativa ospedaliera*, 44 (1), 1-38.

Anessi Pessina, E., Cantù, E. (2011). Il modello di analisi, l'impostazione del Rapporto e i principali risultati. *Rapporto OASI 2011*, Milano, Egea.

Appelbaum, E., Bailey, T., Berg, P., Kalleberg, A. (2000). *Manufacturing Advantage: Why High-Performance Work Systems Pay Off*. Ithaca: Cornell University Press.

Armeni, P., Costa, F., Sommariva, S. (2015). Il confronto dei sistemi sanitari in una prospettiva internazionale. *Rapporto OASI 2015*. Milano, Egea.

Barley, S. R. (1986). Technology as an occasion for structuring: evidence from observations of CT scanners and the social order of radiology departments. *Administrative Science Quarterly*, 31 (1), 78-108.

Bergamaschi, M., Fosti, G. (2002). Lo sviluppo dei processi di dipartimentalizzazione ospedaliera: aspetti di funzionamento e meccanismi operativi. *Rapporto OASI 2001*. Milano, Egea, 429-466.

Bévort, F., Suddaby, R. (2016). Scripting professional identities: how individuals make sense of contradictory institutional logics. *Journal of Professions and Organization,* 3 (1), 17-38.

Blomgren, M., Waks, C. (2015). Coping with contradictions: hybrid professionals managing institutional complexity. *Journal of Professions and Organization*, 2(1), 78-102.

Bloom, N., Sadun, R., Van Reenen, J. (2013). Does Management Matter in Healthcare. *London School of Economics Working paper*.

Bloom N., Dorgan S., Homkes, R., Layton D., Sadun R. (2010). Management in Healthcare: Why Good Practice Really Matters Report, available http://cep.lse.ac.uk/textonly/_new/research/productivity /management/PDF/Management_ in_Healthcare_Report.pdf

Blumberg, M., Pringle, C. D. (1982). The missing opportunity in organizational research: some implications for a theory of work performance. *The Academy of Management Review*, 7(4): 560–569.

Blumenthal, D. M., Bernard, K., Bohnen, J., Bohmer, R. (2012). Addressing the Leadership Gap in Medicine: Residents' Need for Systematic Leadership Development Training. *Academic Medicine*, 87(4), 513–522.

Boselie, P. (2010). High performance work practices in the health care sector: a Dutch case study. *International Journal of Manpower*, 31(1): 42–58.

Boselie, P. (2009). A balanced approach to understanding the shaping of human resource management in organisations, *Management Revue*, 20(1), 90-108.

Boxall, P., Purcell, J. (2011). *Strategy and Human Resource Management, 3rd ed*, Basingstoke and New York: Palgrave Macmillan.

Braithwaite, J., Westbrook, M. T., Iedema, R., Mallock, N.A., Forsyth, R., Zhang, K. (2005). A tale of two hospitals: assessing cultural landscapes and compositions. *Social Science & Medicine*, 60 (5), 1149–1162.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2): 77-101.

Brock, D. M., Saks, M. (2016). Professions and organizations: A European perspective, *European Management Journal*, 34(1), 1–6.

Brock, D.M., Leblebici, H., Muzio, D. (2014). Understanding professionals and their workplaces: the mission of the Journal of Professions and Organization. *Journal of Professions and Organization*, 1 (1), 1–15.

Brock, D., Powell, M. J., Hinings, C. R. (Eds). (1999). *Restructuring the Professional Organization: Accounting, Health Care and Law*. London: Routledge.

Brown, A.D., Toyoki, S. (2013). Identity work and legitimacy. *Organization Studies*. 34 (7): 875–896.

Byrkjeflot, H., Kragh Jespersen, P. (2014). Three Conceptualizations of Hybrid Management in Hospitals, *International Journal of Public Sector Management*, 27: 441–58.

Buchanan, D. A., Addicott, R., Fitzgerald, F., Ferlie, E., Baeza, J. I. (2007) Nobody in charge: Distributed change agency in healthcare. *Human Relations*, 60, 1065-1090.

Cantù, E., Lega, F. (2002). Lo sviluppo dei processi di dipartimentalizzazione ospedaliera: aspetti di processo e scelte di struttura organizzativa. *Rapporto OASI 2001*, Milano, Egea, 394-428.

Cazzaniga, S., Fischer, S. (2014). How ICH Uses Organizational Innovations to Meet Challenges in Healthcare Management: A Hospital Case Study, in Gurtner, S., Soyez, K. (Eds.) *Challenges and Opportunities in Health Care Management*, Springer International Publishing, 355-361.

Cicchetti, A., Baraldi, S. (2001). La diffusione del modello dipartimentale nel SSN: solo un fatto formale?. *Organizzazione Sanitaria*, 1, 71-81.

Cicchetti, A., Ghirardini, A., Mascia, D., Morandi, F., Ceccarelli, A., Vigiliano, V., Poletti, P., Cardone, R., Murolo, G. (2009). Il modello organizzativo dipartimentale nel SSN: risultati dell'indagine nazionale. *Politiche sanitarie*, 10 (3), 153-68.

Chantler, C. (1993). Historical background: where have CDs come from and what is their purpose?. In A. Hopkins (Ed.). *The role of hospital consultants in clinical directorates. The Syncromesh Report.* London: Royal College of Physicians.

Chreim, S., Williams, B., Hinings, B. (2007). Inter-Level Influences on the Reconstruction of Professional Role Identity, *Academy of Management Journal*, 50 (6): 1515–39.

Correia, T., Denis., J. L. (2016). Hybrid management, organizational configuration, and medical professionalism: evidence from the establishment of a clinical directorate in Portugal. *BMC Health Services Research*, 16 (Suppl 2): 161.

