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Autonomy and Integrity—Drivers of Health Care Professionals Dealing with Multiple Obligations

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Till Gabriel

The restatement of the obvious is the first duty of intelligent men.
George Orwell

Abstract

The medical services have undergone substantial changes over the past decades, and the design and content of health care have been determined by economic programmes, streamlining, and rationalization. The calls to cut costs and implement reorganizations have come largely from politicians and have been handled by middle and high-level managers. Advances in medicine and technology have led to heavier burdens on staff, and another challenge concerns having to deal with patients who are more knowledgeable and demanding than was previously the case. Therefore, health care professionals are required to carry out more tasks simultaneously, and they also have to contend with additional obligations to different stakeholders.

The main objective of the research underlying this thesis was to gain a better understanding of how medical and health care personnel are affected by having multiple obligations, which can even be conflicting in relation to these professionals themselves, their patients, and their employers. To identify and elucidate the experiences of care personnel in this context, data were collected by use of an open interview form in the first study and by performing in-depth interviews in the three subsequent investigations. The gathered data were assessed by content analysis in Study 1, by grounded theory in Studies 2 and 3, and by modified analytic induction in Study 4. All of the participants in the four investigations had in common the fact that they were licensed practitioners in various fields of medicine and health care, and thus they were responsible their own professional conduct.

The first study included 42 resident physicians, and the results showed that these professionals were highly engaged in their work and were satisfied with their career choice, but they had mixed emotions about their work situation. It was clear they needed confirmation, more support, and greater opportunity for reflection under stressful working conditions.

The eight participants in the second study represented all levels in one psychiatric care organization, which was being reorganized with respect to the authorities in charge, as well as the treatment strategies in use. It became apparent that a change in a theoretical frame of reference or a revision of internal obligations proceeded according to a completely different time table compared to a more technical transformation of a method or an external

change in the organization. Professional autonomy and authority were threatened, and professional identity was shaken.

Ten middle managers took part in the third study. They had developed strategies and above all a personal-professional maturity that gave them non-negotiable independence and authority. They were guided by their basic values, respect, and integrity in relation to how they perceived themselves, their personnel, and their patients, and even with regard to their own superiors and the organization in which they worked.

The fourth study included 13 clinicians who served as both teachers and researchers, and had several formal commissions and different employers. These individuals had an extremely complicated and demanding work situation, but they felt that the various tasks they performed enhanced each other. They got feedback on their work, and their authority was not questioned. Furthermore, the work they did was stimulating and challenging, and led to self-development.

The medical and health care services will be continually restructured to meet the demands of patients and society. One of the most important challenges is to make this an attractive area of work, so that the personnel will not want to leave. Health care professionals are not going to stand idly by while their autonomy and authority are undermined, rendering them a mere cog in an industrialized health care system. They want to contribute their expertise, and when they feel they are appreciated and treated with respect, they become involved in and committed to both the organization and their original mission—to give their patients the best possible care.

Keywords: professional development, middle managers, health care, conflict, autonomy, organizational change, integrity, professional identity, commitment, qualitative research

Sammanfattning på svenska

Sjukvården har under de senaste decennierna varit föremål för stora förändringar. Ekonomiska styrinstrument, effektivisering och rationalisering har varit tongivande för vårdens utformning och innehåll. Kraven på besparingar och rationaliseringar har i mycket stor utsträckning kommit från politikerhåll och omsätts av chefer på mellan- och hög nivå. Kunskapsutvecklingen inom medicin och teknik ställer stora krav på personalen och mötet med patienter utgör ytterligare en utmaning i takt med att de blir mer och mer informerade och krävande än tidigare. Personalen ställs därför inför att hantera flera parallella krav; flera förpliktelser från olika uppdragsgivare.

Med denna avhandling är det övergripande syftet att få ökad kunskap om hur personal inom hälso och sjukvård påverkas av att ha många, olika och till och med motstridiga uppdrag gentemot sig själva, till sina patienter och till arbetsgivaren.

För att få en ökad förståelse och generera ny kunskap av personals upplevelser och erfarenheter har data insamlats med hjälp av ett öppet frågeformulär för första studien och djupintervjuer för de tre följande. Data analyserades med innehållsanalys för studie I, för studie II och III grounded theory och studie IV modified analytic induction. Gemensamt för deltagarna i de fyra delstudierna var att samtliga har en legitimationsgrundande yrkesutbildning och därmed ett eget ansvar för sitt yrkesutövande.

I första studien med 42 läkare under specialistutbildning framkom ett påtagligt engagemang och att de var nöjda med sitt yrkesval, men också blandade känslor inför sin arbetssituation. De påtalade tydligt ett behov av bekräftelse, mer stöd och fler tillfällen till reflektion i sin stressade yrkesverksamhet.

I andra studien var alla nivåer i organisationen representerade av de 8 deltagarna. Organisationen var föremål för en omorganisation, såväl av huvudmannaskap som av behandlingsstrategier. Det visade sig att förändringen av en teoretisk referensram eller en revision av interna förpliktelser förlöper enligt en helt annan tidtabell än förändringen av den mer tekniska förändringen av metod eller den yttre förändringen av

organisation. Den professionella autonomin och auktoriteten blev hotad och den professionella identiteten kom i gungning.

I tredje studien deltog 10 mellanchefer. De hade utvecklat strategier och framför allt en personlig-professionell mognad som gav dem självständighet och icke förhandlingsbar auktoritet. Vägledande var deras grundläggande värderingar, respekt och integritet, i hur de ser på sig själva, sin personal, patienterna och även i förhållande till egna chefer och den organisation de tillhörde.

I fjärde studien intervjuades 13 kliniska lärare, som samtidigt var forskare. De hade därmed flera formella uppdrag och olika uppdragsgivare. Deltagarna beskrev en mycket krävande, komplicerad arbetssituation men de olika uppgifterna berikade varandra. De fick feedback på sina arbetsinsatser och deras autonomi var inte ifrågasatt. Arbetet var stimulerande, utmanande och utvecklande.

Hälso och sjukvården kommer fortsatt att reformeras för att möta patienternas och samhällets krav på sjukvård. En av sjukvårdens stora utmaningar är ett bli en attraktiv arbetsplats istället för att vara en som personalen vill lämna. Professionerna kommer inte stillatigande vara med om förändringar som åsidosätter deras autonomi, hotar deras auktoritet och gör dem till kuggar i en industrialiserad sjukvård. De vill bidra med sitt professionella kunnande och när de blir uppskattade och mötta med respekt blir de engagerade och tar ställning för organisationen såväl som till den uppgift de från början engagerat tagit sig för – att ge patienterna den bästa vård som finns att tillgå.

List of publications

The thesis is based on the following papers, which will be referred to in the text by their roman numerals:

I. Bergin, E., Johansson, H. and Bergin, R. (2004), “Are Doctors Unhappy? A Study of Residents With an Open Interview Form”, *Quality Management in Health Care,* Vol. 13, No. 1, pp. 81-87.

II. Bergin, E. and Rønnestad, M. H. (2005), “Different timetables for change: understanding processes in reorganizations - a qualitative study in a psychiatric sector in Sweden”, *Journal of Health Organization and Management,* Vol. 19, No. 4/5, pp. 355-377.

III. Bergin, E. (2009), “On becoming a manager and attaining managerial integrity”, *Leadership in Health Services,* Vol. 22, No. 1, pp. 58-75.

IV. Bergin, E. and Savage, C., “Surviving multiple obligations through stimulation, autonomy, and variation”, Submitted.

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Introduction

Organizing health care

According to Peter Drucker, the "father of modern management," the best example of a large and successful knowledge-based organization is a hospital, where all the professionals have a common mission, namely, to perform the work required to deal with the diagnoses and conditions of the patients.

To those who work in health care, this statement might come as a surprise. But to the researcher, health care presents us with an interesting dynamic: to meet all the challenges facing health care, it has been necessary to examine and reform aspects related to organization and management. Old models have been questioned and new ones have emerged. According to Mintzberg (1983), health care was long organized as a professional bureaucracy consisting of a traditional administrative system with a distinct hierarchical structure and authoritarian roles. In contrast to the situation in manufacturing industries, management in professional organizations is primarily administrative in nature and aimed at coordinating activities, and it is the staff members that have the competence and expertise. Authority is possessed by the professions, which have a strong influence on the planning of activities and also determine what rules must be followed (Freidson 1971).

The idea of medical professionals functioning as the leaders and managers in health care services was proposed in the 1980s by Drucker (1988), who was convinced that in the future the very best specialists would be the ones who would report directly to the top of the organization. In other words, management would be primarily a task for the medical specialists. Ouchi (1979) used the term "clan control" to describe the running of an organization based on perceptions and values, which are regarded as factors that are decisive for being able to achieve desired quality. Physicians may have previously been considered to act as clan members, but a somewhat new work situation in which those professionals serve as the natural leaders and managers began to arise as changes occurred in the organization of health care (Schöldenström 2003).

The demands for savings and rationalization in the Swedish health care system have come mainly from politicians. Care is funded through taxes and is provided by public agencies that make decisions about the objectives,

extent, and quality of the services offered. Reforms brought about as part of the new type of management have been continual and have engaged personnel at all levels. However, many directives for change have seldom or never been realized or assessed, and, above all, many of the new organizational models have not been properly evaluated before being introduced into the care system (Axelsson 2000). It seems that an unsuccessful change has been regarded as the best argument for making yet another change (Brunsson 1989). Bigelow and Arndt (2000) have questioned the appropriateness of transferring business practices into hospitals, and they argued that health care staff should do nothing and adopt a lie-low attitude, since "the more things change , the more they stay the same."

Reforms in the health care sector have far-reaching effects on organizational culture, because they shift organizational goals and the associated inherent values. The core of the issue of motivation concerns how well individual goals are aligned with the goals of the employing organization (Franco et al. 2002). There are differences between the political, professional, and administrative logics that influence the way that health care is managed (Blomgren and Sahlin-Andersson 2003). Such disparities and the various organizational cultures that are formed by the central norms that characterize an organization (Schwartz and Davis 1981) will make reforms in health care a risky business, because when it is neither the politicians nor the managers that are the carriers of the culture, it must be the health care professionals. Well-established professions such as those in health care develop their own culture through a group learning process (Schein 1992).

Allebeck (2002) has stressed that an understanding of the values and the professional culture in health care is needed when changes are to be implemented. During the process of introducing a new organization model, culture plays a critical role, because beneath the norms there is a deeper taken-for-granted set of assumptions that the individuals in the organization are seldom aware of (Schein 1996). The culture holds the whole organization together (Mintzberg 1999), and cultural bonds between the people in the organization need to be strengthened, not threatened. Reorganizations can mean a shift in or destruction of the culture of the system, and Schein (1992) has further indicated that reorganization will destroy the old organization that is the carrier of a given culture and severely damage the new organization that is beginning to build its own new culture. This process can be traumatic and should be chosen only if economic survival is at stake.

The professionals in health care

Medical and paramedical professionals share the characteristic of having occupations that require an academic education. During their long period of clinical training, they acquire the knowledge and skills required to satisfy the different needs of their patients, and they strive to increase and reinforce their confidence in coping with increasingly difficult tasks. Moreover, they internalize and follow rules of ethics that make them accountable for, and hence trusted by, their patients and also respected by society. Their professional associations continue to strengthen the group affiliation they began to develop during their period of clinical training, because knowledge and ethics make individuals alike with respect to their way of thinking and their values. The professional identity is successively secured through their long training and the process of gaining work experience (Rønnestad and Skovholt 2003).

All professionals participating in the studies included in this thesis were licensed in their professions, and such accreditation implies restricted access to the profession in question and establishment of an occupational monopoly. Licensing by a government agency further involves exclusive official permission to work within a profession, and it also entails personal responsibility for performing the work according to the Health Care Act (HSL 1982). Thus being licensed bestows upon professionals the authority to carry out tasks, and it also gives them guidance in the form of values and an ideology related to how their work should be done, and all of this enhances their autonomy (Freidson 2001).

Autonomy is the central component of, and the basis for, defining any profession (O'Connor and Lanning 1992), and health care comprises a large number of autonomous professions. Having autonomy implies the freedom and the ability to make decisions about and commitments to the work that must be done. However, exercising autonomy requires space (Forrester 2000), and Hirschhorn (1998) has argued that the conditions necessary for authority will exist when one is free to make one’s own choices. Possessing authority, which is highly important for health care professionals, entails the right to influence others in specified ways (Yukl 1989). Indeed, having authority and autonomy, and being guided by values and ethics can be seen as the hallmark of professionalism. The organization can make these conditions possible and thereby support the professionals whose authority would otherwise be undermined (Evetts 2006).

In 2003, the Swedish Medical Association celebrated its 100th anniversary by, among other things, publishing a special book focused on the years that had passed. In one chapter of that book, Schöldenström (2003) rather pessimistically discusses some aspects of the work situation of physicians over the period. In short, he described a situation that has deteriorated during the last decades, and he also noted that physicians today encounter alienation and frustration, and they feel like they constitute a cog in a large hospital wheel that is ruled by politicians and administrators. Schlesinger (2002) has given another overview of what has happened to the medical profession over the past 100 years. In the first part of the 20th century, physicians had a mixed reputation, but that gradually changed so that these professionals came to have a high standing and substantial influence on things like policy making in the health sector. However, during the latter part of the century, the confidence in physicians began to wane, and over the last two decades the term "deprofessionalization" has been used to describe the loss of autonomy and authority in this group of physicians.

In a study published in 2001 (Thomé and Arstam 2001), an alarmingly large proportion (39%) of junior physicians indicated being doubtful or negative about their choice of profession after only three to four years of clinical work. They referred to their work situation as entailing little appreciation and few opportunities to influence conditions, circumstances that can lead to a feeling of insufficiency in relation to patients. It seems that being able to influence the work situation is crucial for these new doctors. Moreover, according to a report (Larsson and Ericsson 2003) compiled by the Swedish Junior Hospital Doctors' Association, as many as 87% of this group of medical professionals showed interest in working for a non-public employer, and 41% could consider positions outside the health care sector. Notably, negative feelings towards having a public employer were even found among medical students in a study conducted at Uppsala University (Holmström 2002).

The above-mentioned findings may be related to an important aspect of autonomy, namely, that the opportunity for independence in the workplace is a predictor of remaining in the profession and being committed to the career (Kidd and Green 2006). Reconsidering one's choice of profession due to difficulties in doing a "good job" is not restricted solely to doctors. It is plausible that the economic changes in the health care system can expose the personnel who are close to the patients (e.g., nurses) to a situation in which they clearly want to help the patients as efficiently as possible, but they are

confronted with new instructions that may contradict or hinder that ambition (Newman et al. 2002). People working in health care have usually started their careers—and chosen their professions—with the ambition to aid and support their fellow human beings (Henry et al. 1971). Those who are committed to that goal have a strong desire to apply the knowledge they have acquired, and they experience significant frustration if the organization in which they work does not give them the opportunity to do so. It is well known that the turnover of nursing staff is high, and this trend must be challenged in order to ensure the quality of the care that is provided (Sellgren et al. 2007).

