

11. Artikkel 3: Management in hospitals – a career track and a career trap. A comparison of physicians and nurses in Norway²⁷

11.1 Abstract

Purpose – The hospital sector has expanded in Norway with reforms and a strong demand for better management. In this article, we examine: 1) how this has affected physicians and nurses in management, 2) how management roles in hospitals are changing, and 3) how these two professions are tackling their new roles.

Methodology – The article presents a review of the secondary literature and a case study undertaken in the spring, 2012.

Findings – In Norway, two reforms have been introduced aimed at creating stronger management positions with less professional influence. The leader has full responsibility for a particular unit, which means that the jurisdiction of managers has expanded and that management has become more time consuming. Physicians – traditionally those in charge of hospitals – are facing competition from other professions, especially nursing, which has gained representation in top management positions, particularly at middle management level.

Originality/value – The originality of this paper is the comparison of the evolvement of management among physicians and nurses since the reforms. While the medical profession was critical of management to begin with, i.e. viewing management positions as a trap, it is gradually adapting to the new ideas. Physicians are facing competition from nurses, who readily adjust to the new conditions, and perceive management as a new career track.

Key words: Management, hospitals, reforms, physicians, nurses, Norway

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11.2 Introduction

As the hospital sector has expanded, there has been increased emphasis on efficiency and management – a fact that has been reflected in the literature on healthcare in organizational theory. Hospitals have previously been regarded as dual hierarchies (Goss 1963) or professional bureaucracies (Mintzberg 1983) where management has been carried out implicitly with a great deal of autonomy in the hands of the professionals, who seem to be taking a more hybrid managerial role. Some argue that there is increasingly a merger of the two hierarchies of professionals and managers (Noordegraaf 2007). With few exceptions, the focus in the research literature has been on the role of physicians, while there has been much less interest in other professions that may have been involved in the management of hospitals. It seems as if organizational theorists who have studied healthcare may have been blinded to the role of the other health professions in healthcare management.

This oversight may readily be explained by the fact that the medical profession has been predominant in hospitals, while nurses and other health professionals have taken a subordinate role (Turner 1995). What is of interest in this context, however, is why this tendency has been stronger in, for instance, Germany and the United Kingdom than in Norway and Sweden. One reason could be that there are distinct variations between countries, e.g. with regard to the extent that nurses are excluded or included in the discourses and practices of hospital management. In this article we focus on the changing roles of nurses and physicians in Norwegian hospitals. Peculiar to the situation in Norway is not primarily that physicians have had a central role, but rather that nurses, too, have established a relatively strong position in management (Johansen & Gjerberg 2009; Mo 2006; Torjesen, Byrkjeflot, & Kjekshus 2011).

Norway introduced a change in the healthcare system in 2002 with hospitals becoming more like enterprises. In parallel, a new law that was introduced aimed at establishing a stronger and more general and individualistic management role, with a focus on personal managerial accountability and a clearer division of labour between the various levels in the hierarchy.

Since these reforms, nurses and physicians have been able for the first time to compete for the same management positions. Here, we ask how the introduction of general management and an enterprise model may have affected the relationship between physicians and nurses in management. In the first part we review the literature in order to highlight the institutional conditions that have changed, and, to keep things in perspective, we take a look at the previous history of hospital management in Norway. Thereafter, we highlight structural changes in management and supplement with data from a case study giving insights as to how physicians and nurses see their respective roles in management. We also present a brief comparison with other countries in order to provide a larger perspective.

Reforms in the Norwegian hospital system between 1995 and 2010 were inspired by New Public Management (NPM) and formulated as responses to perceived weaknesses in the traditional public administration model, which, according to the reformers, was too rigid and inefficient. The remedy was to develop: better measurements of outputs, incentives for administrators to become managers and a ‘voice’ for the citizen as consumer (Hood 1991). The emphasis was on choice, management, autonomy and transparency, i.e. creating pressures for the introduction of new forms of governmental control (Byrkjeflot 2011).