Croft, C., Currie, C., Lockett, A. (2015). Broken 'two way windows'? An exploration of professional hybrids. *Public Administration,* 93 (2): 380-394.

Currie, G., Burgess, N., Tuck, P. (2016). The (un)desirability of hybrid managers as 'controlled' professionals: comparative cases of tax and healthcare professionals. *Journal of Professions and Organization,* 3(2), 142-153.

Currie, G., Burgess, N. and Hayton, J. C. (2015). HR Practices and Knowledge Brokering by Hybrid Middle Managers in Hospital Settings: The Influence of Professional Hierarchy. *Human Resource Management*, 54: 793–812.

Currie, G., Dingwall, R., Kitchener, M., Waring, J. (2012). Let's dance: Organization studies, medical sociology and health policy. *Social Science & Medicine*, 74 (3): 273-280.

Currie, G., Lockett, A., Finn, R., Martin, G., Waring J. (2012). Institutional Work to Maintain Professional Power: Recreating the Model of Medical Professionalism, *Organization Studies*, 33, 7, 937–62.

Daudigeos, T. (2013). In their profession's service: how staff professionals exert influence in their organization. *Journal of Management Studies*, 50, 722–49

De Bruijn, J. A. (2010). *Managing Professionals*. London: Routledge.

Deem, R., Hillyardand, S., Reed, M. (2007). *Knowledge, Higher Education, and the New Managerialism: The Changing Management of UK Universities*. Oxford: Oxford University Press.

Deephouse, D. L., Suchman, M. C. (2008). Legitimacy in Organizational Institutionalism, in Greenwood, R., Oliver, C., Sahlin, K., Suddaby, R. (Eds.), *The SAGE handbook of organizational institutionalism*, 49-77, Thousand Oaks CA, Sage.

Degeling, P., Zhang, K., Coyle, B., Xu, L., Meng, Q., Qu, J., Hill, M. (2006). Clinicians and the governance of hospitals: a cross-cultural perspective on relations between profession and management. *Social Science & Medicine*, 63 (3), 757–775.

Denis, J.L., Van Gestel, N. (2016). Medical doctors in healthcare leadership: theoretical and practical challenges. *BMC Health Services Research,* 16(Suppl 2), 158.

Denis, J.L., Ferlie, E., Van Gestel, N. (2015). Understanding Hybridity in Public Organizations. *Public Administration*, 93 (2), 273–289.

Denis, J.-L., Lamothe L., Langley, A. (2001). The Dynamics of Collective Leadership and Strategic Change in Pluralistic Organizations. *Academy of Management Journal*, 44 (4), 809–37.

Dent, M. (2005). Post-New Public Management in public sector hospitals? The UK, Germany and Italy. *Policy & Politics*, 33(4), 623-636.

Dent M. (2003). *Remodelling hospitals and health professions in Europe. Medicine, nursing and the state*. Basingstoke: Palgrave Macmillan.

De Pietro, C., Prenestini, A. (2008). Governance professionale nelle aziende sanitarie pubbliche: il ruolo del Collegio di direzione e del Consiglio dei sanitari, *Rapporto OASI 2008*, Milano, Egea, 301-326.

De Wit, B. (2013). *Loyale leiders [Loyal Leaders]*. PhD thesis, Utrecht University.

Dwyer, A.J. (2010). Medical managers in contemporary healthcare organisations: a consideration of the literature. *Australian Health Review*, 34(4), 514-522.

DiMaggio, P., Powell, W. W. (1983). The iron cage revisited: institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, 48, 147-160.

Doolin, B. (2002). Enterprise Discourse, Professional Identity and the Organizational Control of Hospital Clinicians. *Organization Studies*, 23, 369–90.

Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, 14, 532–550.

Eisenhardt, K. M., Graebner, M. E. (2007) Theory Building From Cases: Opportunities And Challenges *Academy of Management Journal,* 50 (1), 25–32.

Fantini, M. P., Randazzo, C., Rustico, E., Tedesco, D., Lega, F. (2015) Le Direzioni Sanitarie ospedaliere: sfide e traiettorie di rinnovamento. *Politiche Sanitarie*, 16(3), 177-184.

Fattore, G., Longo, F., Sartirana, M. (2013). Il curriculum vitae dei Direttori Generali. *Rapporto OASI 2013*. Milano; Egea.

Ferlie, E., Ashburner, L., Fitzgerald, L., Pettigrew, A. (1996). *The New Public Management in Action*. Oxford: Oxford University Press.

Ferré, F., de Belvis, A. G., Valerio, L., Longhi, S., Lazzari, A., Fattore, G., Ricciardi, W., Maresso, A. (2014). Italy: Health System Review. *Health Systems in Transition*, 16(4), 1–168.

Fitzgerald, L., Dufour, Y. (1998). Clinical management as boundary management, a comparative analysis of Canadian and U.K. healthcare institutions. *Journal of Management in Medicine*, 12 (4/5), 199–213.

Floyd, A., Dimmock, C. (2011). 'Jugglers', 'copers' and 'strugglers': academics' perceptions of being a head of department in a post-1992 UK university and how it

influences their future careers. *Journal of Higher Education Policy and Management*, 33(4), 387–399.

Forbes, T., Hallier, J., Kelly, L. (2004). Doctors as managers: investors and reluctants in a dual role. *Health Services Management Research*, 17 (3), 167–176.

France, G., Taroni, F. (2005). The evolution of health-policy making in Italy. *Journal of Health Politics, Policy and Law*, 30 (1-2), 169–187.

Freidson, E. (2001) *Professionalism: The Third Logic*. Chicago: University of Chicago Press.

Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy and Policy*. Cambridge: Polity Press.

Freidson, E. (1985). The reorganisation of the medical profession, *Medical Care Review*, 42 (1) 11–35.

