NO ONE WANTS TO GET STUCK WITH THE LOSING CARD
–The conditions of management in conjunction with hospital mergers

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Abstract

Problems
The rate of turnover of hospital managers has been high in Sweden. Hospitals are regarded to be difficult to manage, which is connected with different discourses and action logics such as politics, medicine, care and management creating complex conditions for hospital management.

Purpose
To analyse hospital managers’ management conditions in conjunction with hospital mergers.

Method
Two case studies concerning hospital mergers illustrate these management conditions by means of analysing how different actions are communicated by politicians, county council directors, and hospital managers. The author’s own experiences as a hospital manager have been made use of, as have document studies. In the analysis, conducted with the support of several theoretical perspectives, certain themes emerge which touch upon these management conditions.

Conclusions
In connection with hospital mergers, leading hospital actor carry out communicative games controlled by different action logics. No one wants to get stuck with the losing card.

Implications
To clarify under which management conditions the hospital manager acts.
Introduction

The rate of turnover of hospital managers has been high in Sweden (Hallin 2002) and sometimes the position of the hospital manager is described in terms of sitting on an ejector seat. This position\(^1\) is normally task managed by politicians in public healthcare. It seems to be particularly vulnerable in connection with major organisational changes, in combination with cost-cutting\(^2\), being carried out under the direction of the hospital manager. How then do the management conditions, i.e. the conditions in the form of assignments, organisation, discourses, and action logics which influence and frame the hospital manager’s position, look? In this introduction, there is a review of the research field of hospital management and a description of the purpose of the article.

In the field of hospital management, Jespersen (2005) has shown how hospitals are affected by the entry of “New Public Management” and he asserts that the power of the profession exerts an effect on its implementation. Operational managers’ conditions are dealt with by Östergren & Sahlin-Andersson (1998) and by Öfverström (2008) who describes how physicians experience the step from doing clinical work to becoming operational managers. Hallin (2002) shows how the establishment of hospital management comes about within a merged university hospital. Carlström (2009) analyses how middle managers in healthcare “slide” in order to be able to deal with an increased level of complexity in assignments and positions. Norbäck & Targama (2009) emphasize that, in public sector operations, there is an over-belief in what local managers can accomplish, as the professions prefer collegiality (ibid.). In her study of the merger between the Karolinska and Huddinge university hospitals, Choi (2011) observes the collision between “managerialism” and “professionalism”, which is described as vertical, a collision which must be dealt with through dialogue according to Choi, who shows the difficulties of achieving the goals set for hospital mergers. Hospital management’s actions are seen as transparent (ibid). Mintzberg (1997) discusses assignments for hospital management. Learmonth (2008) shows, using examples from healthcare, how the term leadership can be seen as performative. No study, however, has explicitly dealt with the hospital manager’s conditions with regard to managing a hospital, which is the purpose of this article.

The purpose is to analyse hospital managers’ management conditions in connection with hospital mergers. One way of doing this is to analyse how leading hospital actors describe the change process. The cases analysed deal with two hospital mergers at the end of the 1990s. Merging hospitals is a rather new phenomenon in Sweden and only a small amount of research has been published on the subject (Choi 2011).

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\(^1\) Previously, it was regulated in law. Between 1999 and 2002, 11 hospital managers quit in the county of Västra Götaland (Provincial Swedish daily Göteborgsposten 2002). F. Reinfeldt (spokesperson in healthcare issues for the Swedish Conservatives) said in Almedalen on 2010-07-04 (Swedish healthcare sector weekly Dagens Medicin) that “Healthcare managers should stay longer in their jobs.”

\(^2\) Often, cost-cutting has been mitigated as a consequence of government funds being injected.
Methodology

As the purpose is to analyse the hospital manager’s management conditions in connection with hospital mergers, two case studies were carried out. Additionally, the author’s own experiences of hospital management were also made use of. In-depth interviews were carried out, in one of the cases, with the hospital manager and his political chairman. In the other case, the hospital manager and his most immediate superior, the county council director, were interviewed. The interviews focused on terms of employment, assignments, the course of events, how the hospital managers had quit, and communication between the actors. The interviews were printed out and used for analysing the managerial conditions from various perspectives (see the next section). Studies of minutes and documents from the respective county council were also conducted, as was the writing of the basis for a play about hospital management, used at a conference for hospital managers.

Theoretical perspectives

With the aim of creating understanding of the management conditions affecting hospital managers’ management conditions, several theoretical perspectives will be used as tools. These are hospital management (Mintzberg), power (Foucault), communicative action (Habermas), as well as power play (Clegg, Simmel) and sense making (Weick 1995). Even if the perspectives of Foucault and Habermas may appear to be asymmetric, I will still use them anyway in order to be able to understand the manifold circumstances characterising hospital management. My aim is not to integrate them into a common frame of reference.