Although organized as state enterprises, Norwegian hospitals still come under ministerial control with physicians given the task of acting as gatekeepers to the services. The organizational structure is similar to that of private firms with regional and local boards and enterprises, each with their own managerial hierarchy. At national level, Parliament prepares and determines health policy, oversees legislation and allocates funds. The Government sets the budgets for the health regions, but delegates daily responsibility to the regional enterprises, which oversee the activities in local enterprises. The hospital enterprises are decentralized and self-governed. However, since the Ministry of Health and Care Services has overall responsibility, it has a great deal of involvement in the daily running of affairs. The Board of Health monitors compliance with minimum standards and processes complaints from patients. The Directorate for Health and Social Affairs serves central government with the aim of developing higher quality services – guidelines, quality

indicators, research and administration of medical databases (Magnussen, Vrangbæk, & Saltman 2010; Opedal & Stigen 2005).

11.3 Theory

Balancing between managers and professionals and between nurses and physicians varies across national contexts. For instance, it was pointed out as long ago as in the 1960s that physicians in the United States had a more distant relationship to management in hospitals than was the case in many European hospitals (Glaser 1963). The general management function was historically stronger, first in the U.S. and thereafter in the United Kingdom. In this article, general management is viewed as a pure form of management (Byrkjeflot 1997) with unitary responsibility for the unit, i.e. for the budget, for all the staff and for professional development (Kjekshus & Bernstrøm 2010). The willingness of physicians to take on management positions varies across nation-states and over time, depending on how the relationship between the state, hospitals and professions has been institutionalized (Nancarrow & Borthwick 2005). The extent to which nurses are able to acquire management positions depends on their relationship with physicians, the way management is organized and whether there actually are positions available. This depends on legal expansion, reforms or similar changes, and we therefore focus also on development in state regulation and on what has been called the “regulatory pillar” (Scott 2008).

Within the framework of organizational institutionalism, physicians and nurses are carriers of distinct institutional values, norms and practices. Nurses are described as taking a more holistic approach to their work and view treatment more as a collective and multidisciplinary process. They focus on both cure and care, while physicians focus on curing patients based on skill and judgment (Currie, Koteyko, & Nerlich 2009; Degeling, Kennedy, & Hill 2001; Freidson 1994). If physicians and nurses have different professional rationalities, we expect this to affect their conception of management and what they do in management positions.

This way of defining professions, i.e. characterizing them as carriers of institutional logics and rationalities based on their place in the system of professions, is contentious (Evetts 2011). In the past, professionalism has been defined as a way of serving society (Parsons 1964) and of achieving power positions (Freidson 1994; Larson 1977). These models of professionalism may have served clients and professionals well in their time, but professionalism has changed under the influence of New Public Management (Evetts 2009). Professional autonomy has been challenged as a consequence of ideological developments as well as fiscal crises related to rising costs in welfare states. Cutbacks in funding have been combined with pressure to implement managerialist techniques and cultures. Professionalism has had to become more budget focused, commercially aware and entrepreneurial (Kuhlmann 2003). Evetts conceptualizes a “new” form of “organizational” professionalism. This inclines towards a shift from “notions of partnership, collegiality, discretion and trust, to increasing levels of managerialism, bureaucracy, standardization, assessment and performance review” (Evetts, 2009 p. 407). The changes in professionalism are categorized as professionalization “from within” and “from above”. Professionalism from within is made by the profession itself and might have substantial returns for the group. Professionalism from above relates to organizational objectives that regulate the practitioners by organizational managers and supervisors. The professional exercise of discretion in the practitioner–client interaction is reduced and replaced with organizational objectives. The focus changes from the client to the organization.

Governmental regulation can be used to change the health sector (Kuhlmann 2003), thus affecting both physicians and nurses. As a result of increased fragmentation within the medical profession, the borderlines with other professions are becoming less rigid and providing new opportunities in, for example, management. The introduction of professionally “neutral” positions such as unitary management, case management and disease management opens new opportunities for nurses and other health professionals. Cooperation is emphasized as a central value and this means that there is less emphasis on autonomy of the individual physician, while the medical profession as such may still be associated with the values relating to professional autonomy (Kuhlmann 2003).