The change in working conditions and the accompanying strain of professional dilemmas have been discussed as a plausible source of the increase in sick leave among health care personnel (Eklund 2003, Szücs et al. 2003). In 2008, a report concerning the work environments of physicians employed at all levels in the care organization run by the Stockholm County Council indicated that the higher the positions held by physicians, the lower the confidence of these professionals in both their immediate supervisors and the leadership of the organization, and also the more they felt that their own health is negatively affected by their work (Joneborg et al. 2008). This has ramifications, not only for the individual physicians, but also for the health care workplace as a whole.

In the public sector in the mid 1990s, market-based models were implemented that had been obtained from various other sectors, above all from industry. Attempts were made to introduce a novel form for management that Hood (1995) referred to as "new public management" (NPM). The implementation of market-oriented reforms in health care was inspired by NPM and was initiated in health care with the intention of increasing effectiveness and reducing costs (Aberbach 2003). Agevall (2005) has identified the ingredients of NPM as efforts to steer goals, results, contracts and performance, and also benchmarking and evaluation—all with the aim of achieving efficiency. Over the past decades, this has set the trends in the structure and content of health care, so that it seems that "economics is rewriting medicine" (Morreim 1990). In Swedish health care, a disaggregation between the purchaser and provider has been applied as a condition for creating competition and opening up the care services to different stakeholders. Health care has become a business, which has resulted in increased administrative control and decreased authority of the medical professionals (Stoeckle and Reiser 1992).

Introduction of NPM has entailed a shift from collegial authority based on knowledge and ethics to a type of hierarchical authority, which means that management has taken over the power to allocate the resources and make decisions about what work should be done and the limitations for how it can be performed. This contradicts what has long been the guiding principle for professionals, namely, that the control process is monitored mainly by colleagues, since they are the only individuals who can judge what work should be done (Freidson 1971). When health care professionals have no control over the resources of their organization, it might be said that they are helpless and dependent, although at the same time they are autonomous with respect to deciding how to conduct their work, and Freidson (1986) has maintained that this is a paradox. Health care professionals are indeed exposed to multiple obligations.

Managerial work and health care

It is easy to get lost in the vast amount of literature concerning how to manage or lead an organization. The present research focused on management in its entirety, and thus in this thesis no distinction is made between being a manager and being a leader, two concepts that often have different connotations in different countries (Mintzberg 1999). Being a leader and handling leadership is frequently referred to as one of the important roles of a manager (Yukl 2006), and some of the earlier organizational theorists have obviously influenced the development of management. For example, at the beginning of the 20th century, Fredrick Winslow Taylor introduced the idea of scientific management, indicating that analysed knowledge on the work process is to serve as a basis for the rules and ordinances that employees should obey in the performance of their duties, considering those individuals as cogs in the machinery. Taylor's ideas were widely accepted, and the contemporary opinion was that management represented a process of planning, organizing, coordinating, and controlling (Gergen and Thatchenkery 1996).

Another influential theorist at that time was Henry Fayol, who stressed that it is the manager's task to create a sense of belonging among the employees (Fells 2000). Fayol was one of the first theorists to describe and underscore that an organization is a social system, and his notions regarding managers' needs for training in and understanding of the roles of leadership are still of interest today. Good managers should know their personnel very well, they should be role models, and they should not practice detailed leadership.

Somewhat later, as an alternative to existing methods and principles, Mary Parker Follett proposed a new way of managing (O'Connor 2000). According to her ideas, to be able to change and influence the attitudes of employees in relation to their workplace, a manager must be able to listen and be open to the questions and complaints of the subordinates. Parker Follett argued in favour of democratic workplaces, emphasizing active participation of employees in making decisions, supervising, and administrating their work—circumstances that today would be called empowerment. She also believed that managers need to establish themselves as representing a profession, a separate occupational group with its own ideas and principles.

Many middle managers in health care start their careers as medical or paramedical specialists, and they have gained their professional identity and authority in those occupations. In 1997, new legislation was introduced in Sweden that made it possible for professionals other than doctors to become mangers in the health care sector, and nurses came forward to fill that role. Education aimed at teaching nurses how to perform administrative tasks was already being conducted around 1910, and not much later it became possible for nurses who were heads of departments to enrol in university courses. Borthwick and Galbally (2001) have maintained that nurses are better equipped than other medical professionals to adapt to the altered conditions in the health care system. Furthermore, Allen (1998) is of the opinion that nurses who choose positions as managers have a desire to organize, influence, and contribute to the development of their subordinates.

Continuous calls for cuts and streamlining in the health care sector are coming largely from the political arena, and these measures are to be implemented by middle and senior management. This has resulted in more responsibility and authority being entrusted to middle managers, who are impelled to take over tasks such as budgeting and strategic planning from senior managers. Leavitt (2004) has described middle managers as primarily being leaders who focus on transforming, persuading, and demonstrating competence, which is in contrast to management that relies on exercising control and having the authority to do what is expected. Above all, middle managers have to balance results and accountability with consideration for the needs of the personnel, and they must also act to unite the top and the bottom of their organizations. Leavitt claimed that not only top managers, but also middle managers, should define vision and values for their work groups. The demands made from both above and below are making the job

tough for middle managers, who are required to handle more responsibilities and lead larger groups with multiple needs (Nilson 1998). According to Thomas and Linstead (2002) it is important to understand middle managers' identity at work when greater flexibility is essential due to increasing instability of the organizations in question.

Roher (1989) has indicated that the primary duty of managers in health care is to supervise the most important mission of their organizations, namely, the process of patient care. Another way of putting it is to say that a manager's central task is to ensure that the organization is run so that it concurs with and reaches the proposed targets without decreasing the vitality of the system (Zuckerman et al. 2000). Thus, in short, good middle managers are supposed to turn policy into action by reinterpreting policies and strategies to render them comprehensible to the personnel (Wall 1999). This is a delicate commission, since it is well known that such managers often find themselves wedged between different assignments and demands from several organizations, their subordinates, and patients (Gabel 2002). Moreover, their professional values may be in conflict with market-oriented values, in which case these leaders must face the dilemma of balancing their values with authoritarian realities in managed care.

Health care professionals at academic medical centres

The work performed by health care professionals employed at academic medical centres (AMCs) comprises three distinct tasks: providing clinical care, performing research, and teaching. Accordingly, these individuals have to play diverse roles related to the different ways they serve as agents of knowledge in those three disparate contexts. They face multiple challenges that require the ability to continually adapt to changing contexts and new directives. They have to meet the expectations of numerous stakeholders, including their patients and their students, and, perhaps of greatest consequence, those who fund their research. In addition, they have to deal with matters that can be due to changes in working conditions, new technologies, political imperatives, and economic constraints, which can be associated with health care as well as on the academic institutions where they are employed.

The situation of universities is also being altered through the influence of market control and ever-important fiscal issues (Middlehurst and Elton 1992). Such workplaces often undergo reorganizations, and, as employees,

the health care professionals are expected to be equally productive, effective, and efficient throughout such restructuring. In a report describing the work situation of academic teachers in Sweden (Åström 2008), it was pointed out that research is being set aside. In that report, it was also indicated that constant and ubiquitous reorganizations have led to disharmonious working conditions that hamper prioritization because immediate demands must be taken into consideration first.

The various tasks and associated obligations assigned to medical professionals are further complicated by the presence of multiple employers (Heyssel 1984) and managed care (Ludmerer 1999). The source of the conflict appears to be the employers, that is, the institutions and organizations and their different objectives. Watson (2003) has said that such a work situation at academic medical centres invariably gives rise to difficulties. In Sweden, public health care is organized and run by the county councils, whereas the universities fall under the domain of the national government.

Inasmuch as health care professionals employed at AMCs work in the three areas of clinical care, research, and teaching, it is inevitable that they will be exposed to multiple diverse and simultaneously connected obligations. These tasks can obviously collide with each other, and this has been recognized as a problem for both universities and academic health centres. Watson (2003) has pointed out that the original mission of the medical school has changed focus from education to research, and at the same time clinicians have been pressured to generate revenue and/or cut costs, which has made it difficult for them to have time for teaching. Several studies have detected conflicts between research and teaching, as well as between research and clinical work (Anonymous 1987, Hattie and Marsh 1996, Magill et al. 1998), and the solution to these problems that has been proposed most frequently is to separate the tasks (Elton 1986, Regan-Smith 1998, Levinson and Rubenstein 2000, Wright and Wedge 2004). Medical professionals involved in all three areas have highlighted the need for balancing the tasks to avoid work overload and role conflicts (Oermann 1998).

Given the constraints under which AMCs operate, it is important to continually develop strategies that facilitate combination of the three work areas (Barchi and Lowery 2000, Joiner et al. 2008, Pizzo 2008), and Ludmerer (1999) has emphasized that this is a crucial issue in academic leadership. Such multitasking creates an exceptionally difficult work situation

for the professionals, although at the same time the three fields are extremely important, because they complement and are dependent on each other. These professionals have to deal with diverse work situations that entail a great number of highly varied demands from many different sources.

Challenges for health care

The health care sector is a workplace that is subject to considerable change, and thus care organizations have undergone major transformations in recent decades, and more changes are on the way as the dramatic developments in that area continue. Numerous and serious challenges lie ahead for health care organizations. The proportion of the ageing population is growing—people are living longer. Many patients suffering from chronic illnesses need extensive care, and medical advances are leading to more treatments that can help prolong survival. Individually or in groups, patients can exert strong influence on the content of the care that is supplied, and the staff of treatment facilities will be confronted with patients who are better informed and more demanding than was previously the case (Tomes 2007).

Another challenge is related to the equality of access to health care, which entails the fundamental issue of respecting each individual's need for treatment and care (HSL 1982). Also, in the 1990s costs increased due to improvements in modern medicine, including novel therapeutic approaches and new drugs, but at the same time the economic resources were diminishing due to a nation-wide recession. During that period, the number of people working in health care was downsized by about twenty-five percent, which in part is ascribable to a shift from county-managed care to commune-managed care for the elderly and patients with chronic psychiatric conditions. In general, the majority of the employees leaving the care sector have had less qualified jobs, although the exit of that group is gradually decreasing, while the proportions of licensed professionals such as doctors, nurses, psychologists, and physical and speech therapists are increasing (Landstingsförbundet 2003).

The need for multiprofessional teams that can care for patients with chronic illnesses will definitely increase, and that situation will be accompanied by growing demands for training in multidisciplinary problem solving (Shine 2002). Due to the rapid development of knowledge within the fields of medicine and technology, care professionals also require further education and training in relation to their capacity to change, which is already being

tested by, among other things, frequent reorganizations. The greatest difficulty facing health care staffs today is to manage economic control mechanisms, the objectives of which have been to increase efficiency and rationalize services.

The assertion that “changes are here to stay” (Mintzberg 1994) is clearly very relevant in the case of future health care services, which must have the ability to adapt to multiple divergent demands. Moreover, those responsibilities must be met by personnel who are already facing a heavy workload. An editorial in the *Lancet* (Anonymous 2004) has described the conditions for workers in the twenty-first century as being affected by undercurrents of anxiety and diminished loyalty and commitment, as well as an erosion of morale by a chaotic and often dysfunctional environment in which individuals are devalued and discounted altogether. With this statement in mind, the following question arises: How are health care professionals influenced by their work situation involving multiple obligations?

Aim

Main aim

The overall aim of this research project was to investigate how professionals in health care were influenced by multiple obligations in relation to themselves, patients and employer.

Specific aims

Study I

To explore the views of physicians in specialist training (residents) with regard to their work situation and their employer.

Study II

To explore and to obtain an understanding of how health care professionals were influenced by multiple obligations in the context of changing surroundings.

Study III

To explore and understand the experiences of middle managers in relation to multiple obligations, how they were affected by their work situation.

Study IV

To explore and develop an understanding of the influence of multiple obligations by building on findings generated from the Study II and III to see how the findings would fit health care professionals associated with academic institutions.

Materials and Methods

Research process

During the performance of the four studies underlying this thesis, many questions had to be asked and answered in order to find methods and materials to enable investigation of the area that attracts my interest and curiosity. According to Guba and Lincoln (1994), the methodological query in research is as follows: "How can one find out what is supposed to be possible to find out?" This constitutes a starting point for the decisions that must be made in the research process. Furthermore, it can be necessary to choose between a deductive and an inductive approach. A deductive strategy is theory driven and aims to prove or disapprove a generated hypothesis (Popper 1972), and therefore data are analysed according to an existing framework (Patton 1990). By comparison, an inductive method is data driven in that it uses collected information to generate a theory (Fulop et al. 2001), and it is designated "inductive" because it emanates from inferences based on experiences of social phenomena (Johnson 1998). For example, it entails discovering patterns, themes, and categories in the data under consideration, and the analyst's interaction with the data become part of the emerging findings and insights (Patton 1990).

Gummesson (2006) has maintained that grounded data are needed in management research and that that requirement can be achieved by inductive investigation, because such an approach "lets reality tell its story on its own terms and not on the terms of received theory and accepted concepts" (Gummesson 2003). Theory will instead be linked to empirical enquiry that emerges inductively. The comprehensive aim of the present research project guided the choice of using an inductive approach.

The four investigations included in the current research were gradually developed through a focus on how to go about gaining a better understanding of the way that health care professionals when exposed to multiple obligations experience their work situations. The area of inquiry—not the research problem—was identified and served as the starting point for applying a qualitative strategy to obtain the needed data (Maxwell 1996). Such a design was chosen because its purpose is to capture aspects of human experiences that are expressed in feeling, thinking, and behaviour (Malterud 2001a).

At the onset of this research project, it was necessary to choose a deductive or an inductive approach. Gummesson (2000) has concluded that iteration between those two strategies will occur in all research, regardless of which one is chosen from the beginning. That was indeed the case in the current project. In grounded theory, the process of constant comparative analysis with verification as a part of collecting, coding and analysing implies inductive methodology comprising deductive elements (Glaser 1978). Analytic induction includes both an inductive and a deductive approach, since formulating hypotheses begins before analysing the data, and involves generating theory as well as testing theory (Fulop et al. 2001). Mixed methods allow, Patton (2002b) maintains, a creative research approach to the questions posed in the particular setting.

Method choices

Sampling

In order to obtain relevant data for analysis, it is always necessary to use certain criteria when selecting samples (Williams 2000). The selection of the four samples in this research project was an ongoing process that was guided by the desire to discern the multiple obligations of health care professionals working under different conditions, as well as the methods chosen and findings of previous studies within the project. In short, the goal was to obtain information that was as rich as possible and to discover as many nuances as possible in the data, and thus two strategies were chosen: purposeful sampling (Sandelowski 1995, Coyne 1997) and theoretical sampling (Glaser and Strauss 1967). The sampling in the four studies was delimited in that all the participants were licensed in their respective professions.

Data collection

Study I. The first endeavour was essentially a pilot study in which the participants' spontaneous perceptions of their work situation were investigated by use of an open interview technique that did not include any previously formulated questions or leading statements. The open form was inspired by the method that Shalit and co-workers (Shalit et al. 1983, Shalit and Carlstedt 1984) employed to assess aspects of perception and coping strategies, which was used strictly as a qualitative instrument in Study I and had been used in the same manner by other investigators (Wengström et al. 2001).

Studies II, III, and IV. The method chosen involved conducting interviews, because the aim was to explore the experiences of the participants more thoroughly than was possible in Study I. Interviews can provide empirical data about the social world, because participants can be asked to talk about their lives (Holstein and Gubrium 1997). The data in Studies II–IV were gathered by conducting individual open-ended interviews (Kvale 1996).