Hospital management

Hospitals, which are normally defined as professional organisations (Mintzberg 1983), are deemed difficult to manage, which is connected with an ongoing struggle regarding influence between certain discourses and how they express themselves (Nordgren 2003). While doctors say that care is provided more quickly, economists talk about more efficient processes. Brante (2010-06-18) has observed “the increasing gap between operational professionals and management professionals, or organisational professionals, whereby the latter nowadays attend special management courses and constitute intermediary links between operatives and, most frequently, politicians”. The new organisational professionalism, management, is said to be a threat to professional values, but can be dealt with if operational professionals learn to use management (Evett 2010).

When a public hospital is ultimately governed by political assignments, a political rationality and action logic will set the framework for hospital management.

Hospital management takes on an intermediate position between policy and profession.

According to Mintzberg (1997, p. 9), hospital management, besides being responsible for resource housekeeping, should also deal with different issues; “These include, among others, the fragmentation of efforts, confusion in mission (and in mission statements), the problems of bundling research with clinical work, selectivity in informing board members, the dangers of professional management, and the difficulties of combining external advocacy with internal reconciliation in the senior manager’s job. The article concludes that hospitals could better learn how to solve problems systematically, and that to do so will require not the wish lists of strategic planning and structural reorganizing but tangible changes in their collective behaviour.”

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3 Alvesson’s (2002) book Kommunikation, makt och organisation [Communication, power, and organisation] has inspired this effort.

4 The article builds on a framework of cure, care, control, and community (Mintzberg 1997, p. 9).

5 According to Brante (2011), it is reasonable to define professions on the basis of scientific knowledge.

6 According to Mintzberg (1980) managing concerns communicating with the environment.
Inadequate problem-solving can be seen as a consequence of inadequate action-focused meetings between “medicine” and “management”. A doctor is expected to work with interventions. Discussing hospital-wide issues in the form of meetings can thus create a feeling of unproductiveness for doctors. Hospital management, on the other hand, works with hospital-wide issues and emphasizes collective action, often in the form of meetings. Fragmentation, too, counteracts joint problem-solving, which is illustrated by the following example from an A&E unit. The problem had been in existence for a long time, but there was no solution as only a few of the medical managers concerned were getting involved. When an external threat got the organisation moving, an interdisciplinary group of healthcare representatives was formed, which solved the problems.

Communicative action

Habermas (1984, 1996) pleads for free conversations based on good will, argumentation, and dialogue. Such conversations are not characterized by power games, the exercising of influence, status, prestige, ideology, manipulation, expert domination, fear, uncertainty, or misunderstanding, but by strength of argument. It is a matter of expressing oneself intelligibly, of giving the listener something to understand, of making oneself understood, and of achieving mutual understanding and it is a matter of what is said being comprehensible, honest, true, and legitimate. The opposite of interference-free is distorted communication, within which power relations, ideological dominance, and goal-rationality hamper the questioning of statements and desires regarding intelligibility, honesty, correctness, and legitimacy. Instead, ambiguities, dishonesty, manipulation, rhetoric, and distortion dominate. Habermas’ theory has a utopian character as differences of interest can hardly be eliminated purely through good argumentation.

Power

Various forms of knowledge, e.g. medicine, are linked to power as they function in a disciplining way by specifying what is suitable and right to do (Foucault 1974, 1980). The professions are responsible for this type of knowledge. Management can also be seen as a form of such knowledge (Alvesson 2002).

Different ways of thinking, speaking, and acting, which form the basis for what is taken for granted in both everyday life and organisations, are affected by different language usages, which arise from definite discourses (Foucault 1972). Discourses exercise power over individuals and make them act in a certain way (Foucault 1982). In a leadership perspective, it is, thus, discourses that govern leaders. A leadership discourse accentuates, for instance, management’s major importance regarding the results within the respective organisation (Alvesson 1992, 2002)

The cases

In this section the two hospital mergers (case 1 and 2) are described. It begins with an introduction followed by interviews with the leading actors

Case 1 Restructuring three hospitals into one

Three major hospitals were to be merged, starting in 1997, into one hospital under a single management and with joint finances. In 1996, a manager was recruited externally who would lead the project and the new university hospital, subordinate to a board of management consisting of 13 board members and 13 alternates. Above this

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7 “especially hospitals need devoted, continuous, holistic, and preemptive care, not interventionist, intermittent, specialized and radical cure. They need collaborative efforts at tackling their problems, led by champions who are both involved and committed” (Mintzberg 1997, p. 17)