The healthcare services are undergoing continuous change as a consequence of technological and professional development, but also increasingly through challenges from marketization and managerialism (Nancarrow & Borthwick 2005). Market-inspired reforms and other NPM-inspired reforms may alter the balance between professions in management (Torjesen 2008). The emphasis on management contradicts the established rationalities or institutional logics (Friedland & Alford 1991; Thornton & Ocasio 2008) of the professions, which might respond by refusing to adjust to the managerial mode of control. The boundaries between the healthcare professions have never been static (Abbott 1988; Nancarrow & Borthwick 2005) and reforms can lead to further jurisdictional conflicts between professional groups (Abbott 1988), e.g. regarding who is entitled to be in charge of hospitals. The most powerful and prestigious status groups may use this power to exclude others (Nancarrow & Borthwick 2005). The development of management may be seen as linked up with several professional projects where each profession seek to gain influence through their influence in and over management positions (Larson 1977; Sommervold 1997). Physicians and nurses have had different projects. Nurses have fought for the right to manage the nursing area, and thereafter were given equal status with physicians in recruitment and access to general management positions (Jespersen 2005; Sommervold 1997). Physicians fought to preserve their right to manage treatment, but also the right to inspect and instruct other professions. The professions that are losing ground as a consequence of the new management structures and frames might respond by social closure (Abbott 1988) attempting to retain monopoly and control over their field of knowledge and their position in society. Professions can also act as institutional entrepreneurs by promoting new ideas or reframing old ones (Jespersen, Nielsen, & Sognstrup 2002), while another solution is to combine some of the ideas associated with general management with professional logic and become so-called hybrid managers (Jacobs 2005; Kurunmäki 2004; Llewellyn 2001).

It seems easier to change management structures than it is to change professional cultures (Ackroyd, Kirkpatrick, & Walker 2007). In this paper we ask how hospital management has changed in Norway and how this relates to changes in the relationship between physicians and nurses. Physicians and nurses are to different degrees willing to take on management

positions, and there are variations regarding the extent to which they have the opportunity to do so. The development is first examined from a historical point of view and secondly with a focus on structure – particularly how managerial roles have changed; thirdly, how management roles are affected by changes in professional relationships.

Against this background, we ask three research questions:

- 1) How have reforms affected physicians and nurses in management?
- 2) How are management roles at different levels in hospitals changing?
- 3) How do physicians and nurses engage in these new roles?

11.4 Methodology

The principal method is a review of studies of reforms and changes in management structures in the Norwegian hospital sector, the starting point the literature we knew from the field in Norway, which was expanded through a snowball method (Kirkpatrick m.fl. 2009; Ryen 2006), i.e. a search through references in this literature. In order to understand how the balance between medical physicians, nurses and other managers plays out, we also searched in international data bases using the key words ‘nurse’, ‘physician’, ‘hospital’, ‘management’, but with modest results. A more historical and comparative approach was also taken (Kirkpatrick m.fl. 2009) identifying studies describing the historical development in Norway and other countries in order to be able to make comparisons. The methodology employed in this secondary literature was of various kinds: text analysis, interviews with hospital managers and employees, and survey data giving a comprehensive picture of development trends in the sector. A number of the Norwegian studies included both physicians and nurses, as these groups compete for the same management positions. The predominant theoretical approach has been institutional theory and theory of professions.

The literature review is our main source for finding answers to the research questions. However, since several of the studies were performed soon after the reforms, we checked whether there were changes in attitudes and engagement in roles. One of us did a case study

in the spring of 2012, the findings from which are a useful supplement to previous research. It was carried out as semi-structured in-depth interviews with 16 managers in a medium-sized general hospital in Norway with 5,000 employees and around 2,000 nurses and 600 physicians. The participants were managers with medical and nursing background from levels below the CEO of the hospital. In the following we try to answer the three research questions.

1. The development in management of hospitals

To get an understanding of how reforms have affected the two professions in management of hospitals in Norway, we start with a historical background. Physicians were the “natural leaders” until the end of the 1960s (Berg 1996; Torjesen 2008). The medical profession had a prominent role to play in development of the health policy in this period, and the medical profession dominated in policymaking and in the Health Directorate and Ministry of Social Affairs, but this influence gradually diminished in the 1970s and 1980s (Byrkjeflot 2011). The predominant position of physicians was challenged during the 1970s when other groups, for example nurses, achieved the right to be represented in the governance of hospitals. The new hospital law in 1969 transferred ownership of the hospitals from municipalities, private for profit and non-profit organisations to the counties, and with this came increasing demands for expenditure control and steering from external authorities. This meant that physicians gradually had to give up some of their autonomy. Technological development and more complex treatment procedures made the work of physicians more demanding, at the same time as administrative tasks expanded and hospital management became more professional. Physicians now had to compete with lawyers, officers, economists and other social science professions if they were to get into central positions in management (Berg 1996).