Analysis

Study I. The participants in this investigation were asked to give direct descriptions of
their experiences. The material acquired gave the need for a qualitative descriptive method as proposed by Sandelowski (2000). Manifest content analysis of the data was performed to illustrate the visible and obvious, to describe their comments and to deal with the aspect of content (Downe-Warmboldt 1992). The descriptions of patterns in data were in part confirmed by what Miller and Crabtree (1992) refer to as a "quasi-statistical analysis style."

Study II and III. In order to explore and understand human behaviour, grounded theory was chosen from an array of available methods to analyse the transcribed interview data. Stern (1980) has suggested that "the strongest case for the use of grounded theory is in investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation," which agrees well with the objective of the present research project. Inasmuch as grounded theories are drawn from data (i.e., are derived from the real world), they are likely to offer insight, enhance comprehension, and provide a meaningful guide to action. In 1967, Glaser and Strauss first described Grounded Theory as a voyage intended to make discoveries, not to find evidence (Glaser and Strauss 1967). As a researcher, you have to discover what is really happening in data instead of forcing the data into existing categories to allow you to develop an understanding of what the core issue is for the study participants.

Glaser and Strauss (1967) emphasized that the purpose of research is to generate abstract concepts and propositions about the relationships between those generated concepts. In contrast to theory-based methods, grounded theory does not emanate from existing hypotheses. The pertinent research literature is read once the theory is well developed, and, after that, theoretical aspects that are found to be relevant for creating a theory or an empirically grounded model can be integrated. According to Glaser (1992) the product of

research using grounded theory is “a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study.”

Study IV. The findings of Study II and III aroused my curiosity about whether those results would also apply to another sample in a different context. All data to be used in Study IV were gathered before beginning the analysis, which was started by formulating hypotheses based on the findings of Study II and III. The interview data were subsequently evaluated essentially as reported by Bogdan and Biklen (2007) and Gilgun (1995), with modified analytic induction. In this process, the initially formulated hypotheses and the concepts upon which they are based can be grounded in research and theory, or they can be derived from data, such as interview results (Bogdan and Biklen 1982). Analytic induction was originally described by Znaniencki (1934), and it involves testing of hypotheses derived from an individual instance; this is done to disconfirm and revise one instance in order to formulate a new instance, and is continued in an iterative process until there are no exceptions.

Conducting the studies

Study I

The aim of Study I was to explore the views of physicians in specialist training with regard to their work situation and their employer.

Participants

The sample consisted of residents who took either of two courses in leadership for residents offered by the Medical Management Centre (MMC) at Karolinska Institutet (KI), Stockholm, Sweden. The residents represented seven different specialities. One decided not to take part in our investigation, which left 21 participants from each course. The total of 42 participants were considered together in the evaluation, because there were no particular differences between the two courses held at KI. There were 24 males and 18 females, with a median age of 38 years (range 30–51 years) and a median time in the profession of seven years (range 3–19 years).

Procedure

The participants were presented with a topic consisting of a key term and were asked to write down their spontaneous views on that subject. Two separate four-step open interview forms were used: one for the term “occupational situation” and the other for the term “employer.” The forms

had 12 empty spaces for 12 possible comments, and the participants were asked to write as many comments as desired, but only one in each empty space. They were also requested to evaluate three different aspects of each comment they gave. The first aspect concerned the importance of a comment, and this entailed ranking it in comparison to all other comments, which even allowed the comments to be equally important. The next aspect involved considering a comment in terms of how positive or negative it was perceived according to five levels ranging from very positive to very negative. Thirdly, the participants were asked to choose between the options "none," "some," and "a great deal" to indicate how much control they felt they had over the central issue in each comment. It took the participants about 30 minutes to fill in the two interview forms.

Analysis

The beginning of the analysis involved gathering the comments for each topic. Thereafter, similar comments were classified into groups according to how often they were given and by how many of the participants. The comments were also sorted into groups of main themes, and I performed this task together with the second author of the paper. The values stated for the comments were noted, along with the perceptions of degree of control.

Study II

The main goal of Study II was to explore and gain an understanding of how health care professionals were influenced by multiple obligations in the context of changing surroundings.

Participants

The study was based on interviews with eight people employed in the psychiatric care organization in a county in Sweden. The respondents were selected through what is called theoretical sampling (Glaser and Strauss 1967), which can be described as an ongoing process in which the researcher decides where—and how—to find subsequent data, in order to discover as many nuances as possible in the information. There were two guiding principles in this work: (1) the theoretical sampling strategy was applied to fully elaborate and validate theoretically derived variations discerned in the data (Sandelowski 1995); (2) the number of qualifying participants selected was set to obtain information that was as rich as possible (Coyne 1997). Six interviews were performed in the first round. After initial analysis of the material, two more interviews were carried out, one with a woman who had

shorter period of employment and the other with a man who had a different theoretical background.

Of the eight participants, five were women and three were men, and they were chosen to represent different positions and professions. Three were physicians, four were psychologists, and one was a trained social worker employed as a psychotherapist. Two of the psychologists were also licensed psychotherapists. The physicians were all specialists in psychiatry. Seven of the informants had training in psychodynamic methods, and the eighth had training in cognitive behavioural techniques. The participants represented different levels in the organization, from therapists to the head of the organization. Two belonged to a management team and no longer had any contacts with patients. The other six worked at two different psychiatric centres. The directors of those centres were among the interviewees, and they both had patient contacts as well as managerial tasks. The median age of the participants was 48 (range 38–56), and the median time in their profession was 18 years (range 4–25 years).

During the decade preceding Study II, the county psychiatric organization in question had been subject to several changes, including reduced economic resources, incorporation into another local authority and modifications in the theoretical framework with accompanying adjustments in professional norms. At the same time, there were demands for greater efficiency and more rapid turnover, as well as new legislation related to prioritization in health care.

Procedure

Data were collected by means of open-ended, interactive interviews (Kvale 1996). The respondents were initially asked to describe their work situations and the assignments they had. As an interviewer, I was aware of what was important to the participants and applied my interviewing skills to achieve a narrative that was as comprehensive and vivid as possible. Probing and reflective questions were used to deepen the informants' own understanding of their circumstances and to ensure that nothing was taken for granted. All the interviews were conducted in the interviewees' offices. Each one lasted about an hour and was tape-recorded, and the tapes were later transcribed by a professional secretary.

Analysis

Out of a range of available methods for analysing transcribed interview data,

we chose to use grounded theory, and our intention was to essentially follow the procedures described by Glaser (1978, 2001).

During the first thorough reading of each protocol, notes were taken to capture the thoughts and ideas that emerged. Thereafter, the data were analysed to obtain all segments related to multiple obligations, which resulted in 494 segments. This process was followed by substantive coding (*i.e.,* discovery of indicators of significant phenomena in the interviews), which yielded 110 codes that were then changed and assembled in categories. The indicators from each successive protocol were sorted into relevant existing categories. The creation of categories was a process of moving back and forth between the data and the categories in an iterative process, which Glaser (1978) has described as a systematic effort to check and refine emerging categories. This process was continued until the core category "professional authority" emerged, according to the following criteria stipulated by Glaser (1978):

- Having a clear and grabbing implication for formal theory;
- Having a considerable carry through, with relevance and explanatory power;
- Having a dimension of the problem in itself, that in part explains itself and its own variation.

In the final step, there were major categories to which most of the phenomena in the data could be linked, and they were all linked to the core category. The following concepts constituted the major categories: external demands, internal obligations, conflicts, coping strategies, and professional authority.

Theoretical memos sampled from the data during the substantive coding brought up ideas about connections between the concepts emanating from multiple obligations. These ideas conceptualized the process and gave rise to an emerging understanding. This comprehension was strengthened during the final steps of the analysis, which made it possible to create a theoretical model based on the concepts and the relationships between them.

Study III

The aim of Study III was to explore and understand the experiences of middle managers in relation to multiple obligations and to how these professionals are affected by the work situation.

Participants

This study involved individual interviews with ten middle managers in health care, all of whom took a course in leadership at the Medical Management Centre (MMC) at KI. The respondents were selected as described in Study II through what is known as theoretical sampling (Glaser and Strauss 1967). In a first round, eight participants were interviewed. After an initial analysis of the material, two more interviews were carried out, both with managers who had organizational backgrounds different from those of the other eight participants.

All ten interviewees were women; nine of them were nurses and one a physiotherapist. Their median age was 48 (range 38–53) years, and their median time as managers was 15.5 (range 10–20) years. They were each in charge of a median of 40 (range 15–140) subordinates and one to four first-line managers. They worked in highly specialized multi professional care at university hospitals as well as in municipal long-term care. They were all responsible for budget, personnel planning, and development of competence and the work environment.

Procedure

The objective was to thoroughly explore the experiences of the ten participants. Open-ended, interactive interviews (Kvale 1996) were conducted, all in an office at the university department (KI). As in Study II, at the beginning of the interviews the informants were asked to respond to the one lead question—to describe their work situation and work assignments—in order to understand how they were influenced by multiple obligations. The interviews lasted about an hour each, and they were audio recorded. The tapes were later transcribed by a professional secretary.

Analysis

The motivation for the analytical method used in Study III is the same as in Study II. Each protocol was initially read, and memos were written to capture the thoughts and ideas that arose during the first thorough reading of these records. The data were then analysed to obtain all segments relating to multiple obligations, which resulted in 327 segments. This process was

followed by substantive coding, which gave 138 codes that were subsequently changed and assembled in categories. The indicators from each successive protocol were sorted into relevant existing categories. Increasingly more abstract categories were created by constantly referring to the initial data.

A core category referred to as "respect" was identified according to the criteria of having considerable carry through with relevance and explanatory power, as stated by Glaser (1978). In the final step, three major categories emerged and were designated "responsibility," "conflicts," and "power." Most of the phenomena in the data could be linked to these categories, all of which were related to the core category.

The ideas induced by theoretical memos sampled from the data contributed to the conceptualization of the process. They also gave an understanding based on the emerging concepts and the relationship between them, which made it possible to create a theoretical model.

Study IV

To explore and develop an understanding of the influence of multiple obligations by proceeding from findings generated from the Study II and III to see how the findings would fit health care professionals associated with academic institutions.

Participants

Purposeful sampling (Patton 1990, Coyne 1997) was used to obtain interviewees who could give much information and also to help broaden the theoretical explanation. Eleven teachers at KI were interviewed (in 2001–2002). All were in mid-career and had completed the first year of a two-year teacher training program. They were chosen because they were all researchers, teachers, and clinicians and thus performed multiple tasks and had more than one employer. They were asked and consented to participate individually. The group consisted of eight doctors, one optician, one dentist, and one speech therapist (six women, five men), with a median age of 41.5 years (range 35–53 years). To ensure anonymity, no further description of the interviewees is given.

Procedure

Data were collected by open-ended interviews to gain an understanding of the way the interviewees perceived their world (Kvale 1996). As in Study II and III, the interviews were begun by asking the participants to respond to a

single leading request: “Describe your work situation and the assignments you have.” The data were gathered before applying the framework developed in Study II and III. Most of the interviews took place in the offices of the participants; a few were held in an unoccupied office at the workplaces. Each interview lasted about 45 minutes and was tape-recorded and then transcribed by a professional secretary.

Analysis

Modified analytic induction (Gilgun 1995, Bogdan and Biklen 2007) was used in order to apply findings from Study II and III in the analysis of the data. Based on the results of these two studies, three hypotheses were formulated:

- What drives health care personnel to influence their work situation are their internal obligations (values, beliefs, knowledge, experience).
- Conflicts arise when external demands are at odds with internal obligations.
- When faced with conflicting demands, the strategy which preserves self-respect is chosen.

The aim was to explore and obtain a picture of how the interviewees were affected by drivers, conflicts, and self-respect—concepts based on these hypotheses. I coded the interview data in accordance with these concepts, and the data were subsequently verified by the second author. We found data that neither fit nor supported the concepts, and in some cases directly disproved them. Coding of the data led to emergence and identification of new concepts. However, in some cases subsequent iterative testing of the hypotheses against the data and further development and refinement of the hypotheses as examples did not fit. Clearly, when testing in this context, it is important to find evidence that prove as well as evidence that disprove the hypotheses (Patton 2002a). During the progressive analysis of the present data, hypotheses were modified to fit the identified concepts, and new hypotheses were formulated that described the relationships between the concepts as the data demanded.

My role as researcher

I conducted all the interviews in the present project. Notably, Kvale (1984) has proposed that the interviewer is a research tool and in that capacity is largely responsible for the quality of the data that are gathered (Patton 1990). Moreover, Holstein and Gubrium (1997) have asserted that the interview encounter is an active process between the interviewer and the interviewee.

To improve validity it is important that the interviewer is well versed in both the topic at hand and human interactions (Morse 1994). My professional background as a psychologist and psychotherapist combined with application of an explorative qualitative approach enabled me to use my experience and knowledge in the interviews and analysis of the collected data. From a psychotherapeutic perspective, research interviews differ from clinical interviews: both may lead to increased self-understanding and change in behaviour, although the former emphasize intellectual understanding, and the latter focus on personal change (Kvale 1984). Patton (1990) expressed it somewhat differently, saying that "the purpose of a research interview is first and foremost to gather data." To obtain experience in research interviewing and to evaluate the previously mentioned research query, before interviewing the participants in Study II, I performed three pilot interviews with psychotherapists. Those interviews are not presented here.

I left clinical work twenty years ago, and since then my main focus has been on professional development of health care personnel. As a lecturer and consultant in leadership for managers at KI, I have met representatives for a variety of professions and sectors that have given me insights and a pre-understanding of their work situations. Gummesson (2000) has maintained that pre-understanding is a prerequisite for understanding in management research but it must be combined with a curiosity and openness for new information. It's like knowing how to open the gate to a new place but not knowing what to expect on the other side, meaning that it will be a challenge if you are obliged to ensure that your pre-understanding does not prevent the participants from relating their experiences (Chew-Graham et al. 2002). With this challenge in mind, I analysed all the data in the four studies, and I recognize that prior experience and reflections on the topic in question preclude the pure inductive construction of knowledge; it is more proper to view it as a pragmatic heuristic.

Ethics

The Ethics Committee of KI approved the studies. All participants were given both written and oral information about the investigations, and they were informed that their participation was voluntary and that they could withdraw at any time. The data collected were coded so that complete anonymity could be guaranteed. Informed consent was obtained from all participants.

Use of computer applications

The analyses in Studies II, III, and IV were performed with the aid of Qualrus software from Idea Works Inc, which was used to store, order, and retrieve data.

Findings

Study I

Choice of profession correct, but insufficient support for professional development

This section presents the most significant findings of Study I, which was conducted to examine the views of 42 residents on their working life. This investigation was based on an open interview form in which the participants were asked to write down their own comments about their perceptions concerning two areas, namely, their professional situations and their employers. It was found that the vast majority of the participants had had predominantly positive experiences related to those two aspects: out of a total of 593 comments (334 concerning work situation and 259 about employers), 314 were positive and 214 were negative. This indicates that most of the study participants were content with their occupational situations and their employers.

It was possible to classify the 42 participants according the nature of the comments they made, as follows: 25 made predominantly positive and 12 predominantly negative comments, and five made comments that could not be assigned to either of those categories. Furthermore, four of the participants made only positive comments and three only negative comments.