8 According to Mintzberg (1997, p. 13) “...things get done when a champion sees to something, someone committed to action. In medicine, the most seriously ill tend to get the greatest attention. But this is not the best model for administration, where issues have to be dealt with before they become crises. In effect, care (and nursing) provides a better model for management than does cure (and medicine).”
board of management, there was a collaboration council appointed by a confederation tasked with running the hospital. As the board of management would only meet a few times a year, it appointed a working committee which in turn appointed an executive committee consisting of four full-time politicians. The role of the board of management (the interviewed politician was the chairman) was to be responsible for the delivery of healthcare. As much as possible was delegated to the working committee. In other respects, the political organisation was divided into an owner with two parties and a purchaser consisting of 8 different committees tasked with commissioning hospital care. Between the owner and the purchaser, there was a certain amount of personal union. The owner put demands on the hospital to save money. The political organisation was deemed difficult to communicate with as it had distributed the responsibility between different political bodies. The decision to restructure was preceded by a project aimed at achieving structural changes. Previous attempts at coordinating the hospitals had failed.

In conjunction with the manager assuming his duties, there was some discussion regarding what combined savings effect consolidation would bring. In the autumn of 1996, after the hospital manager had been hired, the owner presented the combined financial demand being placed on the newly-formed hospital for a three-year period commencing in 1997. Operating costs were to be cut by a good SEK 400 M amid an unchanged volume of care, which was significantly higher than what was put before the manager at the time he was hired. He estimated, however, the real cost-cutting as being double, as the hospital was suffering from a structural deficit that had not been defined when the restructuring work was commenced on.

The structural change was to be achieved via level structuring, chain of care thinking, and the concentration of highly-specialised operations. It would be implemented with full security of employment for all permanent employees in close collaboration with the medical faculty, the trade unions, and the patient and disability organisations. A reasonable amount of time for consultation would be earmarked. Order volumes, prices, and points of service were set by the owners, the purchasers, and in some cases by regional authorities after consulting with the hospital. In the discussions that took place, the owners had the preferential right of interpretation.

The hospital manager’s story (case 1)

“The prerequisites for the assignment were unreasonable”, said the hospital manager and embarked on an exposé of the problems characterising the merger.

“There were 2 owners, 3 hospitals, and 3 cultures. We were given cost-cutting assignments that did not take into account the fact that there was a previous structural deficit. Academia was not governable in the traditional way; it has many loyalties where hospital interests very often take a low priority. The political power structure was divided. The decision-making processes were frequently disrupted by a very complicated grounding and negotiation process on the part of the owners. This became apparent when the level of frustration increased regarding the financial realities. A hospital manager was not a secure thing to be. Time was increasingly being spent on dealing with the frustration concerning the governance systems’ deficiencies, the procedures in the decision-making process, and individual issues. The problem was noticed early on. The political system always has the upper hand, with many channels of its own towards professions and individual co-workers. The channels are used diligently by many parties. Due to the consequences of the restructurings, the cost-savings and proposed measures went all the way to the top of the political system. Other executives and politicians, too, were dragged along upwards. Many would say their piece on the way up. Would I go all the way up through the system myself? In that case, I would be forced to cross the line of the democratic system. If I wanted to retain my faith in the system, this would neither be possible nor appreciated. Special interests are cultivated and defended in all possible ways and it is a tricky game. The focus ends up on one person. The lack of understanding of the mass media as regards complexity and change work does not facilitate long-term endeavours”.

The hospital manager said; “the challenge was right and the structure OK, but I should have done this as a limited-duration assignment”. The new hospital structure was described in terms of vision, divisions, and processes. The Chief Medical Officers raised questions “that one didn’t entirely buy” concerning the
organisation. The divisional managers were recruited first and then the operational managers. Some professors became touchy when they were not automatically appointed as managers. The dialogue with the one’s own politicians worked well.

According to the hospital manager “The major problem was that gigantic savings were added without a calculation or any realistic prerequisites for coping with the assignment”, simultaneous to inheriting a structural deficit, from the time prior to the merger, consisting of hundreds of millions of SEK. During an early phase, the hospital manager drafted a memo, without registering it, which recorded the size of the deficit. The deficit was not negotiated with the owners. Things would work out in conjunction with the structural deficit being investigated, said the politicians. A consultancy firm was tasked with analysing the deficit and found that it would end up on a significantly lower level than envisaged by the hospital manager. In reality, the deficit increased gradually over the year.

The hospital manager said; “the financial department’s forecasts were not very good. The political conflict surrounding how the deficit would be paid for was one of the major problems”. Once the final accounts had been completed for the first year of operations, insight into the financial situation improved, creating frustration among the owners. The auditors and the consultancy firm reviewed the results. The political system started closing ranks and the internal conflicts became increasingly visible to those in that setting who were involved. The local executive committee ended up in-between and it became difficult to bring clarity to the political aims.