Ever since the beginning of the 1900s the Norwegian Nurse Association has worked to improve conditions for nurses, to increase salaries, establish equal status with physicians and be counted as a profession (Melby 1990). In 1925 the association established a higher level education for administration. Nurses gradually took on more administrative tasks, but

physicians continued to be in charge. During the 1970s, with the cultural and political radicalization that took place, nurses gained more legitimacy for their demands through the women's liberation movement. At the lower level, physicians had to relinquish some administrative tasks to nurses. Dual management was established in 1970. In this model, the physician was in charge of the treatment of patients and had medical responsibility, while the nurse manager was in charge of nursing functions and carried out most of the administrative tasks in the unit. The physician still had the final say in matters regarding management of the unit. In 1984 nursing science was established at universities – nurses gaining professional status and physicians losing certain rights to instruct nurses.

In 1996, 90% of hospitals operated with this dual management structure, but there was also a third pillar of administrators and hospital directors dealing with budgets, administration and managing the relationship up to the political level (Berg 1996). Most physicians and nurses were happy with this (Johansen & Gjerberg 2006), but the model was considered to be problematic by some politicians and experts. The Ministry of Health and Care Services therefore established a committee to find a management model that would meet the increasing demands of their complex and expensive hospitals (NOU 1997:2). The unitary management reform, which was introduced in 2001, did not favour professions for management positions. In this “professionally neutral” model, other professions could compete with physicians in managing at all levels. At levels close to the patient, it was recommended that the manager held qualifications within a relevant health profession, leadership training and education (NOU 1997:2). If the manager was not a physician, there had to be a physician appointed who was medically responsible for the unit, and who reported to the manager (HOD 1999).

The Norwegian Medical Association supported the reform, still pushing the idea that physicians were the natural leaders in hospitals and arguing that management positions ought to be earmarked for physicians. They were caught by surprise when other professionals began to apply. The Norwegian Nurse Association also supported the management reform – their emphasis on leadership qualifications consistent with the recommended model. The

introduction of unitary management resulted in severe conflict in some hospitals. Physicians refusing to subordinate to nurses and threatening to leave their positions (Johansen 2005) was prominently reported in the national press, culminating in 2002 when the public dispute began to burn out. However, 50% of departments in Norwegian hospitals reported still experiencing conflict on this issue three years after unitary management was introduced (Gjerberg & Sørensen 2006; Spehar & Kjekshus 2012).

As this description shows, the medical profession in Norway has undergone a period of reduction of authority and influence at central policy-making level and at hospital level in recent decades, partly as a result of changes in institutional conditions after the influence of NPM reforms, and partly as a result of changing boundaries between professions and jurisdictional struggles about management. The strong interest taken by nurses in management positions can on the one hand be viewed as part of their struggle establishing first a position in the jurisdiction of these tasks and second a more independent position from the medical profession (Larson 1977; Sommervold 1997). By putting management on the agenda in the way the government has done with these reforms, the monopoly position the medical profession had in management came under challenge at the same time as its strong position in the field of healthcare management was becoming transparent. This is reflected in the legal requirement that there has to be a responsible medical physician in place and in charge in units with other professions.

After 60 years of struggle, the nurses finally achieved support for their demands, encouraged by the democratic trend in the 1970s and supported by state regulation. The holistic approach to management and the institutional logic of care were more in line with the managerial focus that characterized the NPM reforms than the alternative medical logic. Many nurses have moved into management positions and become leaders of physicians. Physicians have protested and several attempts have been made to exclude nurses from management (Gjerberg & Sørensen 2006; Johansen 2005; Spehar & Kjekshus 2012).

In 2002, a hospital reform (HD 2001) was introduced that changed the management roles of hospitals in ways that will be further outlined in the next paragraph.

2. Changes in management roles at different levels of the hospitals

As a consequence of the hospital reform, the ownership of hospitals was transferred from the counties to the state, thus strengthening the role of the central state in governance of the sector. The hierarchy increased as the country was divided into five health regions (thereafter four) and 80 local hospitals were merged within about 20 health enterprises (Kjekshus & Bernstrøm 2010). Organized with departments and a head physician reporting directly to the CEO, a new level was introduced known as *clinics*. Unitary leaders at all levels in the new hierarchy replaced the dual leadership within departments and the three separate hierarchies (medical, nursing and administrative). The clinics are divided according to medical specialities, e.g. surgical, medical and psychiatric clinics, with a director in charge. Beginning at the top, there is a hospital board above the CEO and then a group of directors from the patient-related clinics together with directors from the support services as the administrative staff, technical and financial units. This group constitutes the management group of the CEO. Clinics contain departments with different specialities and these are again divided into sections. This gives four levels of managers from the level closest to the patient to the CEO (Kjekshus & Bernstrøm 2010).