The comments were classified into eight main themes. Three of those were exclusively positive, describing the work as stimulating, challenging, and developmental; involving good comradeship and relations; and giving satisfaction. The theme comprising responsibility and autonomy was regarded as being essentially positive. Four of the themes were negative, as shown by comments implying that the work was difficult and complicated and had to be performed alone; the workload was too heavy; and the participants experienced lack of time, isolation, powerlessness, and dissatisfaction. Several comments also revealed insufficient appreciation, low salaries, and poor leadership.

The most common theme (found in 94 comments) involved having an occupation described as being stimulating, challenging, and developmental in nature. Thirty-seven of the participants indicated that that was the case, or, in other words, only five of the participants did not offer such a description.

This theme was also the one that was most often ranked as most important. The second most common theme (found in 58 comments) was related to workload, lack of time, stress, and similar aspects. This was indicated by 35 of the participants, and thus only seven did not use this description of their work.

Comments about employers were predominantly positive for 24 of the participants, predominantly negative for 14, and neither positive nor negative for three. One participant had not made any comments about the employer, 16 had not made any negative comments, and four had made only negative comments.

The comments could essentially be divided into three groups. The first of these comprised a total of 259 comments, 139 of which were characterized by predominantly positive descriptions of the qualities of a leader/manager, as exemplified by use of the following words: distinct, knowledgeable, goal-oriented, persistent, structured, communicative, influential, and attentive to every individual. The second group included 74 comments, and here the leader/manager was described in a negative way using words like diffuse, invisible, punishing, difficult to contact, and demanding without visible goals or visions. The third group encompassed 32 comments that defined who the employer was, mentioning for instance politicians, the county, or the head of the clinic, although eight of them referred to the patient (scored as positive).

The participants ranked their comments on a scale ranging from none to a great deal to indicate the extent to which they could influence the situation that was mentioned. Regarding professional performance, a clear majority felt that they had a considerable impact on the situation. However, things were less positive with regard to the possibility of influencing the employer. In short, most of the participants felt that they had some degree of power in that context, whereas many also said that they were completely unable to affect issues controlled by the employer.

The comments of the 42 participants in this study suggest that these physicians had mixed emotions about their profession. Regardless of age, gender, or specialty, most of these individuals felt that their work was challenging, developing, and stimulating, although it is also apparent that they perceived being isolated and powerless, and at times also dissatisfied with what they described as a complicated and difficult occupation. This does not mean that these physicians did not recognize and experience problems

related to both the work they performed and their employer. Workload and associated stress constituted an aspect that many of them regarded as having a negative impact. The participants also frequently expressed that leadership was of poor quality and that they felt they were not appreciated within the organization. Only one of the 42 physicians made comments that were completely negative with regard to his profession and his employer.

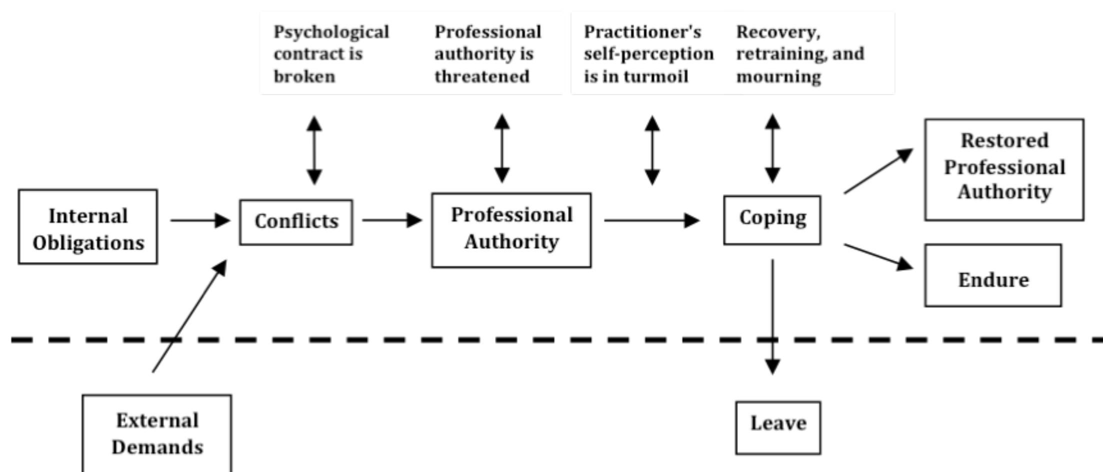
Study II

Different timetables for external and internal change

Changes in the organization can constitute a serious threat to health care personnel who possess a strong professional identity that has developed over many years. That conclusion can be drawn from the results of Study II, which involved eight interviews with professionals working in psychiatry—physicians, psychologists, and psychotherapists. Four of the study participants also had managerial positions in different levels in the organization. All eight described dramatic changes that had occurred in the organization and, for those with patient contact, had had a substantial impact on aspects representing the core of their professional identity.

A number of key issues emerged when the interviewees were asked to describe their work, and four themes were particularly prominent: external demands, internal obligations, conflicts, and coping strategies. In the work situation that was undergoing the above-mentioned radical changes, the common thread or core concerned “professional authority,” which the study participants felt was essential to allow them to be confident and credible in their professional relationships.

Two different processes of change were identified, one originating from external demands and the other derived from internal obligations and based on beliefs and values (see figure below). The external employer-expressed demands necessitated a process of change that most of the interviewed professionals experienced as being too hazardous and in conflict with their internal obligations.



A majority of the interviewees had extensive experience of working psychodynamically with their patients. Indeed, they had chosen workplaces that would allow them to have a long-term and psychodynamic perspective based on the needs of the patients. Over the years, their professional identity had become increasingly integrated into themselves as individuals, and they had gradually acquired the professional authority that they described as necessary for handling the often difficult problems of their patients.

Due to the organizational changes, psychodynamic methods were no longer considered to be effective or desirable as elements of treatment strategies. According to the interviewees, instead of basing treatment measures on the needs of the patient, consultations with patients were more frequently being guided by external demands and the availability of resources. The study participants believed that methods oriented towards patient flow and psychodynamics had been pushed aside in favour of drug-oriented therapy and cognitive behavioural approaches. These psychiatric professionals found themselves in a conflict situation: they wanted to help their patients to the best of their ability, and at the same time that ambition was being contradicted or obstructed by new guidelines and treatment alternatives. In addition, they felt that strongly increased demands from the entities that commissioned their tasks (e.g., social welfare agencies or courts) created role conflicts in consultations with patients, because these professionals were

expected to act as representatives of the public authorities in those interactions.

The participants said that they had initially had reciprocal, respectful relationships with their employers, and that the employers had previously trusted them to apply their professionalism in the best interests of their patients. The reorganization was described as a “cultural revolution” that had broken old contracts, including psychological contracts, between employers and employees. They also said that in the past they had to a great extent been able to influence the “shape” of their tasks. Their work situation had provided the conditions necessary for continuous development, their experience had given them confidence and authority, and, after many years of working in the organization, they felt that they were valued and that their knowledge had given them status. They also said that they had experienced a change that affected the core of their profession, that is, what they deemed to be high-quality patient treatment. One of the interviewees described the situation as follows:

> *An incredible dilemma for the individual workmate—there are those, you know, that are pretty much confused. They’re trained for a particular job and find themselves dealing with something completely different—which they are to a certain extent not trained for and for which they haven’t agreed to as part of their conditions of employment. They were employed as handball players but we changed it to ice hockey and we haven’t retrained them completely to play ice hockey, oh well it’s a clumsy analogy*

The new altered organization led to serious conflicts between personal convictions and external demands, and the study participants felt compelled to abandon their patients and what they felt was appropriate to offer those individuals. It was suddenly necessary for them to perform work tasks that did not correspond to the ideology that had originally motivated them to choose their profession and had also been a driving force during their careers. They described how the professional ethics and professional identities that had taken them so long to acquire were suddenly under strong pressure. The employment contract they had initially accepted no longer applied, and that change was most difficult to accept for those who had worked in the organization for a long time. Several informants mentioned that those who have only 5–10 years left to work before retirement find it more difficult to cope with changes and retraining, and those individuals may

simply have to endure the changes. Of course that is a very sad alternative for professionals who may have assumed that they would be able to rely on their experience and wisdom for the remainder of their working life, but instead have to start over and become a junior on the team.

The interviewees related that the implemented changes had induced strong feelings of powerlessness and uncertainty. They felt that both their professional security and their authority were threatened and could no longer serve as a source of support or strength. They also expressed regret over the loss of their professional role and indicated that they were in need of support from and dialogue with managers as well as colleagues. They also wanted greater clarity on the part of the employer with regard to division of responsibility, setting limits, and anything else of importance for creating awareness about the new stipulations.

Many of the interviewed professionals arrived at various solutions to cope with the undesired changes; several colleagues had reduced their working hours, and others were on long-term sick leaves. However, those who had only recently acquired their positions in the organization, and were in demand on the labour market due to their theoretical background and education, did not express such apprehensions and therefore tolerated the changes in their working conditions.

Two different timetables were evident in Study II: a fast-track schedule for external events and a much more prolonged agenda for the internal reorganization. Thus it is apparent that a change of method considered from a technical point of view occurs at a different, and faster, pace than a change that includes the removal of old professional norms and working habits and the integration of new ones.

Study III

Becoming a manager with integrity—a result of professional development

All the interviewees had chosen a second career as managers, and, when asked to describe their work situation, they talked about how they had changed over their years in managerial positions. Previously, as nurses and physiotherapists, the respondents had been used to taking responsibility, solving conflicts, showing respect, and carrying out their duties with authority, but significant adjustments had to be made when they became

managers. As middle managers, they worked in a different context with other preconditions, and their relationships with patients, former colleagues, superiors, and the organization changed. Once again they were obliged to find new roles and identities through training and, above all, through learning by doing, which involved both positive and negative experiences. They all emphasized that leadership without a higher level of self-awareness is built on weak foundations.

When the managers described their work in their multiple realities, a number of key concepts gradually emerged. According to those individuals, the main theme or core of their positions as managers was about respect. Respect was also a recurrent topic when they talked about their development as managers from the perspective of the three areas that could be categorized as particularly important: responsibility, power, and conflicts. Respect constituted a central aspect of their attitudes towards interested parties and in relation to themselves and their own convictions, but also with regard to how they were treated by people in their surroundings, primarily their superiors and colleagues.

The interviewees related that in their managerial careers they had initially been anxious to prove that they were capable of handling their commission and that they wanted to perform their numerous tasks perfectly. To achieve the objective of influencing their assignments, they had tried to satisfy everyone else's demands and needs. However, they slowly realized that they were responsible not only for the needs of their patients, but for their own needs as well. They had to develop the ability to set limits in relation to expectations, demands, and workload, and they had to accept the fact that they could not do everything on their own, that they support and assistance. They changed from having wanted recognition from others to being able to establish boundaries and believe that "this is good enough." They also gradually learned to trust their own judgment to a greater extent and to value their own experience and competence.

These managers described not only a complex reality, but also very changeable operations that included rapid turnover of political decisions. In some cases those directives could be both ambiguous and unpopular. As managers, the respondents had to ensure that the commitments were carried out and at the same time they had to be able to confront and handle the apprehensions and sometimes even the dissatisfaction of the staff members. Motivating subordinates and co-workers to accept undesired changes could

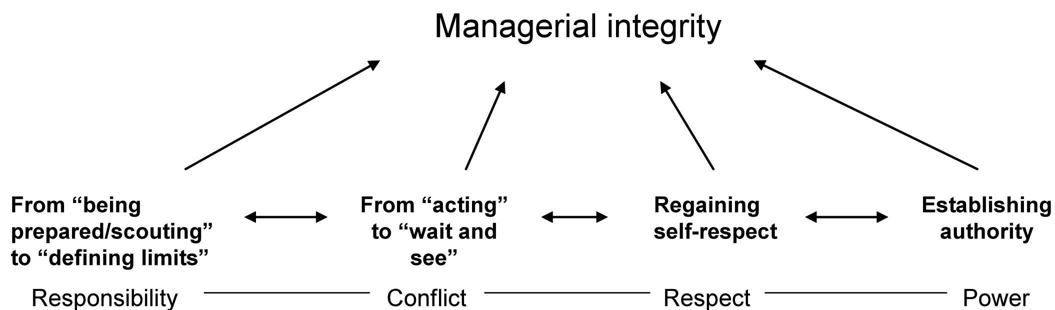
lead to conflicts, and it was part of a manager's job to handle such discord. Several of the respondents said that they gradually learned not to let that type of changes worry them, and that they tried to avoid arousing unnecessary anxiety among personnel, for instance by adopting a "wait-and-see" attitude. They developed the ability to obtain and harbour information until they knew whether or not the decisions in question would in fact be implemented. All of the interviewees also said that many of the directives that came from politicians and superiors were never actually applied, and therefore they felt that it was not necessary to try to look very efficient by quickly putting every decision into effect.

When changes were really put into action, it took time for both the managers and their subordinates to understand the meaning of the new demands. A number of conflicts could arise under such conditions, for example, the managers could be stuck in the middle between external and internal obligations. Their approach to handling such situations was to avoid being in a hurry or being tempted by the desire to be capable and efficient. Instead, they took their time to think and learn in order to understand the situation at hand, which gave a higher level of self-awareness, an aspect they described as necessary for being able to continue in their managerial positions.

All of the respondents had chosen to become managers because they had gradually begun to want to play a more independent role in influencing the content and structure of health care. An essential factor in accomplishing that goal was the extent of their authority to take initiatives, make decisions, and establish their own objectives for their organization.

> *I don't work to meet the budget anymore, now I work to manage the organization, and that means we have a different goal, and you know that feels pretty good, and then I think that they can just give me the sack [if they want to].*

Many of the interviewees said that they actually had a considerable degree of authority, but they also clearly indicated that they were prepared to leave their managerial positions if the scope of their tasks became too limited, or if the demands from superiors were in conflict with their professional or personal convictions. Several of the respondents had also left previous jobs because they were no longer able to perform the managerial duties that had initially prompted them to accept such a role.



Study III identified a process of managerial development, as depicted in the figure above

The interviewees described autonomy as being a decisive factor for the ability to function as a manager, and they felt that it involves a feeling of control over one’s own situation and choices—it becomes a way to capture one’s own self-authorization. In a reality that comprises many different demands from various sources, and in the end and ultimately there is one demand that is more important than all others, namely, to provide treatment for patients. The interviewees also indicated that they were not willing to abandon their convictions or to risk losing their self-respect, all to maintain integrity.

Study IV

Challenges can be stimulating if combined with autonomy

All eleven of the professionals who took part in Study IV were engaged in teaching, research, and clinical work. Accordingly, when performing daily tasks, they had to balance their efforts between three highly disparate work areas, and they were required to do so in relation to two different employers. In short, their working lives were much more complex than those of the participants in Studies I–III.

The findings of Study II and III served as a starting point for the analysis of the interviews conducted in this study, and the following hypotheses were formulated:

- Internal obligations (values, beliefs, knowledge, experience) drive health care personnel to influence their work situation.

- Conflicts arise when external demands are at odds with internal obligations.
- When faced with conflicting demands, the strategy which preserves self-respect is chosen.