At the same time, the election was approaching. The nervousness ahead of this increased the conflict and led to political manoeuvring. The owners then decided to inject more money subject to certain pledges from hospital management.

The hospital manager led the newly-established hospital for two years and then quit following a period of “swimming upstream and being hung out to dry in the press”. The press talked about a poor climate at the hospital, about patients who did not receive care, and about deficits. The hospital manager asked himself; “am I the best manager at this hospital? Am I about to sacrifice my family - it feels as if I’m about to lose touch with my son. Is it worth the cost? Once the hospital manager had decided to quit, it was important to leave immediately. The hospital manager made this decision known to the owner’s executive management group, then to his political chairman, and then to the press. A limited-duration project assignment would have worked better than permanent employment; however, at the time of being hired, the manager was unaware of the risk attached to this assignment. It was stressful to have attention constantly being focused on one person - the hospital manager. His working hours peaked at 80-90 hours a week, and there was no mentor.

Why did the hospital manager quit? The circumstances surrounding the merger were difficult to deal with, due to unclear and diffuse information from the principals. The hospital manager thus considered himself to have a low degree of security and to lack a candid message that supported the change process, saying; “while the politicians avoided a number of major decisions, they did address the operational issues”. Another reason was that the structural deficit was not specified in time. The hospital manager did not feel there was any disloyalty on the part of his co-workers, even though few of them publicly supported the merger and its management. On the other hand, there were informal leaders, Chief Medical Officers, who did not support the restructuring but played the part of “fishes”. Similarly, some politicians, who after a while had also started criticising the restructuring publicly, gave way. There was no parachute for the hospital manager who conducted concluding talks with his old co-workers and wrote down his reflections on his work.

The politician’s story (case 1)

“Is it possible to govern a hospital?” asked the politician while drawing a picture of how the political organisation was composed. This was divided up into owner, purchaser, and supplier. The politician was on the board of management and was responsible for suppliers.
“In reality, it’s a strange no-man’s-land having this board of management, this working committee, and the executive committee. It’s difficult being a supplier politician. The part isn’t a good one. Am I to refer patients who call me to other politicians who are purchasers? Which interests do I have to defend as a politician, really. It’s difficult to explain the complex organisation to people. This type of political organisation will be impossible to have in the future. It has too many levels and the roles are not clear. Being a chairman is difficult and it was lucky I didn’t understand that better before taking on the assignment. I have a lot of bitter experience of this merger project. I’ve learnt a lot, but it hasn’t been fun. At times, we’ve been steamrollered from above. It’s a game and no one wants to get stuck with the losing card, but none of it has occurred through ill will, there were no nasty games”.

The owner set cost savings for the new hospital for three years ahead. The board of management got behind these, supported by a previous inquiry, but with no calculation of the savings. In order to keep operations running, the board of management was forced to have an unbalanced budget. The structural change was deemed politically well-founded and the majority were agreed about the decision, with the exception of two political parties. Recently, the change had, however, been criticised by politicians who had previously been in favour of the decision.

One motive for the change was to “break up the old structure” in order to be able to use shared resources. At the same time, there would be three hospitals with three different cultures within the same organisation, which gave rise to tensions primarily between two of the hospitals, one of which did not wish to be involved in the merger. The resistance manifested itself as pronouncements, made by certain Chief Medical Officers, which had an impact in the press and among critical politicians. The previous hospital manager acted duplicitously by saying he was positively inclined towards the new hospital while nevertheless supporting his own hospital.

“It’s a major problem when people run to the papers instead of investigating the issue. You can’t discuss the issue via the newspapers. It’s difficult to have your say. There are big mental differences between the hospitals and there are many angles to this. One of the hospitals feels wronged against, but it’s not like that. Speaking badly of your own hospital means that you yourself will lose out. Several Chief Medical Officers are acting, but there’s one in particular. There’s a limit to what we can put up with. The papers have been used ruthlessly by the staff.”

The politician brought up the relationship with the hospital manager.

“It wasn’t me, who hired him, but we established a good rapport immediately, we met one evening and had dinner and our personal chemistry chimed well. His leadership was good, but he lacked a few “tough guys” around him. There should have been a stronger leadership and there should have been one or two people from inside the old culture. On our side of things, the hospital manager was free to obtain the co-workers needed. He worked too much on his own. As the manager had been promised a hospital that was in balance financially, it was discovered too late how serious the financial crisis was. The truth about the financial position and the structural deficit emerged after a consultancy firm had gone through everything. The forecasts fluctuated and that’s how it is with forecasts. The hospital manager then almost worked himself to death trying to turn the financial situation around.” The politician underlined again that “No one wants to get stuck with the losing card.”