Ninety-four percent of the hospitals were organized with this clinic structure in 2009 and 91% have introduced unitary management. At the top levels of hospitals, 41% of managers have a medical background, 22% are nurses, 11% have a social science background, 11% are economists, 4% are from the natural sciences and 10% others. Sixty percent of those leaders are responsible for clinical work – numbers that have been stable since 2003. At the department level, 39% of middle managers are physicians and 48% have a nursing background (Kjekshus & Bernstrøm 2010).

As the ownership of hospitals became centralized, the public administration body changed to a health enterprise model (P. Læg Reid, S. H. Opedal, & I. Stigen 2005). The intended goals of the reform were to enhance performance, quality, efficiency, equity and economy. Stronger central government control and responsibility were the main tools, together with clearly defined responsibilities for the enterprises and increased operational flexibility, and this affected management at all levels in the hospital sector. The emphasis was on leaders running things financially efficiently and controlling the budget. Managers were made responsible with the budgets delegated from central government to regional health enterprises, to local health enterprises and the different hierarchical units (Torjesen 2008).

By viewing this descriptive section in the light of our theories, the influence of the market dimension and NPM is obvious together with signs of managerialism (Nancarrow & Borthwick 2005). The new clinical structures illustrate the development away from the traditional ways of organizing and managing in hospitals rooted in the professions. Professional titles, management roles and the disciplinary content in management (Degeling, Kennedy, & Hill 2001; Freidson 1994) were all replaced by a general management logic. A few hospitals have retained old titles, indicating the persistence of the old dual model (Kjekshus & Bernstrøm 2010). From a focus on treatment and cure of patients (Degeling m.fl. 2003), medical managers now have an expanded focus that includes more matters of equity, efficiency and economy, together with responsibility for all professions in the unit. This indicates a development towards organizational professionalism (Evetts 2009). Quality is still in focus, but along with a focus on enhancing performance (P. Læg Reid, S. Opedal, & I. M. Stigen 2005). Signs of managerialism, with a strong belief in hierarchical government as a way of reforming the hospitals, are reflected in the new ownership model – including stronger central government – at the same time as responsibility is delegated within the hierarchy. A broader range of non-medical professions is involved in management, and in some cases given precedence over managers with a health background (Hood 1991; Torjesen, Byrkjeflot, & Kjekshus 2011).

3. Engagement in the new manager roles from physicians and nurses

In order to answer question 3, we examine how nurses and physicians engage in the new management roles, and here we complement with findings from our case study. After the introduction of the new management system, managers took on full responsibility for all employees in the unit (physicians, nurses, secretaries, etc.), which was a new situation for both physicians and nurses. As a consequence, the focus has expanded and managerial work has become more time consuming (Mo, 2008).

Our case study indicates that physicians are involved in national and international projects with a professional and managerial focus on quality and development in their field. Furthermore, they follow up, motivate and serve the different categories of employees in their unit. Planning, control and following up the economy is part of their job. Physicians also mention administration, even though most of them report that they have delegated this part of the job. Managers with a nursing background report that they do the same tasks as medical managers, but with more emphasis on the economy, and they are more involved in work related to a new reform, the Coordination Reform (HOD 2009).

There are differences between nurses and physicians in regard to time spent on management. Most physician managers at department level divide their time between middle management and clinical work. Only 2% of physicians work full-time as managers (Kjekshus & Bernstrøm 2010), while over 50% use less than 50% of their time on management (larger departments – more time on management). Of nurses as middle managers, 76% work full-time as managers and only 5% use less than 49% of their time on management. The involvement in management is also mirrored in management education. Fifty percent of physician leaders report having management education, while 80% of nurse leaders have it (Johansen & Gjerberg 2009).

Findings from our study about time spent on management are in accordance with findings at department level. Physicians in management positions in hospitals divide their time between

managing and treating patients. All the nurses work full-time as managers. Management education level is low among the physicians in our selection – only internal courses in the hospital – while there are only two nurses with similar low education level. The rest of the nurses have from one to four years management education at university level.