Gibeau, E. M., Van Schendel, N., Langley, A. Denis, J. L. (2016). Towards new forms of governance in health care: Experiments in medical-administrative co-leadership. Paper presented at 32nd EGOS conference, Naples.

Gibeau, E.M., Reid, W., Langley, A., (2015). Co-leadership: contexts, configurations and conditions, In J. Storey, K. J. Hartley, J.-L. Denis, P.T. Hart & D. Ulrich (Eds.) *Routledge Companion to Leadership*, London, UK: Routledge

Glouberman, S. Mintzberg, H. (2001). Managing the care of health and the cure of disease–part I: differentiation. *Health Care Management Review*, 26(1), 56–69.

Goodall A. (2011). Physician-leaders and hospital performance: is there an association? *Social Science & Medicine*, 73(4), 535-539.

Gould-Williams, J. S., Gatenby, M. (2010). The effects of organizational context and teamworking activities on performance outcomes: a study conducted in England local government. *Public Management Review*, 12(6), 759–787.

Greenwood, R., Raynard, M., Kodeih, F., Micelotta, E. R., Lounsbury, M. (2011). Institutional complexity and organizational responses. *Academy of Management Annals*, 5(1), 317–371.

Griffiths, L., Hughes, D. (2000). Talking contracts and taking care: managers and professionals in the British National Health Service internal market. *Social Science & Medicine*, 51 (2): 209–222.

Ham, C., Dickinson, H. (2008). *Engaging Doctors in Leadership: What we can learn from international experience and research evidence?* NHS Institute for Innovation and Improvement, London.

Harrison, R. Miller, S. (1999). The contribution of clinical directorates to the strategic capability of the organization. *British Journal of Management*, 10 (1), 23-29.

Harrison, S., Pollitt, C. (1994). *Controlling health professionals: the future of work and organization in the National Health Service*. Buckingham: Open University Press.

Hartley, K. (2016). Untangling approaches to management and leadership across systems of medical education. *BMC Health Services Research*, 16(Suppl 2), 180.

Helay, J., McKee, M. (2002). *Hospitals in a Changing Europe*. Buckingham: Open University Press.

Hoff, T.J., (2001). Exploring dual commitment among physician executives in managed care. *Journal of Healthcare Management*, 46 (2), 91-111.

Hoff, T.J., (1999). The paradox of legitimacy: physician executives and the practice of medicine. *Health Care Management Review*, 24 (4), 54-64.

Hoff, T.J. and McCaffrey, D. (1996), "Adapting, resisting, and negotiating: how physicians cope with organizational and economic change", *Work and Occupations*, 23(2), 165-189.

Hunter, D.J. (1992). Doctors as managers: poachers turned gamekeepers?. *Social Science & Medicine.* 35 (4), 557–566.

Ibarra, H. (1999). Provisional selves: experimenting with image and identity in professional adaption. *Administrative Science Quarterly.* 44 (4), 764-791.

Jiang, K., Lepak, D. P., Hu, J., Baer, J. (2012). How does human resource management influence organizational outcomes? A meta-analytic investigation of the mediating mechanism. *Academy of Management Journal*, 55, 1264-1294.

King's Fund. (2011) *The Future of Leadership and Management in the NHS: No More Heroes.* Available at http://www.kingsfund.org.uk/sites/files/kf/future-of-leadership-and-management-nhs-may-2011-kings-fund.pdf

Kirkpatrick, I., Ackroyd, S. Walker, R.M. (2005). *The New Managerialism and Public Service Professions: Change in Health, Social Services, and Housing*. Basingstoke: Palgrave-Macmillan.

Kirkpatrick, I., Bullinger, B., Lega, F., Dent, M. (2013). The translation of hospital management reforms in European health systems: a framework for comparison. *British Journal of Management*, 24, S48–61.

Kirkpatrick, I., Dent, M., Lega, F. Bullinger, B. (2012). The development of medical manager roles in European Health Systems: A Framework for Comparison. *International Journal of Clinical Practice*, 66 (2), 121–124.

Kirkpatrick, I., Jespersen, P.K., Dent, M. Neogy, I. (2009). Medicine and management in a comparative perspective: The case of Denmark and England. *Sociology of Health and Illness*, 3(5), 642–658.

Kirkpatrick, I., Kuhlmann, E., Hartley, K., Dent, M., Lega, F. (2016). Medicine and management in European hospitals: a comparative overview. *BMC Health Services Research,* 16(Suppl 2), 171.

Kirkpatrick, I., Noordegraaf, M. (2015). Hybrid professionalism: the re-shaping of occupational and organisational logics. In L. Empson, D. Muzio, J. Broschak & B. Hinings (Eds.). *The Oxford Handbook on Professional Service Firms*. Oxford: Oxford University Press.

Kitchener, M. (2002). Mobilizing the logic of managerialism in professional fields: The case of academic health centre mergers. *Organization Studies*. 23 (3):, 391–420.

Kitchener, M. (2000). The "bureaucratization" of professional roles: the case of clinical directors in UK Hospitals. *Organization*, 7 (1), 129–54.

Kroneman, M., Boerma, W., van den Berg, M., Groenewegen, P., de Jong, J., van Ginneken, E. (2016). The Netherlands: health system review. *Health Systems in Transition*, 18(2), 1–239.

Kuhlmann, E, Burau, V., Correia, T., Lewandowski, R., Lionis, C., Noordegraaf M., Repullo, J. (2013). A manager in the minds of doctors: a comparison of new modes of control in European hospitals. *BMC Health Services Research*, 13(1), 246-256.

Kuhlmann, E., Rangnitt, Y., von Knorring, M. (2016). Medicine and management: looking inside the box of changing hospital governance. *BMC Health Services Research,* 16(Suppl 2):171.

Kurunmaki, L. (2004). A hybrid profession - the acquisition of management accounting expertise by medical professionals. *Accounting Organizations and Society,* 29**:** 327-347.