The hospital manager was tired at the end of the change work and chose to resign. The manager communicated his decision to those concerned and to the press and quit immediately. “It was logical for the hospital manager to quit”, said the politician. “The hospital manager did not live here but should really have moved here. Not doing that created a sneaking distrust against the hospital manager and undermined some of his legitimacy.

Is it possible to govern a hospital? ” asked the politician by way of conclusion.
Case 2 Structuring two hospitals into one

Within the county council, there are three hospitals. Since 1991, work had been conducted on the basis of the purchaser/supplier model. In practice, the model was abandoned as early as 1995 since structural changes could not be managed within this model, being decided on instead at the political level.

In November 1996, the county council assembly decided to combine, with effect from 1997, two healthcare districts into one, entailing the joint organisation of two hospitals, located in different areas, into one district under the management of one director of healthcare. The intention was to concentrate operations and to gradually achieve increased collaboration between the hospitals. The initiative originated from the directors of healthcare from the respective healthcare districts. In the spring of 1996, they saw major opportunities in a merger which would bring organisational, professional, and administrative gains. No calculation was made as to what the merger would bring in terms of financial effects; on the other hand, there were expectations that it would lead to cost savings. The directors of healthcare emphasized that all structural changes were to be decided by political bodies. In a special structural review, which was independent of the merger, it was assessed that different rationalization measures would be able to reduce costs by SEK 94 M. These measures were deemed capable of being facilitated by a merger.

The change work was to take place quickly. The director of healthcare was hired, at the initiative of the director of the county council, even before the turn of the year 1996/1997 for the position, something which also included being the project manager for the merger. Initially, the assignment was to communicate ideas and guidelines to the organisation in order to create commitment and involvement. The work of merging got going at the beginning of 1997. The cost-cutting for the new hospital amounted to SEK 80 M for 1997 and was to be achieved in parallel with the merger. It was not possible to realize these savings, however. One reason for this was that the hospitals concerned had made major savings prior to the merger.

In the spring of 1997, a political discussion was conducted regarding the merger per se, had it been that successful? A number of Chief Medical Officers also took part. Following dialogue with healthcare management at a special meeting, county council management decided that the decision would stand and that the work of merging would continue under the supervision of the director of healthcare. At the end of the year, the director of healthcare left his post with immediate effect.

The director of healthcare’s story (case 2)

Prior to the decision to merge officially being decided on, the directors of healthcare had called a press conference regarding the expected merger, something which caused a certain amount of irritation to county council management since the decision had not yet been established centrally. Ahead of the merger, the director of healthcare felt that there was a certain amount of fear regarding this among the smaller municipalities of the county. A new healthcare party was formed in connection with the merger, which affected the other parties’ attitudes towards the merger. The director of healthcare for the new hospital was appointed by the director of the county council. It was then important to quickly form a joint management group for the two hospitals, which occurred at the end of 1996. The director of healthcare was not in direct contact with the political leadership regarding day-to-day work, instead reporting to the director of the county council.

The hospital inherited an old deficit of SEK 80 M, which was to be saved. Thus, various moves were made. One of these was to follow up on the previously made decisions, another was to give notice to some staff members, which was rescinded, however, following a political decision.

After some months’ work on the merger, it started to be called into question, firstly by the new party and then by other parties. Unease spread throughout the hospital and within hospital management. Following a request by the director of healthcare, county council management decided to take part in a conference of 60 or so managers from the newly-formed hospital. It had by then already been decided to stop the merger. After discussions with the representatives and after the director of healthcare had put the issue before the board of the county council, the board decided, however, that the merger would continue. And the director of healthcare was thus able to
continue his work. During the autumn, however, the work of merging became increasingly difficult to cope with and the director pointed out that:

“the route was no longer viable and you have to have people behind you. I felt alone and I received poor support from above. My work was characterized more and more by the taking of urgent measures.”

It was not possible to achieve this cost-cutting. Major stresses and strains resulted from the working situation, as did stresses and strains on the family. There was no mentor. A lively discussion about the structural change took place in the press. Following deliberations with the director of the county council, the director of healthcare resigned from his post. Quitting had been in the director of healthcare’s thoughts for some months. He did not hold any concluding talks with his co-workers. He had a farewell dinner with his closest co-workers at the hospital.

The director of the county council's story (case 2)

According to the director of the county council, the county council had been making savings for a long time and had succeeded well; however, during recent years, a limit had been reached. As long as the patients did not suffer, it would be possible to continue cutting costs. It was also difficult to justify retaining the purchaser/supplier system. From the end of 1995, other paths of reasoning started to be taken and it was time to put forward the notion of a merger between two hospitals. There was no major inquiry behind the proposal, these thoughts had simply matured. The merger would entail economies of scale and advantages for the smaller hospital which had been finding it difficult to recruit certain specialists. The larger hospital would supply the smaller one with expertise. Similarly, there was a natural stream of patients from the smaller hospital to the larger one.