Clinical work seems to be more important for physicians than for nurses and other professions in management (Johansen & Gjerberg 2009; Mo 2008), and can be due to the length of education – and thereby socialization into specific values – and investment in time learning specific skills (Fjeldbraaten & Torjesen 2006). Nurses have a three-year basic education, while physicians usually specialize in a clinical field, some even gaining a PhD before entering a management position (Johansen & Gjerberg 2009). Working clinically is a way for physicians to maintain legitimacy among their colleagues (Mo 2008), but it could also be that the identity of physicians is linked to clinical work to a greater extent than for nurses.

However, our findings balance this image. Clinical work is still valuable for physicians, for legitimacy, but also for maintaining their knowledge. Hence, their identities may change and vary across specialties: managers of large departments and higher in the hierarchy have an identity as manager and as physician managers, while others are first and foremost physicians, with the manager identity in second place. Half of the nurses in management have an identity as managers, while the other half emphasize a nursing background. It seems that the hospital has institutionalized a different way of organizing the work of managers with a nursing background than of physicians. For nurses in management positions it is not an option to work clinically. Most do not question this, but some of the leaders are envious that physicians have this option.

At a professional and occupational level, the medical view of management is different from the nursing view, and this might influence the extent to which individual leaders engage in management. While nurses traditionally have considered management a stepping stone, physicians consider it more a career trap (Berg 1996; Sommervold 1997; Torjesen 2008).

Nurses were getting better salaries by becoming managers, and it meant a climb up the social ladder, whereas clinical specialization was more attractive and valued by physicians. Being a leader was an intermediary state for physicians, and those remaining in management were considered trapped according to what was giving status among professional colleagues (Johansen & Gjerberg 2006). This was the established view in Norwegian research a few years after the reforms. However, recent findings indicate that medical physicians are becoming more established in management and that nurses may be losing ground (Fjeldbraaten 2010). Since 2005, the share of nurses in middle manager positions has dropped from 55% to 48%, and during the same period the share of physicians has decreased from 40% to 39% (Kjekshus & Bernstrøm 2010).

The case study confirms that there is development towards a medical “come-back” in management. Most of the physicians in our material wanted to continue as managers, and did not consider management as an intermediary position. They reported that there was a better understanding among colleagues about the need for their profession to participate in management, and that management was to a certain extent regarded as status giving. A manager who turned down a job offer higher in the hierarchy for practical reasons referred to the director job as a job with higher status:

I rejected an offer as clinic director even though it would have looked good on my CV.

Among nurses there are only a few applicants for management positions. Better payment does not seem to be an incentive towards getting nurses into management. Nurses tend to start their management career at the lowest levels in the hierarchy, where they are at risk of low pay, compared to nurses in the shift system. Once in middle management positions, however, nurses have more to gain from moving into management than physicians have.

Both the secondary literature that we have reviewed and our case study indicate that physicians as managers have expanded their focus from an individual conception, i.e. a characteristic of the medical profession (Degeling, Kennedy, & Hill 2001; Freidson 1994), to a more general management approach, but few have developed an identity as “general

manager”. This means that the focus among physicians has changed from so-called professional professionalism to organizational professionalism (Evetts 2009), but to a lesser extent than among nurses. Physicians work more clinically than nurses, they have not been as active in management education and their identity is still more associated with their profession. Owing to their high status in the system, physicians are able to manoeuvre openly in a way that serves their own goals (Torjesen 2008). They can be viewed as entrepreneurs who create a new type of management role, at the same time as parts of the old professional logic are re-institutionalized. In order to stay in management positions they have been forced to broaden their skill base and legitimacy. The focus in management has expanded and does not fit entirely into the category of the medical management project (Jespersen 2005) – with a strong emphasis on treatment – nor into general management. This could imply that segments of physicians are practising a hybrid form of management (Byrkjeflot & Jespersen 2013).