The results revealed that the eleven interviewees in this investigation did not describe and experience their work situations in the same way as the subjects in the previous studies had done. They were aware of the existence of a conflict between their various work assignments, but they chose to handle and tolerate that clash, because they felt that the tasks they performed were stimulating and varied, and that they had the freedom to plan their own time and work. Furthermore, they all indicated that they were satisfied and motivated by the possibility that their research would generate new knowledge and uncover novel relationships. They welcomed the demands and expectations they were confronted with, and even regarded those aspects as encouraging. They also felt that teaching was an inspiring responsibility, because it allowed them to convey their knowledge and discoveries to students who are curious and eager to learn.

> *They ask questions and force one to think about things that one perhaps hadn't otherwise thought of and most importantly they are future colleagues whom one will work with.*

The participants also found clinical interactions with patients rewarding, as illustrated by the following comment:

> *The feedback and feeling that one matters is very nice.*

Moreover, all the interviewees emphasized how important it was that they themselves could influence their own work situation, or in other words that they had autonomy or freedom that gave them control and the right to take initiatives in relation to their time and the goals, organization, and content of their work.

> *To be able to decide oneself how one wants it to be is, I believe, one of the most important things in one's work.*

In addition to the aspects discussed above, all of the participants felt that by keeping the three different roles as researcher, teacher, and clinician led to

professional improvement and even allowed them to avoid the tedious parts of their work.

Based on the mentioned observations, it was apparent that the driving forces influencing the eleven interviewees in Study IV differed from those affecting the participants in Study II and III. Therefore, the hypothesis regarding internal obligations was reformulated to comprise the conclusion that these “three-role” professionals are motivated by the variation and autonomy in their work, and by the stimulating nature of the tasks they perform. This does not mean that they managed their work without conflicts, but rather that they had different kinds of conflicts. There was no evidence that these individuals were torn between internal obligations and external demands; instead, it was more a question of being able to combine the three different types of work and having enough time to succeed in those efforts. Nevertheless, none of the participants said that they wanted to leave their areas of expertise, and they preferred to face the internal-external conflict head on and try to handle it. The interviews also revealed that the fact that the three work areas were run by two different employers contributed to the difficulties in coordinating the tasks to be done.

> *It feels as if one is constantly in different places, both physically and psychologically, sometimes we are even scheduled to be at two places ... one time I was scheduled to be at three, scheduled at three places is very hard, but we are starting to get used to it, unfortunately.*

A solution to combining the three different work areas was to blur the boundaries between work and private life. The work day was extended by taking tasks (primarily research) home, which could obviously be experienced as very taxing on family life. Indeed, several of the interviewees indicated that a spouse or cohabitant must be understanding and supportive. Another solution was to prioritize one or two of the three work areas, a choice that was often based on the main focus of the professional in question and also depended on that individual’s personal interests and desire to do a good job. Among the participants in this investigation, incompatibility between personal convictions and external demands was not the cause of conflicts. Accordingly, when attempting to resolve any clashes that occurred, these individuals did not turn to the idea of being faithful to personal values as a means of maintaining their self-respect, as had been described in Study II

and III. These professionals underlined the importance of being steadfast in relation to the goals they had set for themselves.

Thus it can be concluded that the eleven professionals who took part in this investigation were well aware of the incongruities between their three areas of work, but, despite that, they preferred to acknowledge and handle the conflicts that arose, and remain in the work situation they themselves had chosen. This was the case because they considered the tasks they performed to be stimulating and highly varied, and they were autonomous in relation to the content, organization, and goals of their work. A new understanding emerged and drivers were identified:

- Stimulation, autonomy, and variation are the drivers for university faculty engaged in teaching, clinical work, and research.
- Conflicting demands are accepted and balanced to sustain the presence of these drivers.

Discussion

The participants in the four studies were all highly engaged in their work. The residents in the first study were satisfied with their career choice, but it was clear that they needed confirmation, more support, and greater opportunity for reflection under very stressful working conditions. It became apparent in the second study that a change in a theoretical frame of reference or a revision of internal obligations proceeded according to a completely different time table compared to a more technical transformation of a method or an external change in the organization. Professional autonomy and authority were threatened, and professional identity was shaken. The middle managers in the third study had attained non-negotiable independence and authority during their managerial work development. They were guided by their basic values, respect, and integrity in relation to how they perceived themselves, their personnel, their patients, with regard to their own superiors and the organization in which they worked. The participants in the fourth study had an extremely complicated and demanding work situation with several formal commissions and different employers. They felt that the work they did was stimulating and challenging, and led to self-development. The various tasks as clinicians, teachers and researchers they performed enhanced each other. They got feedback on their work, and their authority was not questioned.

All of the health care professionals who participated in the current studies indicated that the work situations were demanding and entailed multiple strains related to workload, requirements for increased efficiency, frequent reorganizations, and in many cases also a lack of support. Those who were approaching the end of their working lives emphasized that the changes that were made during the last decade were radical in nature. Furthermore, regardless of their professional positions, many of them experienced that they were distrusted and no longer valued within the organization they had elected to work in and to which they felt committed. They had chosen occupations that they believed would involve both challenges and opportunities for professional development, but they did not expect to be in situations that forced them to adapt to altered work demands that they could not steadfastly support. Therefore, if such changes did arise, they considered leaving their jobs. Low organizational commitment has been described as the most obvious association with turnover intention (Hallberg and Schaufeli 2006).

The residents who took part in Study I were at the beginning of their careers, and thus they had hoped to have prospects for professional development. They expressed mixed feelings about their work situations and little trust in leadership, but they nonetheless considered their choice of occupation to be correct. The weak leadership provided by their older colleagues might be explained by changes in the work objectives and positions of physicians over the past few decades. It has been pointed out that the most evident threats to the authority of the medical profession appear to be the growing influence of employers and the transformation of patients into "informed consumers" (Schlesinger 2002). Another description has indicated that the patient has become a customer, the hospital a corporate enterprise, and the physician an employee rather then the independent practitioner of the past (Stoeckle and Reiser 1992).

In Sweden, Nordgren (2000) has underlined that the position of physicians has changed from being a part in a strong bureaucracy, or the "power elite", to involving little possibility of exerting influence over the planning and organization of the health service system. The professional decision-making abilities of medical experts have been constrained by business-oriented decisions (Boyask et al. 2004) made by politicians, bureaucrats, and representatives of other stakeholders. This transformation can be seen as a result of NPM, and it entails the challenge of converting from traditional professional values to modern market-driven business (Gabel 1998).

The market organization model defines professional practice in terms of mechanisms of external accountability, professional standards, performance indicators, and productivity. This paradigm undermines the significance of the professionals having expert knowledge and stresses a new kind of professionalism, where the professional is more commercialized, entrepreneurial and managerial (Evetts 2006). In the present research, the health care professionals and middle managers with multiple obligations were constantly faced with the necessity of adapting to new conditions, which meant that they also had to re-evaluate their relationships with their employers, their workplaces, and the tasks they were to perform.

An organization changes continuously, and in the resulting processes that affect both organization and its employees, choices must be made when implementing new competencies and new functions (Clegg et al. 2005). The middle managers included in the current research thought that being a manager implied that they had to make compromises (give and take), but at

the same time should not abandon their inner commitments, convictions, and values, which they regarded as the driving forces of their work in health care. Such commitment to one's ideals was a reason for nurses to apply for management positions (Bondas 2006). McNerney (1985) described personal courage and deep commitment to one's own values as necessary qualities of health care managers, because such professionals have to deal with moral issues and ethical choices. The present managers indicated that altogether overly manifest clashes between demands and internal commitments created situations of choice in which the need to be congruent and credible was not negotiable. This is exemplified by the fact that five of the interviewees decided to change jobs. Notably, Holmberg and Åkerblom (2006) found that being autonomous in the role of middle manager in Sweden is a factor that contributes to outstanding leadership. Thus it seems that the health care organization sustained a heavy loss when the middle managers included in the present project left their jobs because they felt that they had less freedom to make decisions about their work.

Holmberg and Strannegård (2005) have described two ways that people approach the new economy: they accept uncertainty and try to find ways to cope and thereby achieve good working conditions, or they resist it and thus end up with poor working conditions or no job at all. It might be that implementation of NPM has also created such a relationship in the health care workplace. Moreover, it has been proposed that those who survive change can do so because they can accept working in an environment that is in a state of constant transformation, and also because they themselves have the ability to change (Chreim 2006). Such acceptance can be seen as a requisite for continued employment and career advancement.

In response to what they regarded as excessively radical demands for change, some of the current participants left their positions and looked for new places of employment, where their knowledge and experience would be valued. It is an open question whether they took that step as an expression of resistance, or if they chose to leave due to the conflict that according to Chreim (2006) arises when valued identity attributes are inconsistent with a required change, and also, as proposed by the same author (Chreim 2002), because new frames and targets must be appropriate for the individuals who are influenced if a change is to take effect. This situation was definitely of interest to and influenced not only the clinical professionals, but also the participating managers who were exposed to new working conditions. Those managers wanted a dialogue between personnel and management, and,

notably, an article by Sparks (2001) repeatedly highlighted that good communication is necessary for developing and nurturing confidence and trust as a means of ensuring that the employers at all levels in an organization are prepared to implement new methods.

A change involving beliefs and values is challenging, regardless of whether it is necessary for health care personnel to maintain professionalism towards patients or as a manager towards personnel, taking into consideration the state of discomfort, stress, and anxiety exhibited by those individuals. An important difference has been found between the guiding vision or values held by top management, which reflect how things ought to be, and the beliefs and norms that govern the daily work of those at lower levels in the organization, which show how things actually are (O'Reilly 1989). Ylander (2008) studied an industrial setting and emphasized that changes concern the future for managers but are related to the daily work for employees. Ylander meant that it is necessary to have a common time perspective in order to create and maintain trust in the goal of the organization, which the present research has shown is of critical importance when implementing changes in the context of health care.

Most of the participants in the present project indicated that reorganizations required immediate implementation, which resulted in a high rate of change. Coyle-Shapiro and Kessler (2000) have pointed out that, during rapid organizational transformations, it can be difficult to create mutual agreement between the parties involved, and thus it can be hard for those individuals or groups to fulfil their existing commitments, and obligations can be violated. The professionals who took part in Study II had been exposed to two different types of changes: those that involved economic and organizational aspects, and those that entailed the core of the working methods and were associated with a shift in scientific paradigm. Both types gave rise to two disparate processes of change with different time tables: one that was fast track and adapted to external events, and one that concerned internal reorganization and had a much more prolonged process of implementation.

With regard to the negative effects of the restructurings described by the study participants, a contributing factor may have been that insufficient consideration was given to the professional commitments of these individuals such as internal obligations. Solid, long-established psychological contracts were broken during the radical reorganization of one psychiatric care organization in Sweden. Such contracts are generally viewed as committing

individuals to relationships that are characterized by loyalty and continued membership in the organization (Allen and Meyer 1990). Ouchi (1979) found that when professional commitments differ from the interests of the organization, professionals will usually abandon organizational interests, if they are forced to choose between loyalty to the organization and their professional identity. The present participants who felt that the cost of adapting to or performing required changes was too high had considered leaving their jobs.

In addition to a shared time perspective, the fit of culture and strategy is necessary to ensure increased commitment of the employees to the organization. O'Reilly (1989) has argued that both intensity and consensus are prerequisites for the existence of strong cultures. Health care has created its own culture over many decades, and hence the enormous difficulty that must now be overcome is to develop or change those traditions. Since a strong culture is characterized by only a few core values (O'Reilly 1989), it is a significant challenge for health care to identify the new core values that actually fit today's health care organization and can render personnel committed to the system. Such commitment requires a staunch belief in the goals and values of the organization (Burns and Wholey 1992).

According to Taft et al. (1999), there is a substantial risk that individual and group values can counteract organizational values if the former differ from the latter, which those authors indeed found to be the case during a massive restructuring of a hospital. There is likely to be dissatisfaction with the change process and a concomitant lack of motivation when employees in health care feel that they cannot personally agree with the values that are associated with an implemented reform program (Franco et al. 2002). The same applies when changes are compatible with the professional identity of the individuals under consideration (Chreim 2006). For many of the informants in the current project, the changes they were exposed to involved basic beliefs and values and were thereby linked to a threatened professional identity and questioned professional authority.

Thomas and Davies (2005) have proposed that NPM and its emphasis on reforms and reorganizations can be seen as an identity project for professionals, managers, and their organization. In such an endeavour, the transformations carried out would be more than instrumental, because they would entail a change in the significance of acting in performance-driven ways, toward mechanisms like "payment-per-action" (van Bockel and

Noordegraaf 2006). These aspects may be at stake for professionals when, as suggested by Khapova et al. (2007), professional identity is assumed to be anchored in the occupation of the individuals rather than as an employee of the organization. Health care professionals develop their identities continuously by identifying with an occupational field and a profession. Professional identity is based on personal identity, relating the individual's own personality to the demands of the profession, as well as the attributes, beliefs, motives, and experiences that are associated with professional work. This identity work can be described as a struggle for comfort, meaning, and integration to find a correlation between a self-definition and the work situation (Sveningsson and Alvesson 2003); that description was given by the participants in Study II and III.

For all the health care professionals included in the present studies, a decisive aspect with regard to being able to handle their work situation and its multiple obligations was the ability of management to give them a feeling of being treated well and being involved. Such behaviour by management increases the employees' perception of status and self-esteem, and in the long run affects their professional identity. Tyler (1999) has distinguished the two identity-relevant dimensions of pride and respect. Pride reflects evaluation of the status of the individual in the organization, and respect refers to assessments of how that person is evaluated by others in the organization. Both these dimensions were sought by many of the study participants and were highly appreciated by those who were fortunate enough to benefit from them.

For the professionals and managers in the current project, the organizations had to acknowledge the added emotional burden that a change role involves and establish mechanisms to reduce the stress load. Doyle (2002) has maintained that if individuals find that performing in a change role is beyond their emotional capacity, then the organization must find a way to release them from that responsibility in a manner that preserves self- esteem and avoids any emotional damage. That requirement was clearly pertinent for some of the present participants, when effects on their professional authority and their professional identity were at stake.

Freidson (2001) has pointed out that when the intention of an employing organization such as health care is to intensify efforts to standardize the work of the professionals in order to reduce costs and better control and manage those individuals, it will seriously undermine the ideology that claims that it

is the right, or even the obligation, of professionals to be independent of those who empower them legally and provide them with their livelihood.

According to Reiss (2004), autonomy is a driver, and, for the present professionals, it represented a main drive, regardless of the work tasks they had to perform or their positions. The desire for freedom was highly valued by those who were associated with academic medical centres (AMCs), and it was also a prerequisite for the space they needed to develop and challenge themselves professionally. The sizeable demands they were exposed to were balanced by a large degree of autonomy. Bakker et al. (2005) found that an interaction between significant demands and autonomy hinders the development of burnout symptoms such as exhaustion and cynicism. Furthermore, van Vegchel and colleagues (2004) have indicated that task enrichment and authority are useful tools for achieving job control, space for professional development, and more efficient work. However, autonomy is not a right without responsibilities, and according to O'Conner and Lanning (1992), the medical profession can avoid losing autonomy and being reduced to a trade, if it continuously strives to contribute to and attain quality patient care.