Kvale S., Brinkmann, S. (2009). *Learning the Craft of Qualitative Research Interviewing*. California: SAGE Publications.

Lawrence, T.B., and R. Suddaby. 2006. "Institutions and institutional work". In S.R., Clegg, C., Hardy, T.B., Lawrence & W.R., Nord (Eds.) Handbook of organization studies 2nd edition (pp.215-254). London: Sage.

Lawrence, T. B., Zilber, T. B., Leca, B. (2013). Institutional work: Current research, new directions and overlooked issues. *Organization Studies*, 34 (8), 1023-1033.

Lega, F. (2008). The rise and fall(acy) of clinical directorates in Italy. *Health Policy*, 85 (2), 252-262.

Lega, F. (2005). Lights and shades in the managerialization of the Italian National Health Service. *Health Services Management Research*, 21 (4), 248-261.

Lega, F. (2002). Il mistero del dipartimento ospedaliero. *Mecosan*, 10 (41), 73-77.

Lega, F. (1999). Dalla struttura alle persone: considerazioni su natura, finalità e ruolo del dipartimento ospedaliero, *Mecosan*, 8 (30), 9-24.

Lega, F., Calciolari, S. (2012). Coevolution of hospitals and patients: how changing epidemiology and technology advances drive organisational innovations and lay new challenges. *Journal of Healthcare Management*, 57(1), 17-33.

Lega, F., De Pietro, C. (2005). Converging Patterns in Hospital Organisation: Beyond the Professional Bureaucracy. *Health Policy*, 74(3), 261-281.

Lega, F., Prenestini, A., Spurgeon, P. (2013). Is Management Essential to Improving the Performance and Sustainability of Health Care Systems and Organizations? A Systematic Review and a Roadmap for Future Studies. *Value in Health*, 16, S 46 – S 51.

Lega, F., Sartirana, M. (2016). Making doctors manage… but how? Recent developments in the Italian NHS. *BMC Health Services Research,* 16(Suppl 2), 171.

Lepak, D. P., Liao, H., Chung, Y., Harden, E. E. (2006). A conceptual review of human resource management systems in strategic human resource management research. In J. J. Martocchio (Ed.), *Research in personnel and human resource management*, 25, 217–271. Greenwich, CT: JAI.

Leung A., Zietsma, C., Peredo, A. M. (2014). Emergent identity work and institutional change: the 'quiet' revolution of Japanese middle-class housewives. *Organization Studies,* 35 (3), 423-450.

Liberati, E. G., Gorli, M., Scaratti, G. (2015). Reorganising hospitals to implement a patient-centered model of care: Effects on clinical practice and professional relationships in the Italian NHS. *Journal of Health Organization and Management,* 29(7), 848 – 873.

Llewellyn, S. (2001). Two way windows: clinicians as medical managers. *Organization Studies*, 22 (4), 593-623.

Lockett, A., Currie, G., Waring, J., Finn R., Martin, G. (2012). The role of institutional entrepreneurs in reforming healthcare. *Social Science & Medicine*, 74 (3), 356-363.

Lo Scalzo, A., Donatini, A., Orzella, L., Cicchetti, A., Profili, S.S. and Maresso, A. (2009). Italy: Health System review, *Health Systems in transition*, 11 (6), 1-216.

Marnoch, G., McKee, L., Dinnie, N. (2000). Between organizations and institutions: legitimacy and medical managers. *Public Administration*, 78 (4), 967-986.

Martin, G. P., Armstrong, N., Aveling, E. L., Herbert, G., Dixon-Woods, M. (2015). Professionalism Redundant, Reshaped, or Reinvigorated? Realizing the "Third Logic" in Contemporary Health Care. *Journal of Health and Social Behavior*, 56(3), 378-97.

Martin G., Beech, N., MacIntosh, R., Bushfield, S. (2015). Potential challenges facing distributed leadership in health care: evidence from the UK National Health Service. *Sociology of Health and Illness*, 37, 14–29.

Martin, G., Currie, G., Weaver, S., Finn, R., McDonald R. (2017). Institutional Complexity and Individual Responses: Delineating the Boundaries of Partial Autonomy. *Organization Studies* 38 (1), 103 – 127.

McKee, L., Marnoch, G. Dinnie, N. (1999) Medical managers: puppets or puppetmasters?. in A. Mark and S. Dopson (eds.), *Organisational Behaviour in Health Care: The Research Agenda*. Basingstoke: Macmillan Press.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L. and Waring, J. (2015). Hybrid manager-professionals' identity work, the maintenance and hybridization of professionalism in managerial contexts. *Public Administration*, 92 (2), 412-432.

Meyer, J.W., Rowan, B. (1977). Institutionalized organizations: formal structure as myth and ceremony. *American Journal of Sociology*, 83(2), 340-363.

Mintzberg, H. (1983). *Power in and around organizations*. Englewood Cliffs: Prentice Hall

Mo, T.O. (2008). Doctors as managers: moving towards general management?, *Journal of health organization and management*, 22 (4), 400-415.

Montgomery K. (2001). Physician executives: The evolution and impact of a hybrid profession, in Blair J, Fottler M, Savage G, (Eds.) *Advances in Health Care Management Volume 2*, Emerald Group Publishing Limited.

Morandi, F., Mascia, D., Cicchetti, A. (2011). Il decoupling nelle organizzazioni sanitarie: il caso dei dipartimenti ospedalieri Italiani. *Mecosan*, 20 (79), 57-72.

Muzio, D., Kirkpatrick, I. (2011). Introduction: Professions and organizations – a conceptual framework. *Current Sociology*, 59, 389–405.

Neogy I, Kirkpatrick I. (2009). *Medicine in Management: Lessons across Europe*. Leeds: Centre for Innovation in Health Management. University of Leeds.