For nurses, the focus in general management is in accordance with what Torjesen (2008) refers to as an holistic approach. In the old dual management model, nurses had the daily responsibility of administration and economy, while the physician manager focused on management of treatment. The distinction between the dual management model and the unitary management model was less prominent for nurses than for physicians and this can imply that there is a better understanding of organizational professionalism among nurse managers. From this point of view we are more likely to find nurses as general managers. Working clinically is not an option for nurses in management in “our” hospital, but the different framework conditions are barely questioned among nurses, even if some of them want to work clinically. This could be an indication that nurses show more loyalty to the organization than physicians do (Fjeldbraaten & Torjesen 2006), but it could also indicate that nurses in management do not have the same power to influence priorities that physicians have. The so-called management project of the nursing profession (Jespersen 2005; Sommervold 1997), where nurses seek more influence through management, is not so easy to locate at the individual level. The fact that there are few applicants for management positions and declining numbers of middle managers with a nursing background might be explained by

the increasingly powerful notion among medical managers that they have to combine medical knowledge with management knowledge. The relatively low salaries can also play a role here. Even though there are still more nurses than physicians as managers at this level, at the top level the numbers of nurses and physicians have been stable in recent years (Kjekshus & Bernstrøm 2010).

In the title of this article we highlight the contrast between management viewed as a trap and viewed as a track. The view that management is a trap for physicians might be less influential now, because a new stratum of doctors has established itself in the new managerial positions, among them prominent manager-doctors such as Steinar Kvinsland, the top manager of one of the larger health enterprises, who may serve as a role model for other doctors. Physicians in our study also report that they enjoy being managers, but there are still few who want these positions. One physician explained why he has chosen management:

I cannot resist getting involved. I have always been like this, in the military, as a student ... it is fun to lead others. I like to have influence. That is perhaps the most important thing. You have to be interested in management. But there are not many who want this job!

Even though physicians report that not many want managerial jobs, they also report that there is a better acceptance for physicians in management now than there was a few years after the reforms. This might indicate a better understanding of the logics in general management, and also an acceptance of organizational professionalism (Evetts 2009). This shift has emerged since introduction of the reforms, and can be viewed as professionalization “from above”. Our case study indicates that there has been a professionalization “from within” with a greater acceptance of the ideas from general management among physicians. It can also be viewed as a way of preserving the authority of the profession, of re-establishing the old power balance (Jespersen, Nielsen, & Sognstrup 2002; Spehar & Kjekshus 2012) and as part of a professional project (Larson 1977); physicians are needed in management positions to protect their interests. This might also be an explanation for the reduced number of nurses in management. Management can be viewed as a stepping stone and a new career path, and the

new way of organizing management has opened up a new career track for nurses from first level to top levels of management in hospitals. Excluding strategies from physicians can, on the other hand, influence positions available. One physician reports:

When the old physician finished as a manager of the department, the senior physicians arranged a meeting where it was agreed that I should take the position so that we could prevent someone from another profession becoming our leader.

Condescending behaviour and visible signs of disregard for the skills and competences of nurses may also have scared nurses from applying for positions. A nurse manager who lost a dispute regarding a practical problem, gives her interpretation of why she lost the case:

I had a problem recently, it was completely stupid that I lost ... which was obvious for others also. But the physician who won was a friend and previous colleague of our boss, and they are going to be colleagues again ... then it was much easier for our boss to agree with him than with me!

In this regard, management can actually become a trap for nurses where their professional arguments are regarded less valuable than the loyalty amongst physicians, and they can feel that they are stuck in a position with limited influence,

We did not find many studies comparing the contributions of nurses and physicians in management outside of the Nordic region. This may be an indication of a taken for granted assumption that the central divide is the relationship between general management and medical management. However, it may differ who are regarded as the main challenger for physicians in management. In Norway, the challenge has not come from general management, but rather from the rise of nurses in management positions. In the UK the accounting profession has had significant impact, with physicians traditionally taking little interest in management (Jacobs 2005; Kirkpatrick m.fl. 2009; Miller, Kurunmäki, & O'Leary 2008). Different reforms have been introduced to enhance the role of physicians in management. In the UK, the physicians are still in a position that makes it difficult for nurses

to gain influence, but new types of management positions have been introduced for nurses, such as “modern matrons” who work with hospital infections (Currie, Koteyko, & Nerlich 2009). Still, these positions do not have influence on the work of physicians. In Germany, physicians have been a central profession in management, as in Norway, and nurses are represented as managers in the parallel nursing pillar. New types of management position also emerge here, such as case management and disease management. These positions are profession neutral and have an impact on the work of physicians (Kuhlmann 2003). At higher levels in the hierarchy, it is reported that physicians are facing competition from economists, lawyers and graduates with degrees in public management (Bär 2010). Against this background, it would be of interest to further map the position of nurses compared with the position of physicians in these countries.