Threatened autonomy and authority can be experienced as a workplace trauma and an identity risk. Therefore, in such cases, it is important to preserve "self" through reconciliation, reparation, grieving, and restructuring, as was found to be necessary for several of the participants in Study II and has also been underlined by Lutgen- Sandvik (2008). Preserving self means maintaining essential qualities, attributes, and identities that fundamentally shape the self-concept. By achieving that goal, continuity will be sustained and allow creation of bridges between the past and the future. In a changeable workplace, that should be regarded as highly important and will contribute to the stability of the organization.

Self-respect is "self-esteem under the reign of moral law" (Ricouer 1992), and it is often expressed as "being able to look at oneself in the mirror," which was also expressed by many of the present participants. Being true to your self in the organization has been found to be a driver of authentic behaviour, and authenticity means integrating oneself into the work environment (Pratt et al. 2006). An experience of not feeling whole or true to oneself can entail moral distress (Raines 2000), and this is illustrated by situations described by many of the current participants in which external demands clashed with internal obligations. They expressed the need for integrity, which can be

considered as a character trait and, in the words of Austin et al. (2005), implies “moral uprightness and points to wholeness, soundness, and being in an uncorrupted condition.”

In regard to the middle managers who took part in the present project integrity was noted as an explicit driver. Yukl (1989) has indicated that integrity is high on the list of essential leadership traits, and Thoms (2008) has proposed that very ethical management practices lead to successful business, and also that ethical integrity in leadership is directly linked to organizational moral culture. Furthermore, in a study conducted by Holmberg and Åkerblom (2006), middle managers declared that the task of an outstanding leader is to inspire and engage employees so that they will be honest and trustworthy, and they will work not to achieve their own self-interest but instead for the common good of the organization.

Gardner (2004) has written that to be a good worker, it is necessary “to recognize and confirm the mission of your profession,” meaning that people should not forget their reason for choosing a particular profession, and that it is important that they ask themselves what they can contribute to society. As described by the present participants, work can be a source of meaning and identity, as well as intrinsic satisfaction, if it is interesting and challenging to perform because it is complex and demanding. Tending to patients was and is the core element of health care, and van Vegchel et al. (2004) has called it one of the emotional demands and internal obligations of professionals in that field.

The new organizational culture can be hostile towards qualities that have been essential aspects of health care, for example compassion, fidelity, altruism, and integrity, which can encourage a type of non-reflective professionalism (Coulehan 2005). Professional work is developed by reflective individuals. This is supported by Firth- Cozens (2003), who maintained that not only change, but also stress, is here to stay, and proposed that reflection is essential to help doctors and other health care workers avoid making mistakes and thereby jeopardizing patient safety. Life-long learning has to be accepted by health care professionals, but successful learning uses feedback from experience (Senge 1999). All of the present participants except those affiliated with AMCs indicated that such a situation seldom exists, and instead described a lack of acknowledgement and support.

Feedback that is clear and expressive, and in particular is explicit on an

emotional level, is of great importance in the search for or confirmation of a professional identity (Ibarra 1999). It has been observed that nurse managers who did not receive positive feedback left their jobs (Skytt et al. 2007), and middle managers who lacked support became frustrated and dissatisfied because they were not valued by their organization (Patrick and Laschinger 2006). In Study IV, interviewees expressed that feedback is associated with development, challenges, and a desire to stay in the organization. The participants in the other studies felt that they got little feedback from their managers, and that most confirmation they received was provided by their colleagues and in some cases by their patients. However, if uncertainty arises about the job or the tasks to be performed after a reorganization, positive feedback from colleagues can be in short supply when it is needed most.

On the whole, the professionals who were associated with AMCs were most satisfied with their work situation, even though they had very heavy workloads. This difference seemed to lie in the ability to find mutually enriching stimulation, autonomy, and variation in the various tasks to be performed. The residents in the first study, as well as most of the participants of the other studies, also emphasized that their work could be stimulating and offer challenges and professional improvement. None of these individuals wanted to change professions or leave their workplaces; what they wanted was to have better working conditions to help them meet present and future demands. All of them felt that autonomy was particularly important in allowing them to do their work well. They would not have been satisfied with simply being a cog in the machine, because then they would have lost respect for themselves and their professional performance.

Freidson (2001) has maintained that there are only losers in an industrialization of health care. The physicians become civil servants, which contributes to their deprofessionalization (Reeder, 2006). The patients become "standardized," and hence they are not met as individuals and are referred to health care professionals who are no longer given the opportunity to be reflective, creative, and autonomous in their work. This is a frightening scenario, considering that most of us will sooner or later have to place our fates in the hands of health care professionals.

Methodological considerations

The research process has guided the choice of research approach in the individual studies. The research area has thereby been illuminated by the use

of different data sources and methods. The combination of methodologies is a way to strengthen a study design as different aspects of the phenomena investigated will be revealed (Patton 1990). It has been suggested that the criteria of credibility, dependability, and transferability are important when assessing the trustworthiness of qualitative research approaches (Graneheim and Lundman 2004). The methodological considerations discussed here are focused on the following aspects: data collection, analysis, and applicability.

Data collection

The interview represents a key tool in qualitative research (Cassell 2005). It has previously been estimated that about 90% of all social science investigations rely on interview data (Briggs 1986), and that proportion is probably even larger today. The findings of three of the present studies were based on information from individual interviews, and the results of the fourth investigation emerged from comments collected using an open-interview approach.

The trustworthiness or credibility of a qualitative method refers to the degree to which the results can be relied upon. Central to enhancing the trustworthiness of collected data is to be aware of the local context of the information that is gathered, and it is also important to present the opening question and extracts from interviews (Rapley 2001). In addition to the single lead question, keywords and quotations from the interview data used in the current studies are presented in this thesis in order to give the reader a picture of the data sources that is as comprehensive as possible. In fact, all of the participants are represented by quotations.

Replicating a study is difficult to achieve if the original work was based on an open interviews style. There are several explanations for this problem, one of which is that material gathered in interviews always represents a fragmented picture of the participants' experiences of a specific situation (Silverman 2001). Another reason is that two situations can never be identical, even if they occur within the same research project (Glaser and Strauss 1967). Furthermore, interviews often constitute interventions that affect the participants so as to make it impossible for to them to accurately relate something they have previously experienced, because insights acquired in the interview have made them more conscious of the subject that is in focus (Kvale 1984).

When interviews are used as the method of investigation, the interviewer

represents a research tool, and her/his competence and experiences will inevitably influence the quality of the data collection. Roulston et al (2003) have pointed out that very few researchers have been trained in the interview process. In all interviews, there is tension between the task of collecting the data that are needed and the interactional nature of interviewing (Rapley 2001). Kvale (1996) has stated that, to obtain optimal results, an interviewer should be an expert on the topic to be discussed and on human interactions. In accordance with that view, I was the interviewer in the present studies, and I have extensive knowledge in both of the mentioned areas.

In the literature, there are arguments both for and against having preconceptions, which are nonetheless inevitable for any investigator. Moreover, the knowledge that is gained before starting a research project cannot be erased, and indeed it often helps to actively stimulate curiosity about the area of interest. Chew-Graham et al (2002) have maintained that conditions conducive to understanding are enhanced when the researcher and the respondent share the same preconception. Morse (1994) has argued that validity will be improved if the interviewer is an insider who knows the group and can therefore more readily establish trust. The confidence given should make the interviewer pay attention and be sensitive to the effects that the interview can have on the participants, so that they do not reveal anything that they will later deeply regret (Doucet and Mauthner 2002). Naturally, the opposite is true as well, that is, the interviewees also influence the findings. The informants in all four of the present investigations were largely more or less accustomed to communicating their experiences and reflecting over their competence, which most likely contributed to vivid narratives and well-rationalized comments in the interviews.

According to Holstein and Gubrium (1997), an interactive relationship exists between the interviewer and the interviewee, and that those individuals represent the two active parts of the interview encounter. Cassell (2005) has described an identity work approach to interviews, and Alvesson (2003) has pointed out that the interview is more likely to add to constructing an identity than to revealing one. Clearly, it is impossible to foresee or even retrospectively recognize the potential impact of the interviewing experience.

It was evident that almost all of the present interviewees welcomed the opportunity to share their concerns about the topic at hand. The reason they were positive towards being interviewed was probably associated with the fact that these individuals felt that other people rarely showed interest in

their situations or tried to understand the things they experienced in relation to the matter of interest. A common remark among the participants in Study II was that they had never before delved particularly deeply into their associations with their work assignments and that the interview session brought new insights. After the interviews, the six respondents who had patient contact said that they would discuss the target issue and their new insights with their colleagues.

Analysis

According to Patton (2002b), qualitative analysis transforms data into findings in a manner that depends on the skills, knowledge, experience, and creativity of the analyst, and there are no specific recipes for achieving such transformation. The guidelines available will be of use, but they cannot compensate for qualities that are lacking in the analyst. There is an ongoing discussion as to whether, and if so how, grounded theory is applied or misapplied in qualitative research. Many researchers refer to this method, but few seem to follow the procedures that have been decreed (Baker et al. 1992, Orton 1997, Suddaby 2006, Jones and Noble 2007, O'Conner et al. 2008). My ambition was to be rigorous in this context, but the approach that was eventually applied in the present studies definitely also had my own personal flavour.

Strauss and Corbin (1990) have stated that when grounded theory is applied, the reliability criterion is dependent on how well the investigators have been following the research strategy. To evaluate interview findings in accordance with grounded theory, questions such as the following are formulated:

- Have concepts been developed?
- Are the concepts interrelated in a systematic manner?
- Are there several conceptual relationships and is there a process in the study?

Both analytic induction and grounded theory exploit the constant comparison method as a source of validity in research (Silverman 2001). With grounded theory, the iteration between emerging concepts and data proceeds until saturation is reached; by comparison, in modified analytic induction, the hypotheses is iteratively tested against the data until nothing new is found. The rigour of the analysis is greatly increased when checking upcoming new examples Mason (1998), and Kvale (1989) has suggested that falsification enhances validity.

Glaser (1978) has proposed four criteria that can be used to validate a grounded theory:

- The theory must fit, which means that categories must be indicated by and applied to the data. Every step of the research process has to be checked, referring to the data to ascertain the fit between the data and the emerging hypotheses or theories.
- The theory should work, and the focus should be on the usefulness of the theory that is generated. This is necessary in order to obtain an explanation, a prediction, and an interpretation of what happened, and to determine what is happening, and what will happen.
- The theory must be relevant to the participant and practice group in the field being investigated.
- It must be possible to adjust the theory to new data.

Inasmuch as grounded theory is a method of discovery, the most important quality requirement should be that the findings constitute a new contribution to the subject area. Substantive theory is characterized by describing what is happening in a specific context (Glaser 1978). The models that evolved in Study II and III represent one approach, albeit not the *only* way, to elucidate the processes that the interviewees had experienced in their specific work situations.

Applicability

Numerous reports in the literature have discussed the issue of how many interviews must be conducted to give a thorough understanding of the topic in focus. The present studies were based on data concerning at most eight to 42 informants, which should be taken into account when considering the applicability of the findings. Patton (1990) has stated that a characteristic of qualitative inquiry is that it focuses in detail on relatively small samples (even single cases) that are purposefully selected. Questions about generalization of the results can be tied to the method of sampling (Glaser and Strauss 1967, Williams 2000). When applying grounded theory, the collection of data must be explicit and consistent with the underlying assumptions of theoretical sampling (Baker et al. 1992), which was a guiding principle in Study II and III.

Many authors have stressed that, when using interview methodology in research, it is important that the informants review the data that are collected

(Lincoln and Guba 1985, Burns 1989). Stiles (1993) referred to this type of review and feedback as testimonial validity, an aspect that was especially important in Study II and III, in which I was the sole investigator. In Study I and IV, I performed the analyses in collaboration with the second author.

Almost three years after the interviews in Study II had been conducted, I met with all eight of the original interviewees to review the findings of the investigation. Two of them had left the organization they had worked in, and a third person was in the process of doing so. All of them recognized the circumstances they had described in the interviews, and most of them voiced regret over the way that things had developed at their workplaces at that time. Some of the comments they made indicated that the study had really captured their experiences and that it was exciting to be informed of the results. A number of them mentioned that the work situation was still difficult and stressful for some of their colleagues, and most of them wanted to have the findings of the investigation distributed throughout the organization. The results were also presented to and confirmed by personnel at an office that was not involved in the study, and those individuals expressed the same desire for dissemination of the findings.

The results of Study III were reviewed by nine of the ten participants, whom I met with almost five years after the interviews had been carried out. Five of them had left their organizations after the time of the interviews, and three of those five were no longer managers but instead had consultant or advisory positions. All nine recognized the process of managerial development that was described, and they said that the study had accurately captured and summarized their experiences. They also felt that the model could be used to support first-line managers in health care, who often leave their positions in the early stages of their managerial career.

Obviously, these internal validations cannot predict the validity of the results obtained in other types of organizations. However, the strategy that Williams (2000) designated “moderatum generalization” does allow findings of qualitative studies to be generalized to other spheres, as exemplified in Study III by middle managers in adjacent sectors. Malterud (2001b) has written that the intention of a qualitative study is to describe and produce theories that are applicable within specific settings—not to obtain facts that are valid for the population at large. Utilization of and feedback on the present results will demonstrate the applicability of those findings in other contexts.

Conclusion

The future workplaces of health care professionals will require that these individuals actively participate in the changes that are or will be needed to provide the services expected by society and the general public. These professionals are trained to handle work that is autonomous, challenging, and self-developing in nature, and they have a mission they want to fulfil, namely to care for their patients in the best way possible. The mission of the health care organization is the same.

The success of health care reforms requires personnel who are secure in their professional role and identity. These employees should be regarded as an asset and not a hinder in that context, and there must be an atmosphere of trust and confidence. Health care professionals will be able to deal with external demands and internal obligations, if they are met with respect and are valued for their professionalism and knowledge. To challenge and avoid what Freidson (1986) defined as "the professional-bureaucracy conflict," there is a need for an open dialogue between all those that are engaged in giving patients the best quality care.

To accomplish the mission of health care will require a much larger number of health care personnel, which means, writes Kendall (2003), that health care has to become an attractive field of work instead of one that personnel want to leave. It is crucial to understand different professional cultures in order to interpret all the ways that professionals respond to implemented reforms. Furthermore, knowledge must be acquired with regard to the time needed for reorganizations and for changing work methods. Such information should be taken into consideration as a means of keeping rather than losing professionals who are committed to their jobs and work with a sense of integrity.

Unanswered questions

My curiosity about working conditions in health care was initially awakened as a result of my contacts with colleagues during my time as a clinician. That curiosity continued to be the main driving force throughout this research project, which has also given rise to more questions that need to be answered.

There is a saying "kill your darlings" that, for example, applies to movie producers when they are editing a film and have to decide what should or should not be included in the final version. In the research process, due to the amount of data collected and the various means that are available to analyse that information, the investigator is compelled to make choices regarding what should or should not be given further consideration and eventually submitted for publication.

Everything that might be of interest cannot fit in a journal article or even in a doctoral thesis. Furthermore, all aspects are not equally important, and there are also limits as to what a reader can be expected to scrutinize, and hence it is the task of the author to sort the collected information. Orton (1997) has emphasized that researchers must learn to adapt to the standard of presenting only one main point per article. For that reason, some "darlings" should be saved for later analysis and/or for other uses.