Noordegraaf, M. (2015). Hybrid professionalism and beyond. (New) forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization*, 2 (2), 187-206.

Noordegraaf, M. (2013). Reconfiguring Professional Work: Changing Forms of Professionalism in Public Services. *Administration and Society*, 48(7), 783 - 810.

Noordegraaf, M. (2007). "From "pure" to "hybrid" professionalism. Present-day professionalism in ambiguous public domains. *Administration and Society*, 39 (6), 761-785.

Noordegraaf, M., De Wit., B. (2012). Responses to managerialism: how management pressures affect managerial relations and loyalties in education. *Public Administration*, 90, 957–973.

Noordegraaf, M., Schneider, M. E. Van Rensen, E. L. J., Boselie, J. P. P. E. F. (2015). Cultural Complementarity: Reshaping professional and organizational logics in developing frontline medical leadership. *Public Management Review*. 18(8), 1111-1137.

Noordegraaf, M., Steijn B. (Eds.) (2013). *Professionals under Pressure: The Reconfiguration of Professional Work in Changing Public Services*. Amsterdam University Press.

Numerato, D., Salvatore, D., Fattore, G. (2011). The impact of management on medical professionalism: a review. *Sociology of Health & Illness*, 34 (4), 626-644.

Olakivi, A., Niska, M. (2017). Rethinking managerialism in professional work: from competing logics to overlapping discourses. *Journal of Professions and Organization*, 4 (1), 20-35.

Oliver, C. (1992). The antecedents of De-institutionalization. *Organization Studies*, 13 (4), 565-588.

O'Really D., Reed M. (2011). The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization, *Organization Studies,* 32 (8), 1079-1101.

Pache, A. C., Santos, F. (2013). Embedded in Hybrid Contexts: How Individuals in Organizations Respond to Competing Institutional Logics. *Research in the Sociology of Organizations*, 39: 3–35.

Paauwe, J., Boselie, P. (2003). Challenging 'strategic HRM' and the relevance of the institutional setting. *Human Resource Management Journal*, 13(3), 56-70.

Petracca F, Ricci A. (2015) *La struttura e le attività del SSN. Rapporto OASI 2015*. Milano; Egea.

Peters, L. H., O'Connor, E. J. (1980). Situational constraints and work outcomes: the influences of a frequently overlooked construct. *The Academy of Management Review*, 5(3), 391–397.

Pirola, F. S., Enna, C., Gazzi, M., Riccò, M., Raboini, I., Prenestini, A., Sartirana, M., Sircana, L. (2015) Un nuovo modello organizzativo per l'Azienda Ospedaliero-Universitaria di Parma: gestione e applicazione all'area ortopedica. *Organizzazione Sanitaria*, 39(3), 33-48.

Plochg, T., Klazinga, N., Schoenstein, M., Starfield, B. (2011). Reconfiguring health professions in times of multimorbidity: Eight recommendations for change. In *OECD Health Reform: Meeting the Challenge of Ageing and Multiple Morbidities*, OECD Publishing.

Poser, P., Prenestini, A. (2010). Analisi dei modelli organizzativi e di governance dei teaching hospitals: multiple case studies, in Carbone, C., Lega, F. and Prenestini, A., *Governance e organizzazione delle Aziende Ospedaliero-Universitarie*, Milano, Egea.

Postma, J., Oldenhof, L., Putters, K. (2014). Organized Professionalism in Healthcare: Articulation Work by Neighbourhood Nurses. *Journal of Professions and Organization*, 1(2), 61-77.

Pratt, M.G., Rockmann, K. W., Kaufmann, J. B. (2006). Constructing professional identity: the role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*, 49 (2), 235-262.

Reay, T., Goodrick, E., Waldorff, S., Casebeer, A. (2017). Getting Leopards to Change their Spots: Co-Creating a New Professional Role Identity. *Academy of Management Journal*, 60(3), 1043-1070.

Ritzer, G., Walcak, D. (1988). Rationalization and deprofessionalization of physicians. *Social Forces,* 67, 1–22.

Sahlin-Andersson, K. (1996). Imitating by editing success: the construction of organizational fields and identities. In B. Czarniawska and G. Sevón (eds), *Translating Organizational Change*, 69–92. Berlin: Walter de Gruyter.

Saldana, J. (2012). *The coding manual for qualitative researchers 2nd edition*, Sage Publications Ltd.

Schott, C., Van Kleef, D. D., Noordegraaf, M. (2016). Confused Professionals? Capacities to Cope with Pressures on Professional Work. *Public Management Review*, 18(4), 583-610.

Scott, W.R. (2008). Lords of the dance: professionals as institutional agents. *Organization Studies,* 29(2): 219-238.

Scott, W. R. (2001). *Institutions and organizations*, Sage, Thousand Oaks.

Selznick, P. (1992). *The moral Commonwealth: social theory and the promise of community*, Berkeley, University of California Press.

Senato della Repubblica. (2001). Commissione parlamentare di inchiesta sul Sistema Sanitario: Il funzionamento delle aziende sanitarie locali e delle aziende ospedaliere con particolare riferimento allo stato del processo di aziendalizzazione, Doc. XXII-bis n. 1 All. 8, pp. 1-116.

Siemsen, E., Roth, A. V., Balasubramanian, S. (2008). How motivation, opportunity, and ability drive knowledge sharing: the constraining-factor model, *Journal of Operations Management*, 26(3): 426–445.

Smets, M., Morris, T., Greenwood, R. (2012). From practice to field: A multilevel model of practice-driven institutional change. *Academy of Management Journal*, 55, 877–904.

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

Spurgeon, P., Clark, J., Ham, C. (2011) *Medical Leadership: From the Dark Side to Centre Stage*. Radcliffe Publishing, London.