Reform history and the degree to which reforms are implemented also matters. This is illustrated by the results from studies of reforms and changes in management positions in the Nordic countries. Professional neutral unitary management positions have also been introduced in Denmark, Sweden and Finland, but it is only Sweden that has experienced a reduction of physicians in management similar to Norway. The reason may be that Sweden, like Norway, has introduced a law which makes such an opening of management positions mandatory (Jespersen & Wrede 2009). Physicians still dominate in hospital management in Sweden (70% of managers in 2005), but in primary care the proportion is only 42%. In contrast to the case in Norway and Sweden, the implementation of management reforms is decentralized and voluntary in Denmark and Finland, and the medical associations have strengthened their position. In Denmark, the physicians are in the highest positions of healthcare, and at clinic level the Head Nurse shares management with the Head Physician, who usually has the final say. Finland has introduced multi-professional leadership, particularly higher up in the system, and nurses and workers with a master’s degree in health sciences can apply for these positions, in addition to physicians. Mandatory and top-down implemented reforms seem to open up a possibility for nurses to compete with physicians in management, while decentralized implementation gives the physicians an opportunity to reinforce their strong position.

11.5 Conclusion

In this article, we have examined how reforms introducing general management and an enterprise model have affected physicians and nurses in management in Norwegian hospitals. Structural changes have been highlighted along with insights into how the professions relate to the new management roles. By wrapping up our research questions, question 1 revealed that the dominance of the medical profession in central policymaking and in management in Norwegian hospitals has declined in recent decades, while nurses now have a stronger position in management. From having a hospital sector dominated by physicians with a medical professional focus at all levels, hospitals in Norway now have a greater variety of professions in management roles (Torjesen, Byrkjeflot, & Kjekshus 2011). Their influence has gradually declined from unitary medical management up until the 1960s and dual management from the 1970s when management responsibilities were shared with nurses. The most recent shift came with the reintroduction of unitary management in 2001, but this time as a profession-neutral position. Now physicians in management are facing competition from other health professions, especially nurses. Nurses are represented in top management, but are even more predominant at middle management level. The medical profession still takes a central position at the higher levels of the hierarchy.

Hospital reform (HD 2001) also had a particular influence on management, which is highlighted in question 2. Organized as state enterprises, hospitals became part of the state hierarchy reorganized with a clinic structure based on specialties rather than in accordance with professional hierarchies as earlier. Unitary management positions were introduced at all levels in the hospitals inspired by the general management model. The variety of management roles is particularly visual in top management, where a range of non-medical professions is given precedence over professional experts with a background in health.

Question 3 evaluates how physicians and nurses engage in management, which has become more demanding and time consuming, and the focus in management is expanded for both professions. Physicians in management have expanded their managerial domain, e.g. by

incorporating personnel and budget responsibility, and are spending more time on management. They interpret general management in a way that indicate hybridization of management. Among physicians, professional work is still more valued than management, but the view of management as a trap or a temporary position seems less predominant. Some physicians now take a stronger interest in management and see it as a career track. For nurses, the expanded focus in management seems to be in accordance with their traditional view of management, and the unitary management positions are viewed as a new career track. Since many of the studies in our review were performed shortly after introduction of the reforms, we have supplemented with findings from a more recent study. This study suggests that there has been a development among physician-managers towards organizational professionalism. It seems like the medical profession is now showing a greater understanding for the argument that there is a need for an expanded focus in management. Management is not considered an intermediary or temporary position to the same extent as earlier. From nurses, we found that all were working full-time as managers, and that they did not have the option of choosing in the same way as physicians. In contrast to previous studies, half of the nurses in our study emphasized their nursing background rather than their identity as managers, and this balances the image of nurses as keen to adopt an identity as general managers.

A glance at recent trends and literature from other countries shows that physicians in management are facing competition from different professions. In this comparison, Norway stands out with a particularly strong position of nurses, but there are openings in the legislation for nurses advancing into management in Sweden, Denmark and Finland as well. Findings in this article contradict the predominant view in organizational and profession theory, where it is maintained that it would be difficult to challenge the position of medical managers in the hospital hierarchy. The legislation with mandatory professional neutral unitary management which is introduced in Norway and Sweden seems to have strengthened the position of nurses in management. With the introduction of top-down reforms, it has been possible to change the professional balance in management in the sector, as the Norwegian

and Swedish cases show. On the other hand, physicians have strengthened their positions in Denmark and Finland, where implementation was decentralized and voluntary.

11.6 References

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