Some of the questions that represent the "darlings" in my research are as follows:

- How and for what purposes will health care professionals be useful in the planning of the systems in which they work?
- In what ways will the business-oriented health care organization value and stimulate its work force?
- How can professionals exploit their curiosity and creativity in future health care?
- How will "standardizing" patients into categories impact the way health care professionals approach their work and their patients?
- What guiding principles will define the core values of health care, and how will they match the professional commitments of health care personnel?

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References

Anonymous (1987), "Research in Conflict with Teaching", *Lancet,* Vol. 330, No. 8568, pp. 1128-1128.

Anonymous (2004), "Why business is bad for your health", *Lancet,* Vol. 363, No. 9416, p. 1173.

Aberbach, J. D. (2003), "Translating Theoretical Ideas into Modern State Reform: Economics-Inspired Reforms and Competing Models of Governance", *Administration & Society,* Vol. 35, No. 5, pp. 491-509.

Agevall, L. (2005), *Välfärdens organisering och demokratin - en analys av New Public Management* [Democracy and the organization of welfare - an analysis of New Public Management], Växjö University Press, Växjö.

Allebeck, P. (2002), "Strukturförändringar i vården måste ske med kunskap" [Structural changes in health care must be made with knowledge], *Läkartidningen,* Vol. 99, No. 37, pp. 3617-3618.

Allen, D. W. (1998), "How Nurses Become Leaders: Perceptions and Beliefs About Leadership Development", *Journal of Nursing Administration,* Vol. 28, No. 9, pp. 15-20.

Allen, N. J. and Meyer, J. P. (1990), "The measurement and antecedents of affective, continuance and normative commitment to the organization", *Journal of Occupational Psychology,* Vol. 63, No. 1, pp. 1-18.

Alvesson, M. (2003), "Beyond Neopositivists, Romantics, and Localists: A Reflexive Approach to Interviews in Organizational Research", *Academy of Management Review,* Vol. 28, No. 1, pp. 13-33.

Austin, W., Rankel, M., Kagan, L., Bergum, V. and Lemermeyer, G. (2005), "To Stay or To Go, To Speak or Stay Silent, To Act or Not To Act: Moral Distress as Experienced by Psychologists", *Ethics & Behavior,* Vol. 15, No. 3, pp. 197-212.

Axelsson, R. (2000), "The organizational pendulum - Healthcare management in Sweden 1865-1998", *Scandinavian Journal of Public Health,* Vol. 28, No. 1, pp. 47-53.

Baker, C., Wuest, J. and Noerager Stern, P. (1992), "Method slurring: the grounded theory/phenomenology example", *Journal of Advanced Nursing,* Vol. 17, pp. 1355-1360.

Bakker, A. B., Demerouti, E. and Euwema, M. C. (2005), "Job Resources Buffer the Impact of Job Demands on Burnout", *Journal of Occupational Health Psychology,* Vol. 10, No. 2, pp. 170-180.

Barchi, R. L. and Lowery, B. J. (2000), "Scholarship in the Medical Faculty from the University Perspective: Retaining Academic Values", *Academic Medicine,* Vol. 75, No. 9, pp. 899-905.

Bigelow, B. and Arndt, M. (2000), "The more things change, the more they stay the same", *Health Care Management Review,* Vol. 25, No. 1, pp. 65-72.

Blomgren, M. K. and Sahlin-Andersson, K. (2003), *Managing at a Distance: Constructing Knowledge for Political Control of Healthcare [Ledning på distans: Att skapa kunskap för politisk styrning av hälso- och sjukvården],* Landstingsförbundet, Stockholm.
Bogdan, R. and Biklen, S. K. (1982), *Qualitative research for education : an introduction to theory and methods,* Allyn and Bacon, Boston.
Bogdan, R. C. and Biklen, S. K. (2007), *Qualitative Research for Education: An Introduction to Theory and Methods,* Pearson A & B, Boston, MA.
Bondas, T. (2006), "Paths to nursing leadership", *Journal of Nursing Management,* Vol. 14, No. 5, pp. 332-339.
Borthwick, C. and Galbally, R. (2001), "Nursing leadership and health sector reform", *Nursing Inquiry,* Vol. 8, No. 2, pp. 75-81.
Boyask, D., Boyask, R. and Wilkinson, T. (2004), "Pathways to "Involved Professionalism": Making Processes of Professional Acculturation Intentional and Transparent", *Medical Education Online,* Vol. 9, No. 13.
Briggs, C. (1986), *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research,* Cambridge University Press, Cambridge,UK.
Brunsson, N. (1989), *The Organization of Hypocrisy - talk, decisions and actions in organizations,* John Wiley and Sons Ltd, Chichester.
Burns, L. R. and Wholey, D. R. (1992), "Factors Affecting Physician Loyalty and Exit: A Longitudinal Analysis of Physician-Hospital Relationships", *Health Services Research,* Vol. 27, No. 1, pp. 1-24.
Burns, N. (1989), "Standards for Qualitative Research", *Nursing Science Quarterly,* Vol. 2, pp. 44-52.
Cassell, C. (2005), "Creating the interviewer: identity work in the management research process", *Qualitative Research,* Vol. 5, No. 2, pp. 167-179.
Chew-Graham, C. A., May, C. R. and Perry, M. S. (2002), "Qualitative research and the problem of judgement: lessons from interviewing fellow professionals", *Family Practice,* Vol. 19, No. 3, pp. 285-289.
Chreim, S. (2002), "Influencing organizational identification during major change: A communication-based perspective", *Human Relations,* Vol. 55, No. 9, pp. 1117-1137.
Chreim, S. (2006), "Postscript to change: survivors' retrospective views of organizational changes", *Personnel Review,* Vol. 35, No. 3, pp. 315-335.
Clegg, S. R., Kornberger, M. and Rhodes, C. (2005), "Learning/Becoming/Organizing", *Organization,* Vol. 12, No. 2, pp. 147-167.
Coulehan, J. (2005), "Viewpoint: Today's professionalism: Engaging the mind but not the heart", *Academic Medicine,* Vol. 80, No. 10, pp. 892-898.
Coyle-Shapiro, J. A.-M. and Kessler, I. (2000), "Consequences of the psychological contract for the employment relationship: a large scale survey", *Journal of Management Studies,* Vol. 37, No. 7, pp. 903-930.
Coyne, I. T. (1997), "Sampling in qualitative research. Purposeful and

theoretical sampling; merging or clear boundaries?", *Journal of Advanced Nursing,* Vol. 26, No. 3, pp. 623-630.
Doucet, A. and Mauthner, M. (2002), "Knowing resposibly: linking ethics, research practice and epistemology", Mauthner, M., Birch, M., Jessop, J. and Miller, T. (Eds.), *Ethics in Qualitative Research.* Sage, London, pp. 123-45.
Downe-Warmboldt, B. (1992), "Content analysis: method, applications, and issues.", *Health Care for Women International,* Vol. 13, No. 3, pp. 313-321.
Doyle, M. (2002), "From change novice to change expert: issues of learning, development and support", *Personnel Review,* Vol. 31, pp. 465-481.
Drucker, P. F. (1988), "The Coming of the New Organization", *Harvard Business Review,* Vol. 66, No. 1, pp. 45-53.
Eklund, M. (2003), *Arbetsförhållanden - orsak till sjukskrivning? [Work conditions - a cause for sick leave?],* Riksförsäkringsverket [The National Social Insurance Board], Stockholm; 2003:10.
Elton, L. (1986), "Research and Teaching - Symbiosis or Conflict" [High. Educ.], *Higher Education,* Vol. 15, No. 3-4, pp. 299-304.
Evetts, J. (2006), "Short Note: The Sociology of Professional Groups: New Directions", *Current Sociology,* Vol. 54, pp. 133-143.
Fells, M. J. (2000), "Fayol stands the test of time", *Journal of Management History,* Vol. 6, No. 8, pp. 345-360.
Firth-Cozens, J. (2003), "Doctors, their wellbeing, and their stress", *British Medical Journal,* Vol. 326, pp. 670-671.
Forrester, R. (2000), "Empowerment: Rejuvenating a potent idea", *Academy of Management Executive,* Vol. 14, No. 3, pp. 67-80.
Franco, L. M., Bennett, S. and Kanfer, R. (2002), "Health sector reform and public sector health worker motivation: a conceptual framework", *Social Science & Medicine,* Vol. 54, No. 8, pp. 1255-1266.
Freidson, E. (1971), "Professional Dominance: The Social Structure of Medical Care", Freidson, E. (Ed.) *The Professions and their Prospects.* Sage Publications, Inc, London, England
Freidson, E. (1986), *Professional Powers: A Study of the Institutionalization of Formal Knowledge,* The University of Chicago Press, Chicago.
Freidson, E. (1989), *Medical Work in America: Essays on Health Care,* Yale University Press, New Haven.
Freidson, E. (2001), *Professionalism: The third logic,* The University of Chicago Press, Chicago.
Fulop, N., Allen, P., Clarke, A. and Black, N. (2001), "Issues in studying the organisation and delivery of health services", Fulop, N., Allen, P., Clarke, A. and Black, N. (Eds.), *Studying the organisation and delivery of health services: Research methods* Routledge, London, pp. 1-23.
Gabel, S. (1998), "Leadership in the managed care era: Challenges, conflict, ambivalence", *Administration and Policy in Mental Health,* Vol. 26, No. 1, pp. 3-19.

Gabel, S. (2002), "Leading from the middle: surviving the squeeze of apparently irreconcilable forces", *Leadership & Organization Development Journal,* Vol. 23, No. 7, pp. 361-371.
Gardner, H. (2004), *Changing Minds: The Art and Science of Changing Our Own and Other People's Minds,* Harvard Business School Press, Boston, MA.
Gergen, K. J. and Thatchenkery, T. J. (1996), "Organization Science as Social Construction: Postmodern Potentials ", *Journal of Applied Behavioural Science,* Vol. 32, No. 4, pp. 356-377.
Gilgun, J. F. (1995), "We Shared Something Special: The Moral Discourse of Incest Perpetrators", *Journal of Marriage and the Family,* Vol. 57, No. 2, pp. 265-281.
Glaser, B. (1992), *Basics of grounded theory analyses: emergence vs. forcing,* Sociology Press, Mill Valley,CA.
Glaser, B. G. (1978), *Theoretical sensitivity: Advances in the Methodology of Grounded Theory,* Sociology Press, Mill Valley, California.
Glaser, B. G. (2001), *The Grounded Theory Perspective: Conceptualization Contrasted with Description,* Sociology Press, Mill Valley, California.
Glaser, B. G. and Strauss, A. L. (1967), *The Discovery of Grounded Theory. Strategies for Qualitative Research.,* Aldine, New York.
Graneheim, U. H. and Lundman, B. (2004), "Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness", *Nurse Education Today,* Vol. 24, No. 2, pp. 105-112.
Guba, E. G. and Lincoln, Y. S. (1994), "Competing paradigms in qualitative research", Denzin, N. K. and Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research.* Sage, Thousand Oaks, CA
Gummesson, E. (2000), *Qualitative Methods in Management Research,* Sage Publications, Inc., Thousand Oaks, CA.
Gummesson, E. (2003), "All research is interpretive!", *Journal of Business & Industrial Marketing,* Vol. 18, No. 6/7, pp. 482-492.
Gummesson, E. (2006), "Qualitative research in management: addressing complexity, context and persona", *Management Decision,* Vol. 44, No. 2, pp. 167-179.
Hallberg, U. E. and Schaufeli, W. B. (2006), "“Same Same” But Different? Can Work Engagement Be Discriminated from Job Involvement and Organizational Commitment?", *European Psychologist,* Vol. 11, No. 2, pp. 119-127.
Hattie, J. and Marsh, H. W. (1996), "The Relationship Between Research and Teaching: A Meta- Analysis", *Review of Educational Research,* Vol. 66, No. 4, pp. 507- 542.
Henry, W. E., Sims, J. H. and Spray, S. L. (1971), *The fifth profession,* Jossey -Bass Inc., Publishers, San Fransisco.
Heyssel, R. M. (1984), "The Challenge of Governance - the Relationship of the Teaching Hospital to the University", *Journal of Medical Education,* Vol. 59, No. 3, pp. 162-168.
Hirschhorn, L. (1998), *Reworking authority: Leading and following in the post-modern organization,* MIT Press, Cambridge, MA.
Holmberg, I. and Akerblom, S. (2006), "Modelling leadership - Implicit

leadership theories in Sweden", *Scandinavian Journal of Management,* Vol. 22, No. 4, pp. 307-329.

Holmberg, I. and Strannegård, L. (2005), "Leadership Voices: The Ideology of 'The New Economy'", *Leadership,* Vol. 1, No. 3, pp. 353-374.

Holmström, I. (2002) Gaining Professional Competence for Patient Encounters by Means of a New Understanding. Acta Universitatis Upsaliensis, Uppsala, Sweden.

Holstein, J. A. and Gubrium, J. F. (1997), "Active Interviewing", Silverman, D. (Ed.) *Qualitative Research. Theory, Method and Practice*. Sage Publications Ltd, London, England, pp. 113-129.

Hood, C. (1995), "The New Public Management in the 1980s: Variations on a Theme", *Accounting, Organizations and Society,* Vol. 20, No. 2/3, pp. 93-109.

Hälso och Sjukvårdslagen [*Health Care Act*] (1982), SFS nr 1982:763, Sveriges Riksdag.

Ibarra, H. (1999), "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation", *Administrative Science Quarterly,* Vol. 44, pp. 764-791.

Johnson, P. (1998), "Analytic Induction", Symon, G. and Cassell, C. (Eds.), *Qualitative Methods and Analysis in Organizational Research*. Sage Publications, London

Joiner, K., Libecap, A., Cress, A. E., Wormsley, S., St. Germain, P., Berg, R. and Malan, P. (2008), "Supporting the Academic Mission in an Era of Constrained Resources: Approaches at the University of Arizona College of Medicine", *Academic Medicine,* Vol. 83, No. 9, pp. 837-844.

Joneborg, N., Kyaga, S. and Dunér, K. (2008), *Läkares arbetsmiljö i SLL: Ledarskap, arbetsmiljö och vårdkvalitet* [The work environment of physicians employed by the Stockholm County Council: leadership, work environment, and quality of care], Stockholms Sjukhusläkarförening och SYLF Stockholm, Stockholm.

Jones, R. and Noble, G. (2007), "Grounded theory and management research: a lack of integrity?", *Qualitative Research in Organizations and Management: An International Journal,* Vol. 2, No. 2, pp. 84-103.

Kendall, L. (2003) The Future Health Worker. *EHMA Conference*. Caltanissetta.

Khapova, S. N., Arthur, M. B., Wilderom, C. P. M. and Svensson, J. S. (2007), "Professional identity as the key to career change intention", *Career Development International,* Vol. 12, No. 7, pp. 584-595.

Kidd, J. M. and Green, F. (2006), "The careers of research scientists: Predictors of three dimensions of career commitment and intention to leave science", *Personnel Review,* Vol. 35, No. 3, pp. 229-251.

Kvale, S. (1984), "The Qualitative Research Interview", *Journal of Phenomenological Psychology,* Vol. 14, No. 2, pp. 171-196.

Kvale, S. (1989), "To validate is to question", Kvale, S. (Ed.) *Issues of validity in qualitative research*. Studentlitteratur, Lund, pp. 73-92.

Kvale, S. (1996), *Interviews: An introduction to qualitative research interviewing,* Sage Publications, Inc., Thousand Oaks, CA.