Spurgeon, P., Long, P., Clark, J., Daly, F. (2015). Do we need medical leadership or medical engagement*? Leadership in Health Services*, 28(3), 173-84.

Strauss, A., Corbin, J. M. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory - 2nd edition*. Sage.

Stryker, S. (2007). Identity Theory and Personality Theory: Mutual Relevance. *Journal of Personality*, 75, 1083–1102.

Suchman, M. C. (1995). Managing legitimacy: strategic and institutional approaches. *The Academy of Management Review*, 20(3), 571-610.

Sveningsson, S., Alvesson, M. (2003). Managing managerial identities: Organizational fragmentation, discourse and identity struggle. *Human Relations.* 56 (10), 1163-1194.

Teelken, C. (2015). Hybridity, coping mechanisms, and academic performance management: comparing three countries. *Public Administration*, 93, 307–323.

Thomas, R. Davies, A. (2005). Theorizing the micro-politics of resistance: New Public Management and managerial identities in the UK public services. *Organization Studies*, 26 (5), 683-706.

Thorne, M. L. (1997). Being a clinical director: first among equals or just a go-between? *Health Services Management Research*, 10(4), 205–15.

Tozzi, V. D., Longo, F., Pacileo, G., Salvatore, D., Pinelli, N., Morando, V. (2014). *PDTA standard per le patologie croniche*, Milano; Egea.

Van Maanen, J. (1979). The fact of fiction in organizational ethnography. *Administrative Science Quarterly*, 24, 539–550.

Veronesi, G., Kirkpatrick, I., Vallascas, F. (2013) Clinicians on the board: What difference does it make? *Social Science & Medicine*, 77, 147-155.

Villa, S., Barbieri, M., Lega, F. (2009) Restructuring Patient Flow Logistics Around Patient Care Needs: Implications and Practicalities from Three Critical Cases. *Health Care Management Science,* 12, 155-165.

Vinot, D. (2014) Transforming hospital management à la francaise: The new role of clinical managers in French public hospitals. *The International Journal of Public Sector Management*, 27(5), 406–416.

Vlastarakos, V., Nikopoulos, T. (2007). The interdisciplinary model of hospital administration: do health professionals and managers look at it in the same way? *European Journal of Public Health*, 18(1), 71-76.

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

Wallenburg, I., Helderman, J. K., de Bont, A., Scheele, F., Meurs, P. (2012) Negotiating Authority: A Comparative Study of Reform in Medical Training Regimes. *Journal of Health Politics Policy and Law*, 37(3), 439-467.

Waring, J., Currie, G. (2009). Managing expert knowledge: organizational challenges and occupational futures for the UK medical profession. *Organization Studies*, 30 (7), 755-778.

Weiner, B. J. , Shortell, S. M., Alexander, J. A. (1997)Promoting Clinical Involvement in Hospital Quality Improvement Efforts: The Effects of Top Management, Board, and Physician Leadership. *Health Services Research*, 32 (4), 491–510.

Weiss, R. S. (1994). *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: Free Press.

Wilsford, D. (1994). Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy*, 14 (3), 251–283.

Witman, Y., Smid, G. A. C., Meurs, P.L., Willems, D. L. (2011). Doctor in the lead: balancing between two worlds. *Organization*, 18 (4), 477-495.

Yin, R. K. (2009). *Case study research: design and methods*. Sage.

SUMMARY IN DUTCH - SAMENVATTING

"HYBRIDE MANAGERS"

EEN INSTITUTIONEEL PERSPECTIEF OP DE OPKOMST EN VORMGEVING VAN MEDISCH MANAGEMENT

Achtergrond en onderzoeksvraag

Managementhervormingen bij publieke diensten zoals onderwijs, justitie, sociale voorzieningen of gezondheidszorg vereisen in toenemende mate van professionals dat zij naast doelmatigheid ook rekening houden met efficiëntie, dat ze publiekelijk verslag doen van prestaties, en dat ze verantwoording afleggen aan het brede publiek in plaats van (alleen) aan de beroepsgroep (Ferlie et al., 1996). In de gezondheidszorg zijn medisch-bestuurlijke "hybriden" ontstaan, d.w.z. medische professionals die zich bezighouden met het managen van werk, collega's en andere middelen van de organisatie. De inzet van deze mensen wordt gezien als poging om de spanning tussen traditionele beroepswaarden en nieuwe organisatorische paradigma's te verminderen (Fitzgerald en Dufour, 1998; Montgomery, 2001; Numerato et al., 2011). Om die reden duiken hybriden op in gezondheidszorgstelsels overal ter wereld, van de Verenigde Staten, het Verenigd Koninkrijk, Canada, Nieuw Zeeland en Australië tot landen in Noord-, Centraal- en Zuid-Europa.

Onderzoek heeft echter aangetoond dat professionals die managementfuncties en bestuurlijke functies op zich nemen op verschillende manieren reageren op tegengestelde eisen. Terwijl sommigen hun hybride rol optimaal vervulden en zinvolle combinaties van professionele en organisatie/bestuurlijke waarden wisten te creëren (Noordergraaf, 2007), volgden anderen voor het oog de managementmethoden zonder daar echt inhoud aan te geven (Kitchener, 2002). Over hen wordt gezegd dat zij uit eigenbelang 'managerial' c.q. bestuurlijke karaktertrekken overnemen in plaats van op te gaan in de managementmethode (Waring en Currie, 2009). Het is daarom nodig om de voorwaarden voor het ontwikkelen van hybride rollen op zowel het collectieve als het individuele niveau te bestuderen en om te begrijpen hoe deze ondersteund kunnen worden.