Just how much money would be saved from the new hospital structure was not something the director of the county council was able to specify. In total, SEK 80-100 M was to be saved. However, it turned out not to be possible to achieve the savings during 1997 and a large deficit arose. The cost-cutting was then postponed. It was very difficult, said the director of the county council, for the director of healthcare to achieve the structural change and the savings simultaneously, by and large impossible. “A delay is something we’ll have to live with” said the director.

The director of the county council said that the director of healthcare worked in a socially skilful way with the change, but had encountered difficulties achieving the structural part of the assignment. The director of healthcare was supported in his work by the director of the county council. They met about once a month. The director of healthcare, however, wanted more meetings. One major event was the conference, when county council management, jointly with the hospital’s representatives, discussed the suitability of continuing with the work of merging. In reality, there was no great level of support for the merger among the political parties. On the basis of different motives, county council management nevertheless chose to stick by the decision. A number of Chief Medical Officers, however, wanted to return to the old way and worked towards that.

The director of the county council emphasized the importance of “understanding the game in different contexts”, adding “not everyone does”. In connection with the director of healthcare quitting, of his own volition according to the director of the county council, discussions were conducted between him and the director of healthcare. Once the director of healthcare had quit, their contact ceased.
Analysis of management conditions

The analysis starts with how the hospital as an organisation creates certain conditions. After that, there is some discussion regarding the hospital manager’s position, followed by a description of the different logics the actors work under and the conditions these create. After that, there is an analysis of making sense of leadership for hospital managers and games between actors.

The hospital as an organisation

Hospital managers underline the fact that they manage publicly-owned hospitals and not banks or industrial corporations etc. Hospital management thus requires cultural understanding, which cannot be taken from industrial corporations or banks etc. The hospital managers also gained their principal experience of management from hospitals and county councils. At the same time, they emphasize the cultural differences between the hospitals to be restructured. These characteristics do not seem to have been taken into consideration during the change work.

The hospital can be seen as a variant of a professional knowledge organisation which is borne by professional groups, managed administratively by administrative managers, and governed externally by a political organisation (Mintzberg 1983, Östergren & Sahlin-Andersson 1998). Knowledge is applied individually, but can be institutionalised and located on the organisational level in the form of collective frames of reference, standardised methods of working, and practices where the departure point is “science and proven experience”. Proficiency is achieved via the repetition of cases and via research of one’s own that focuses on defined patient groups. As a rule, the standard is set by medical specialist associations which, in doing so, exercise power (Foucault 1980) over professional officials who in turn, via their specialist knowledge and collegiality, acquire influence.

Organisationally, the hospital is often described as a professional bureaucracy, which is decentralised both vertically and horizontally (Mintzberg 1983). The professionals primarily aspire towards controlling the administrative decisions that affect them, such as the distribution of resources. Supporting structural changes is thus less important to the professions, which is witnessed by the actions in the two cases.

The hospital manager’s position

The hospital manager is squeezed between influential groupings and assumes a weak position between the county council and the clinics, with limited possibilities of sanctions vis-à-vis the doctors. Individual doctors defend themselves against financial governance due to a lack of faith in the governance systems (Öhrming 1997). Furthermore, the government, the county councils, and the professional organisations develop regulations that the hospitals must comply with. The hospital manager is thus forced to legitimize his actions vis-à-vis several stakeholders but is not capable alone of meeting all the demands being made (Östergren & Sahlin-Andersson 1998), which is also confirmed by the interviews.

The MD role stands for certain general notions about duties and rights, including responsibility, power, the power of initiative, status, and formality, which can be seen as an expression of a mixture of social and cultural aspects (Alvesson 1992). The implications for action of appointing someone as an MD are thus strong. Additionally, the MD constitutes a description of a symbolic phenomenon (ibid.). The same description cannot be made of the “hospital manager”. As a symbolic phenomenon, this position is responsible, during recent decades, for cut-backs, mergers of hospitals etc. The hospital managers’ proposals regarding structural changes can be perceived as unpopular by the public as they are perceived to be about impaired service and are illegitimate in an operation with soft values. As one task is to meet one’s cost-cutting (Mintzberg 1997), hospital managers are forced to put forward proposals regarding changes. If they succeed, this is taken for granted – if they fail, they seldom receive the support of those around them. In other words, they are alone, which the study confirms.
It is not unusual for hospital managers to be criticized by patients’ associations and staff, but also sometimes by their principals, even if these have tasked them with cutting costs. Hospital managers then feel unable to act with the freedom necessary for the assignment. They often have long working weeks under internal stress as they feel insecure with their own management.