Landstingsförbundet (2003), *Hälso- och sjukvården i utveckling* [A developing health care], Federation of Swedish County Councils, Stockholm.
Larsson, J. and Ericsson, A. (2003), *Career Questionnaire March 2003. [in Swedish]*, The Swedish Junior Hospital Doctors' Association (SYLF), Stockholm, Sweden.
Leavitt, H. (2004), *Top Down: Why Hierarchies Are Here to Stay and How to Manage Them More Effectively,* HBS Press, Boston.
Levinson, W. and Rubenstein, A. (2000), "Integrating Clinician–Educators into Academic Medical Centers: Challenges and Potential Solutions", *Academic Medicine,* Vol. 75, No. 9, pp. 906-912.
Lincoln, Y. S. and Guba, E. G. (1985), *Naturalistic inquiry,* Sage, Beverly Hills,Ca.
Ludmerer, K. M. (1999), *Time to Heal, American Education from the Turn of the Century to the Era of Managed Care,* Oxford University Press, New York.
Lutgen-Sandvik, P. (2008), "Intensive Remedial Identity Work: Responses to Workplace Bullying Trauma and Stigmatization", *Organization,* Vol. 15, No. 1, pp. 97-119.
Magill, M. K., Catinella, A. P., Haas, L. and Hughes, C. C. (1998), "Cultures in conflict: a challenge to faculty of academic health centers", *Acad Med,* Vol. 73, No. 8, pp. 871-5.
Malterud, K. (2001a), "The art and science of clinical knowledge: evidence beyond measures and numbers. [comment]", *Lancet,* Vol. 358, No. 9279, pp. 397-400.
Malterud, K. (2001b), "Qualitative research: standards, challenges, and guidelines", *Lancet,* Vol. 358, No. 9280, pp. 483-8.
Mason, J. (1998), *Qualitative Researching,* Sage pubilcations, London.
Maxwell, J. A. (1996), *Qualitative Research Design. An Interactive Approach,* Sage Puplications, Thousand Oaks.
McNerney, W. J. (1985), "Managing ethical dilemmas", *Journal of Health Administration Education,* Vol. 3, pp. 331-340.
Middlehurst, R. and Elton, L. (1992), "Leadership and Management in Higher Education.", *Studies in Higher Education,* Vol. 17, No. 3, pp. 251-264.
Miller, W. L. and Crabtree, B. F. (1992), "Primary care research: A multimethod typology and qualitative road map", Crabtree, B. F. and Miller, W. L. (Eds.), *Doing qualitative research.* Sage, Newbury Park, CA, pp. 3-28.
Mintzberg, H. (1983), *Structure in fives: Designing effective organizations,* Prentice Hall, Englewood Cliffs, NJ.
Mintzberg, H. (1994), "Rethinking Strategic Planning Part II: New Roles for Planners", *Longe Range Planning,* Vol. 27, No. 3, pp. 22-30.
Mintzberg, H. (1999), "Managing Quietly", *Leader to Leader,* Vol. 1999, No. 12, pp. 24-30.
Morreim, E. H. (1990), "The new economics of medicine: special challenges for psychiatry", *Journal of Medicine & Philosophy,* Vol. 15, No. 1, pp. 97-119.

Morse, J. M. (1994), "Going in "Blind"", *Qualitative Health Research,* Vol. 4, No. 1, pp. 3-5.
Newman, K., Maylor, U. and Chansarkar, B. (2002), "The nurse satisfaction, service quality and nurse retention chain", *Journal of Management in Medicine,* Vol. 16, pp. 271-291.
Nilson, J. T. (1998), "Life in the middle. What it takes to succeed in middle management.", *Healthcare Executive,* Vol. 13, No. 2, pp. 20-24.
Nordgren, M. (2000) Läkarprofessionens feminisering ett köns- och maktperspektiv. [The effemination of the medical profession a perspective of gender and power.]. Stockholm University, Stockholm, Sweden.
O'Conner, M. K., Netting, E. F. and Thomas, L. M. (2008), "Grounded Theory: Managing the Challenge for Those Facing Institutional Review Board Oversight", *Qualitative Inquiry,* Vol. 14, No. 1, pp. 28-45.
O'Connor, E. S. (2000), "Integrating Follett: History, philosophy and management", *Journal of Management History,* Vol. 6, No. 4, pp. 167-190.
O'Connor, S. J. and Lanning, J. A. (1992), "The end of autonomy? Reflections on the post-professional physician.", *Health Care Management Review,* Vol. 17, No. 1, pp. 63-72.
O'Reilly, C. (1989), "Corporations, Culture, and Commitment: Motivation and Social Control in Organizations", *California Management Review,* Vol. 31, No. 4, pp. 9-25.
Oermann, M. H. (1998), "Role Strain of Clinical Nursing Faculty", *Journal of Professional Nursing,* Vol. 14, No. 6, pp. 329-334.
Orton, J. D. (1997), "From inductive to iterative grounded theory: Zipping the gap between process theory and process data", *Scandinavian Journal of Management,* Vol. 13, No. 4, pp. 419-438.
Ouchi, W. G. (1979), "A Conceptual Framework for the Design of Organizational Control Mechanisms", *Management Science,* Vol. 25, No. 9, pp. 833-848.
Patrick, A. R. M. and Laschinger, H. K. S. P. (2006), "The effect of structural empowerment and perceived organizational support on middle level nurse managers' role satisfaction", *Journal of Nursing Management,* Vol. 14, No. 1, pp. 13-22.
Patton, M. Q. (1990), *Qualitative Evaluation and Research Methods,* Sage Publications, Inc., Newbury Park, Ca.
Patton, M. Q. (2002a), *Qualitative Research & Evaluation Methods,* Sage Publications, London.
Patton, M. Q. (2002b), "Two Decades of Developments in Qualitative Inquiry", *Qualitative Social Work,* Vol. 1, No. 3, pp. 261-283.
Pizzo, P. A. (2008), "Case Study: The Stanford University School of Medicine and Its Teaching Hospitals", *Academic Medicine,* Vol. 83, No. 9, pp. 867-872.
Popper, K. R. (1972), *The Logic of Scientific Discovery,* Hutchinson, London.
Pratt, M. G., Rockman, K. W. and 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,* Vol. 49, No. 2, pp. 235-262.

Raines, M. L. (2000), "Ethical decision making in nurses. Relationships among moral reasoning, coping style, and ethics stress", *JONA's Healthcare Law, Ethics, & Regulation,* Vol. 2, No. 1, pp. 29-41.

Rapley, T. J. (2001), "The art(fulness) of open-ended interviewing: some considerations on analysing interviews", *Qualitative Research,* Vol. 1, No. 3, pp. 303-323.

Regan-Smith, M. G. (1998), ""Reform without change": Update, 1998" [Acad. Med.], 73, No. 5, pp. 505-507.

Reiss, S. (2004), "Multifaceted Nature of Intrinsic Motivation: The Theory of 16 Basic Desires", *Review of General Psychology,* Vol. 8, No. 3, pp. 179-193.

Ricouer, P. (1992), *Oneself as another,* University of Chicago Press, Chicago.

Roher, J. E. (1989), "The Secret of Medical Management", *Health Care Management Review,* Vol. 14, No. 3, pp. 7-13.

Roulston, K., deMarrais, K. and Lewis, J. B. (2003), "Learning to Interview in the Social Sciences", *Qualitative Inquiry,* Vol. 9, No. 4, pp. 643-668.

Rønnestad, M. H. and Skovholt, T. M. (2003), "The journey of the councelor and therapist: Research findings and perspectives on professional development.", *Journal of Career Development,* Vol. 30, No. 1, pp. 5-44.

Sandelowski, M. (1995), "Sample size in qualitative research", *Research in Nursing & Health,* Vol. 18, No. 2, pp. 179-83.

Sandelowski, M. (2000), "Whatever happened to qualitative description?", *Research in Nursing & Health,* Vol. 23, No. 4, pp. 334-340.

Schein, E. H. (1992), *Organizational culture and leadership,* Jossey-Bass Inc., San Francisco, Ca.

Schein, E. H. (1996), "Culture: The missing Concept in Organization Studies", *Administrative Science Quarterly,* Vol. 41, pp. 229 -240.

Schlesinger, M. (2002), "A loss of faith: The sources of reduced political legitimacy for the American medical profession.", *Milbank Quarterly.,* Vol. 80, No. 2, pp. 185-235.

Schwartz, H. and Davis, S. (1981), "Mathing Corporate Culture and Business Strategy", *Organizational Dynamics,* Vol. 10, No. 1, pp. 30 -48.

Schöldenström, U. (2003), "Läkarförbundet under ett sekel. [The medical association during a century]", N.O., S. (Ed.) *Ett sekel med läkaren i fokus [A century with the physician in focus].* The Swedish Medical Association, Stockholm, Sweden, pp. 15-55.

Sellgren, S., Ekvall, G. and Tomson, G. (2007), "Nursing staff turnover: does leadership matter?", *Leadership in Health Services,* Vol. 20, No. 3, pp. 169-183.

Senge, P. M. (1999), *The Fifth Discipline: The Art & Practice of The Learning Organization,* Random House Business, London.

Shalit, B. and Carlstedt, L. (1984), *The perception of enemy threat. A method for assessing the coping potential.,* FOA/ National Defence Research Establishment, Stockholm, Sweden.

Shalit, B., Carlstedt, L., Ståhlberg Carlstedt, B. and Täljedal Shalit, I. L.

(1983), *Coherence of Appraisal: Parachute jump effectiveness.*, FOA/National Defence Research Establishment, Stockholm, Sweden.

Shine, K. I. (2002), "Health care quality and how to achieve it", *Academic Medicine,* Vol. 77, pp. 91-9.

Silverman, D. (2001), *Interpreting Qualiative Data. Methods for Analyzing Talk, Text and Interaction,* Saga publication, London.

Skytt, B., Ljunggren, B. and Carlsson, M. (2007), "Reasons to leave: the motives of first-line nurse managers' for leaving their posts", *Journal of Nursing Management,* Vol. 15, No. 3, pp. 294-302.

Sparks, K., Faragher, B. and Cooper, G. L. (2001), "Well-being and occupational health in the 21st century workplace", *Journal of Occupational and Organizational Psychology,* Vol. 74, pp. 489-509.

Stern, P. N. (1980), "Grounded theory methodology: Its uses and processes", *Image - the Journal of Nursing Scholarship,* Vol. 12, pp. 20-23.

Stiles, W. B. (1993), "Quality-control in qualitative research", *Clinical Psychology Review,* Vol. 13, No. 6, pp. 593-618.

Stoeckle, J. D. and Reiser, S. J. (1992), "The corporate organization of hospital work - balancing professional and administrative responsibilities," *Annals of internal medicine.,* Vol. 116, No. 5, pp. 407-413.

Strauss, A. and Corbin, J. (1990), *Basics of Qualitative Research.,* Sage, Newbury Park, CA.

Suddaby, R. (2006), "From The Editors: What Grounded Theory Is Not", *Academy of Management Journal,* Vol. 49, No. 4, pp. 633-642.

Sveningsson, S. and Alvesson, M. (2003), "Managing managerial identities: Organizational fragmentation, discourse and identity struggle", *Human Relations,* Vol. 56, No. 10, pp. 1163-1193.

Szücs, S., Hemström, Ö. and Marklund, S. (2003), *Organisatoriska faktorers betydelse för långa sjukskrivningar i kommuner [The Effect of Organizational Factors on Long-term Sick Leave in Swedish Municipalties]*, Arbetslivsinstitutet [National Institute for Working Life], Stockholm, Sweden; 2003:6.

Taft, S., Hawn, K., Barber, J. and Bidwell, J. (1999), "Fulcrum for the Future: The Creation of a Values-Driven Culture", *Health Care Management Review,* Vol. 24, No. 1, pp. 17-32.

Thomas, R. and Davies, A. (2005), "Theorizing the Micro-politics of Resistance: New Public Management and Managerial Identities in the UK Public Services", *Organization Studies,* Vol. 26, No. 5, pp. 683-706.

Thomas, R. and Linstead, A. (2002), "Losing the Plot? Middle Managers and Identity", *Organization,* Vol. 9, No. 1, pp. 71-93.

Thomé, G. and Arstam, A. (2001), *Når läkarutbildningen de resultat som yrkeslivet förväntar?. [Does the medical education achieve the results expected in working life?]*, Unit for Medical Pedagogics, Medical Faculty, Lund University, Lund, Sweden.

Thoms, J. C. (2008), "Ethical Integrity in Leadership and Organizational Moral Culture", *Leadership,* Vol. 4, No. 4, pp. 419-442.

Tomes, N. (2007), "Patient empowerment and the dilemmas of late-modern medicalisation", *Lancet,* Vol. 369, No. 9562, pp. 698-700.
Tyler, T. R. (1999), "Why people cooperate with organizations: An identity-based perspective", *Research in organizational behavior,* Vol. 21, pp. 201-246.
Wall, A. (1999), "Middle management. Courtin' the middle", *Health Service Journal,* Vol. 109, No. 5640, pp. 22-5.
van Bockel, J. and Noordegraaf, M. (2006), "Identifying identities: performance-driven, but professional public managers", *International Journal of Public Sector Management,* Vol. 19, No. 6, pp. 585-597.
van Vegchel, N., de Jonge, J., Söderfeldt, M., Cormann, C. and Schaufeli, W. (2004), "Quantitative Versus Emotional Demands Among Swedish Human Service Employees: Moderating Effects of Job Control and Social Support", *International Journal of Stress Management,* Vol. 11, No. 1, pp. 21-40.
Watson, R. T. (2003), "Rediscovering the Medical School", *Academic Medicine,* Vol. 78, No. 7, pp. 659-665.
Wengström, Y., Häggmark, C. and Forsberg, C. (2001), "Coping with radiation therapy: Strategies used by women with breast cancer.", *Cancer Nursing,* Vol. 24, No. 4, pp. 264-.
Williams, M. (2000), "Interpretivism and generalisation", *Sociology,* Vol. 34, No. 2, pp. 209-224.
Wright, J. G. and Wedge, J. H. (2004), "Clinicians and patients' welfare: where does academic freedom fit in?", *British Medical Journal,* Vol. 329, No. 7469, pp. 795-796.
Ylander, J. (2008) Constructive management. Synchronizing relations in change. *Department of Business Administration.* University of Gothenburg, Gothenburg.
Yukl, G. (1989), "Managerial Leadership - a Review of Theory and Research", *Journal of Management,* Vol. 15, No. 2, pp. 251-289.
Yukl, G. (2006), *Leadership in organizations,* Prentice Hall, Upper Saddle River, NJ.
Znaniecki, F. (1934), *The method of Sociology,* Farrer and Rinehart, New York.
Zuckerman, H. S., Dowling, W. L. and Richardson, M. L. (2000), "The Managerial Role", Shortell, S. M. and Kaluzny, A. D. (Eds.), *Health Care management, Organization Design and Behaviour.* Delmar, Thomson Learning, Albany, NY
Åström, E. (2008), *Frihetens pris - ett gränslöst arbete: En tematisk studie av de akademiska lärarnas och institutionsledarnas arbetssituation* [The price of freedom is endless work - a thematic study of the work situation of department heads and teachers], Högskoleverket, Stockholm; 2008:22 R.