Een aantal studies gaat in op de schakelfunctie van context bij het verklaren van de opkomst van de variëteit aan hybride medische bestuursmodellen op collectief niveau. Bijvoorbeeld Kirkpatrick et al. (2012), zij onderkennen drie dimensies die de variëteit tussen landen verklaren, waaronder de aansturing van de ziekenhuissector, de aard van organisatorische regelingen met essentiële beroepsgroepen en de aard en wijze van hervorming van de publieke sector. Dit theoretische raamwerk vraagt evenwel om

empirisch onderzoek dat dit kan uitwerken en dat de nationale verschillen bestudeert ten aanzien van de wijze waarop medewerkers hybride functies institutionaliseren en vervullen.

Maar ook de omstandigheden waaronder de hybridisering van afzonderlijke artsen geschiedt, vereist meer onderzoek, want we moeten verder kijken dan de responsstrategieën van de hybriden en zowel de organisatorische voorwaarden als "the agency and social interaction processes that shape these responses" (Denis et al 2015: 285) bestuderen. Omdat de meeste onderzoeken in de medische wereld zich beperken tot wisselwerkingen binnen de beroepsgroep weten wij met name weinig over de rol van de sociale/organisatorische context op die afzonderlijke krachten.

Deze studie draagt bij aan het vullen van die leemtes en onderzoekt de opkomst en werking van medische managers, met als doel het leveren van informatie aan wetenschappers en aan beleidsmakers en managers in de gezondheidszorg. De onderzoeksvraag van deze studie luidt: "*Hoe hybridiseren medische managers in de loop van de tijd, en wordt – en zo ja: hoe – deze ontwikkeling beïnvloed door de sociale en organisatorische context waarin zij werkzaam zijn*?"

Met het oog op het leveren van een bijdrage aan het terrein van het hybride professionalisme, baseer ik mij voornamelijk op het theoretische perspectief van de institutionele theorie en in het bijzonder op studies aangaande institutionele verandering en identiteit. Die zijn een waardevol uitgangspunt voor het bestuderen van complexe professionele organisaties (bijv. Greenwood et al. 2011, Lockett et al. 2012), aangevuld met inzichten uit de sociologie van beroepen.

Onderzoeksopzet en casusselectie

De empirische analyse werd uitgevoerd na bestudering van de bestaande literatuur. Ik heb gekozen voor een interpretatieve en inductieve benadering en een onderzoeksopzet met kwalitatieve casestudies. De gegevens zijn afkomstig uit verschillende bronnen, waaronder archieven, semigestructureerde vraaggesprekken met medische en niet-medische managers/bestuurders en participerende observatie tijdens management/bestuursvergaderingen. Hierdoor was ik in staat de rijke en praktische context te doorgronden waarin hybride bestuurders ontstaan, waarmee een antwoord wordt gegeven op het "hoe" en "waarom" van dit ingewikkelde verschijnsel.

Omdat ik medisch management analyseer in landen die blauwdrukken voor New Public Management-hervormingen uit het buitenland hebben "geïmporteerd", onderzoekt deze studie hybride functies buiten de Angelsaksische wereld. Ik heb ziekenhuizen in Italië en Nederland (de keuze viel op een academisch ziekenhuis) onderzocht omdat deze landen overeenkomsten vertonen die een zinvolle vergelijking mogelijk maken. In beide landen ontstond midden jaren negentig aandacht voor medische managementfuncties en door de bank genomen staat de ontwikkeling van het medisch management er op gelijke hoogte (Neogy en Kirkpatrick, 2009).

Ik heb twee instellingen onderzocht. De eerste is een groot openbaar ziekenhuis in Noord-Italië. De keuze viel op dit ziekenhuis omdat hybride functies er in toenemende mate werden ontwikkeld en versterkt en het – gedurende de onderzoeksperiode – naar een andere locatie verhuisde en organisatorische wijzigingen onderging. De tweede instelling is een groot openbaar academisch ziekenhuis in Nederland met klinische afdelingen die sinds de vroege jaren negentig in bestuurlijk opzicht autonoom zijn.

Voornaamste bevindingen

In deze studie benoem ik, ten eerste, de omstandigheden die de opkomst van een groep hybride managers in de gezondheidszorg verklaren. Ik kom tot de conclusie dat medisch management grotendeels *padafhankelijk* is, dat wil zeggen: het verleden speelt een rol. Kirkpatrick et al. (2012) formuleerden drie dimensies die van invloed zijn op de ontwikkeling van de functie van medische managers. Ik erken de waarde van dit raamwerk, maar ik laat de betekenis van een vierde dimensie zien, namelijk de mate van institutionalisering van al bestaande vormen van medisch management. Als medische managers reeds geïnstitutionaliseerd zijn, streven nieuwe hybride managers met een formele functie naar legitimiteit en macht. Dit is een belangrijke bevinding omdat zij haaks staat op de internationale "standaardisatie" van beginselen van medisch management, die streeft naar hervormingen in vergelijkbare organisatievormen van ziekenhuizen en managementfuncties in (soms zeer) verschillende landen.

Tevens toon ik aan dat een *organisatorische context* die betrokkenheid bij het management mogelijk maakt een voorwaarde is voor het optreden van hybride identiteitsveranderingen. De bestaande literatuur neemt aan dat professionals, op overdreven deterministische wijze, passief invloed ondergaan van de heersende professionele mentaliteit (Griffiths en Huges, 2000). Daarbij worden individuele professionals met een hybride, bemiddelende functie afgeschilderd als "helden" in een eenzame strijd om alternatieve denkwijzen met elkaar te verzoenen (Creed et al., 2010). Ik laat echter zien dat opbouwend samenspel mogelijk is tussen individueel handelen en de institutionele structuur. Structuren hoeven de hybridisering van professionals niet te hinderen, maar kunnen die ook vergroten door te voorzien in op verandering gericht bemiddelingsgereedschap. Vormen van ondersteuning, zoals betrokkenheid bij besluitvormingsprocessen, het delegeren van organisatorische invloed, het verschaffen van management- en bestuursinvloed en effectieve steun, zijn essentieel in het verklaren van de wijze waarop hybridisering gestalte krijgt.