Hospital headship is largely about managing encounters between different action logics. A developed dialogue with the politicians is one of the recipes according to the hospital managers; another one is increasing the representativeness of the hospitals.

In difficult decision-making situations, incompatible demands regarding savings and operational volumes were put by the purchaser on the hospital manager, who lacked the tools to be able to meet the demands. At the same time, it was a requirement that the hospital manager kept the various groupings together at the hospital (Mintzberg, 1997). In reality, the hospital managers were subordinate to the political forces, but sometimes also to the medical discourse, which through the actions of the Chief Medical Officers creates distance to the management discourse (Eriksen 1998). Relations between doctors and management must thus be seen as a critical factor and it is a matter of creating sense for both (Weick 1995, Hallin 2002, Choi 2011).

**Different action logics**

Different action logics at the hospitals are linked to different discourses; the professional, the political, and the administrative (Östergren & Sahlin-Andersson 1998, Nordgren 2003). These regulate the conditions for hospital management (Mintzberg 1997) and are difficult to combine in shared values and can create inadequate understanding and relations between groups (Norbäck & Targama 2009).

The interest of operational managers and politicians in conjunction with changes is thus not primarily focused on supporting the hospital manager. For the operational managers, loyalty seems primarily to be focused on colleagues and patients while the politicians primarily guard their own political interests.

The hospitals are ultimately governed by the politicians and managed by the hospital managers, who are often administratively knowledgeable. Professionals, particularly doctors, are operational managers. Between the actors, there is a division of responsibility that entails politicians being responsible for financing, owning, and formulating guidelines. The operational managers are responsible for care and treatment. The hospital managers are responsible for hospital management and administration, subordinate to one or more political committees and superior to the operational managers. Hospital management is constituted by the individual(s) who, vis-à-vis various stakeholders, is/are primarily responsible for the hospital’s results.

According to Östergren & Sahlin-Andersson (1998), politics has developed in its direction while the profession has become increasingly specialised. The administrative logic, including the language usage, is influencing more and more both politics and the profession. The logics have previously, prior to recent years’ savings efforts requiring otherwise, have been able to live side-by-side, but rather undisturbed from each other. When joint work is required, as with hospital mergers, it is necessary that people understand each other (Mintzberg 1997).

In order to run a hospital, it is necessary for the manager to maintain the organisation’s boundaries so that it is clear what loyalty is all about (Mintzberg 1997). At the merged hospitals, there has been difficulty with this and

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9 The action logics are basically different, which can give rise to paradoxes. A paradox is about power and responsibility. The strengthened management of healthcare is assumed to lead to more efficient healthcare. The operational managers have been given greater influence and more training in leadership. Nevertheless, they ask for a clearer role and power, responsibility, and authority. Even if formal leadership is increasing, real leadership can be reduced. At the university hospital, the paradox showed itself through the structural changes going right to the top of the organisation despite the organisation being said to be decentralised.
thus there has been a fragmentation between different action logics without the possibility of conducting a joint discussion.

**Leadership in conjunction with structural changes**

Leadership is about influencing conceptions and feelings (Alvesson 1992). It is based on good and voluntarily collaboration and, in doing so, differs from the exercising of power or sanctions. Leadership is also about how the leader makes decisions that those under him/her respect and comply with. The communicative aspect of leadership is then crucial as it is about being able to mobilise support (ibid).

The hospital managers emphasize the communicative aspect of leadership. In the case of the county hospital, the director of the county council says that the hospital manager’s leadership is communicative, but unstructured. The hospital manager’s perception is that the director of the county council does not act as a leader, but as a manager. Both managers seem to be talking at cross-purposes. The manager at the university hospital is dissatisfied with the external communication while the hospital manager at the county hospital lacks a functional relationship with politicians and with the director of the county council. The relationship is, if anything, ad hoc-like and they avoid communication, e.g. regarding press conferences.

The interviews are essentially about how the actors manage their communication and relationships and the degree of trust in each other. They are dependent on each other to make things happen. In conjunction with the implementation of structural changes, their communicative ability is put to the test. If the relationships have not been developed, it will be too late to suddenly build them up. Leadership is thus founded on social relations and understanding each other’s values (Weick 1995, Eriksen 1998).

Leadership is especially vulnerable when the organisation is in the merger phase. It is then that the hospital managers feel they lack support. This is accentuated when the restructurings turn out not to lead to immediate, expected savings. The consequence is that the principals are forced to inject financial funds afterwards. The cost-cutting seems to have come about through central management in advance cashing in structural changes without calculations and without a dialogue with the hospital managers.