Vervolgens belicht ik het belang van *relationele en sociale dimensies* bij hybridisering. Uitgroeien tot een hybride is geen individueel maar een gezamenlijk proces waarin velen een rol spelen. Het bestaande onderzoek over professionele identiteit richt zich op de rol van onderlinge afhankelijkheden binnen de beroepsgroep (Llewellyn 2001; Pratt et al., 2006; Witman et al. 2011), maar ik toon aan dat relevante spelers – met name ondersteunend personeel, niet-medische managers en leidinggevenden – bijdragen aan de verinnerlijking van de nieuwe hybride identiteit en de legitimering van de nieuwe

functie. Een context die sommige vormen van sociale interactie mogelijk maakt, biedt ook aan professionals die aanvankelijk huiverig stonden tegenover hybride functies de ruimte om zich met management bezig te houden.

Deze studie is, tot slot, ook een bijdrage aan de recente literatuur over professionalisme (Noordegraaf, 2105; Martin et al., 2015) door te wijzen op de noodzaak het idee van hybride los te laten in ons denken over de ontwikkeling van medisch management. Om het werk van vandaag te kunnen uitvoeren is het noodzakelijk om de nieuwe vormen te onderzoeken waarin management en professionalisme samengaan en waarin betrokkenheid binnen de organisatie, interactie met belanghebbenden en trouw aan beroepsnormen vooropstaan.

Relevantie

Deze analyse verbindt gezondheidsonderzoek en gezondheidsbeleid met organisatiewetenschappen, waarmee tegemoet wordt gekomen aan oproepen (Currie et al., 2012; Kirkpatrick et al., 2016) om studies uit te voeren met een sterkere koppeling tussen deze complementaire benaderingen. De conclusies van deze studie zijn niet alleen in theoretisch opzicht relevant, maar ook voor de praktijk van gezondheidsbeleid en management die voor een aantal grote uitdagingen staat. Leidinggevenden en beleidsmakers in de gezondheidszorg die worstelen met de vraag hoe professionals bij het management betrokken kunnen worden, dienen kennis te hebben van wijzigingen in het medisch management en te weten of en hoe hybride managers ondersteund kunnen worden. Dit vergroot het vermogen om ogenschijnlijk tegengestelde waarden en prioriteiten met elkaar te verzoenen, dus om een evenwicht te vinden tussen kwaliteit en efficiëntie, verantwoordelijkheid en informele professionele verbanden en tussen het primaat van multidisciplinariteit en patiënt enerzijds en klinische specialisatie anderzijds. Soortgelijke dilemma's spelen in een aantal publieke voorzieningen in westerse landen en hybride managers kunnen (één van) de oplossingen zijn, mits goed ingebed en ondersteund.

ACKNOWLEDGMENTS

This research journey has been the opportunity to explore a fascinating field of study, which is both intellectually stimulating and relevant for society, and offer a small contribution to the academic debate.

I would like to thank my supervisors for their continuous support and guidance throughout the recent years. Prof. Mirko Noordegraaf and Prof. Paul Boselie have welcomed me in Utrecht and, despite the physical distance, have always been present with their competence, professionalism and continuous encouragement, as well as with a unique kindness and courtesy.

I thank the Directorate General for Education of Lombardy Region for its financial support during the first two years of this project. I am also grateful I had the opportunity to dive into the complexities of professional organizations in two countries, interacting with highly competent doctors and top managers. I really wish to thank all of the respondents for their time and patience. Also, being a hybrid myself – as I combined the PhD research with action research and training in healthcare management – I tested these hypothesis in the real world, receiving inspiring and precious insights from many medical doctors and executives.

Of course, this work was possible thanks to the numerous comments and suggestions received during presentations at conferences, from the editors and reviewers of scientific journals, as well as from colleagues at Bocconi University and Utrecht University. I wish to thank them all, in particular Prof. Federico Lega for having inspired my passion for this topic and for having supported me in this project; Prof. Ian Kirkpatrick, Prof. Mike Dent and all the participants of COST Action IS0903, a vibrant and unforgettable community; and Prof. Graeme Currie and Prof. Anna Prenestini for their invaluable ideas on two chapters of this book.

Finally, I wish to thank the greatest gifts I've received, my parents and siblings as well as my families MilanoAccademia and RUI, a unique group of friends and brothers, as "*the two most important days in your life are the day you are born and the day you find out why*". Last but not least, many thanks to the wonderful people at Lepelenburg who have hosted me during my journey making me feel, really, at home.

CURRICULUM VITAE

Marco Sartirana is research fellow at the Centre for Research on Health and Social Care Management (CERGAS) of SDA Bocconi School of Management, and he holds a MSc in International Management from the same University. He has been adjunct professor of Public Management at the Catholic University in Rome and he teaches at Executive programs in Healthcare Management at SDA Bocconi.

His research interests focus on organization and human resource management in healthcare, with a specific attention to the role of hybrid professionals in management. He has been involved in a number of action research projects for hospitals, local health authorities, regions and medical societies. He has been the coordinator of the Early Career Researchers of the COST Action IS0903 - "Enhancing the role of medicine in management". He has published widely in Rapporto OASI, the Report of the CERGAS Bocconi Observatory on the Italian Healthcare System, and in journals for healthcare practitioners. His scientific production has been presented at Italian and international academic conferences (AIES, EGOS, IRSPM, OBHC, EHMA) and appears in leading national and international journals in the field of public and healthcare management.

He is also passionate about educational activities and coaching for university students, and currently serves as the Director of a University College of Merit of Fondazione RUI in Milan.