The actors view the change process in the short-term and have not foreseen the strong reactions that are triggered in connection with this. Will the decision-makers stand by it or revert to the old way? The hospital managers are gradually becoming more and more isolated during the process. They are working more and more with it, but are experiencing criticism from different directions and they feel abandoned.

The managers are extremely vulnerable, feel insecure, and lack the support of their managements, who seem to be unprepared for the consequences that their own decisions bring about. As people, the hospital managers end up in the spotlight as a consequence of the worry triggered by the changes. Their way of managing starts being discussed. They are also made responsible for outcomes that do not follow given patterns. The reason is that there is a tendency to assign managers with far too much significance, despite there being some doubt regarding their impact on events (Alvesson 1992). This has to do with a desire to see people in positions of power as personally responsible for results, which is exactly what happened in the cases investigated.

**Games between actors**

In the cases investigated games are going on, which manifest themselves in the actors using different words and actions (Foucault 1980, Clegg et al. 2007). This can be a matter of power games, as in a political arena, e.g. creating alliances, which can however be precarious (ibid.) and assume different forms.  

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10 They are characterised by a moderate, limited, and relatively stable conflict (Clegg et al. 2007, p. 178).

11 E.g. a triad, which can be seen as a relationship between three parties and be characterized by tensions between proximity and distance (Simmel in Wolff 1964).
The hospital manager is expected to play his game in such a way that it may be recognized; it is to be understood by others and it is important to know it. According to Mintzberg (1997, p. 16) “maneuvering, shrewdness, deal making, playing things close to the chest, and so forth, with all the associated political skills” are required. It is not a matter of an evil game, sooner a sensing of positions (Foucault 1980).

The games are expressed in the following statements from the two cases.

“Special interests are cultivated and defended in all possible ways and it is a tricky game.” said the hospital manager at the university hospital (case 1).

It’s a game and no one wants to get stuck with the losing card, but none of it has occurred through ill will, there were no nasty games” the politician said (case 1)

“No one wants to get stuck with the losing card” the politician said (case 1)

“You have to understand the game” says the director of the county council (case 2).

“understanding the game in different contexts”, adding “not everyone does” said the director of the county council (case 2).

According to these statements, the actors must know and have a good command of the rules of play in order to be able to survive and to be credible (Clegg et al. 2007).

For the hospital manager, it is matter of having the confidence of both the political management and the professionals (Mintzberg 1997). Being successful depends on how well the actors can deal with complex change processes together. The prerequisite is genuine dialogue and the change being managed as a consequence of an idea about improved care. The central managements in the cases investigated seem primarily, however, to have looked at savings.

The hospital manager owns less direct power than leaders in other organisations. Most often, decisions are thus made via the coordination of parallel professional groups. The acting is based on a negotiating game in order to be able to deal with disruptions. “It’s a matter of knowing the game” is a common phrase in both cases. There are no ready-made solutions, i.e. they are the result of the game. No one wants to get stuck with the losing card.

The position of the hospital manager is created by means of trust actively being given by the political board, as the hospital managers’ primary loyalty is focused on that (Mintzberg 1997). According to the hospital manager at the university hospital, “there was a lack of any pronounced official support for the change process and many structural issues were pushed upwards in the organisation”. If the politicians cannot handle the match upwards, a political deadlock will ensue which can lead to paralysis. In this “upstream swim”, created by means of the fixation with the deficit, the hospital managers felt abandoned by their superiors and preferred to quit. The politician on the board of management realized the consequences of the structural change, but did not communicate them to the owner.
Conclusion

Being a sole researcher with a background as a hospital manager has entailed the risk of having preconceptions. My strength has lain in having experience at my disposal that has yielded a deeper understanding of management conditions.

Foucault’s concepts of power and discourse have been useful for reflecting upon the games being played between the actors. Mintzberg’s descriptions of hospital management have generated useful analytical concepts. Habermas’ theory of a continuing dialogue between actors has provided a vision of an envisioned communicative rationality, which appears impossible to achieve in a hospital.

Despite the hospital managers’ desires for dialog regarding the financial prerequisites in connection with the mergers, the owners laid these down unilaterally. The lack of a dialogue meant that the actors did not reach a shared understanding of how the changes should be dealt with. As the cost-cutting was not achievable and the changes were additionally perceived to entail negative consequences for the patients and staff, the hospital managers were turned into scapegoats and an initially weak hospital manager’s position (Öhrming 1997) was, consequently, undermined even more. In both cases, the hospital managers resigned. The analysis also demonstrates the difficulties of implementing radical organisational changes in hospitals (McNulty & Ferlie 2004).

The hospital management conditions include different action logics and an organisational fragmentation. Furthermore, power games are going on between representatives of professions and politics, leading to an unpredictable change process. Hospital managers must have a command of this power play in order to survive.
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