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An empirically-based model for clinician-managers' behavioural routines

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Abstract *Numerous past articles, many of which consist of idealised prescriptions for success or the occasional case study or practitioner's contribution, have commented on the role of hospital clinician-managers. Prior work is circumscribed, however, in that it tends to be normative and a priori (how clinician-managers in principle should manage) rather than descriptive and a posteriori (how clinician-managers* in situ *do manage). In addition, it is apparent that an empirically-grounded, testable model is lacking for the way clinician-managers work. This paper sets out to balance past normative-prescriptive accounts with a descriptive-analytic one, and presents an empirically-based conceptual model of the behavioural routines of hospital clinician-managers. The model, based on multiple studies of clinician-managers' activities, conjectures five major modes of operating and four primary and five secondary pursuits. The paper advances accounts of how clinician-management work is conducted and the time frames for it, and hypothesises about clinician-managers' relationships, and how power and control is experienced and exercised. It also briefly discusses some of the implications of both the research program and the findings. However, following Popper, researchers ought to invite attempts to improve rigor through a systematic critique of their findings. Critical analysis of this work under falsification processes is consequently welcomed.*

Introduction

The status of clinician-management research

Although the amount written on management is voluminous, a great deal of its corpus is anecdotal and opinion-based. In a sea of relative ignorance there are scattered empirical islands, and assorted accounts of what the data mean (e.g. Forester, 1992; Kunda and Van Maanen, 1999; Brooks, 1997; Hamlin, 2002). Literature on clinician-managers seems to be no exception to this general proposition (e.g. Plsek and Wilson, 2001; Thorne, 2001; Marnoch, 1996; Degeling *et al.*, 2003). In an evidence-oriented world some would judge this as less than satisfactory.

It seems clear that researchers of the clinician-management domain cannot hope to put together the systematic evidence-base that, for example, biomedical researchers are seeking to assemble (Trinder and Reynolds, 2000; Gray, 1997). This is mainly because the scientific gold standard, namely randomised trials or experimental studies (Ronsmans *et al.*, 1997; Duley, 1998) are not possible or particularly relevant in the management and organisational behaviour fields where more interpretive, social science approaches hold sway (Morgan, 1997; Gioia *et al.*, 1989). Nevertheless we should expect progress in terms of expanding the research profile for

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clinical-management behavioural routines. This progress has been slow and uneven (e.g. Simpson and Smith, 1997), and single study work based on a sole method such as the administration of a questionnaire rather than multi-method design based on a range of data-gathering approaches is frequently seen in the journals. Yet complexity of the social objects of enquiry to be considered, and density of clinician-management roles, activities and settings, all call for a pluralist research agenda.

Prescription versus description

Further, the majority of literature addressing both general and clinical management activity exhibits a discursive tenor that is normative, and sometimes hortatory. It asserts what ought to be the case (clinician-managers should master A methods, work in B ways, operationalise C approaches, acquire D competencies or develop E skills). More generally, management has been traditionally defined aspirationally, with reference to how managers might ideally: get things done by or through others (Lawrence, 1986), manage people and resources (Sisk, 1977), perform identified tasks and functions (Koontz and O'Donnell, 1968) and formulate and meet goals and objectives (Stoner, 1978). The normative quest is persistent. More recently managers are being urged to commit resources and energies to more evidence-based (Axelsson, 1998; Kovner *et al.*, 1999) or at least evaluation-based (Øvretveit, 1998) approaches to decision making, but paradoxically there is little evidence provided that this will lead to any improvements. A great deal of scholarly and pseudo-scholarly ink has been spent over the years on managerial oughts, shoulds and how-tos[1].

This kind of approach fails to problematise beyond much superficiality the behavioural routines of clinician-managers, and instead prescribes ways of working successfully (Atun, 2003; Thomas, 2003). Contrast this with ways of apprehending and interpreting clinical management activity in terms of discourse and social action, as it is talked about and done, such as in the work of Mintzberg (2002), Thorne (2002), Brooks (1996) and Parker and Dent (1996). More empirically grounded behavioural and linguistic descriptions of the *in situ* world inhabited by clinician-managers are sought as a counterpoint to the idealised world postulated by hortatory writers. The task is to clarify empirically and interpret and analyse conceptually how clinician-managers behave, talk and practise in their organisational habitats in real time.

Aims of the present paper

This article aims to make a contribution to redressing this imbalance. In this respect, the paper follows in the tradition of the managerial empiricists such as Mintzberg (1971), Stewart (1967), Kotter (1982a), Luthans *et al.* (1985) and Jackall (1988) in a line of reasoning which asks questions of the kind: how do managers behave and talk on the ground? What are the distinguishing features of their behaviour and practices? What do they do, how do they do it, and how do they explain it, when they are talking and doing management?

This endeavour is important in health for several reasons. First, health sectors are large and complex, consuming on average between 6 and 14 per cent of gross domestic product in developed countries (OECD, 1994), and many observers believe that these resources could be managed better. Second, as reformers have sought solutions, one popular strategy in the last two decades has been to establish clinical-management positions (Dawson *et al.*, 1995; Harrison and Miller, 1999) in order to fuse

responsibilities for clinical and financial-organisational management activities (Disken *et al.*, 1990; Tap and Schut, 1987). In prior eras there was a tendency to separate management work from clinical work within a dual hierarchy (Pool, 1991). This transition has been under-examined. Third, the broad task facing clinician-managers – that of managing relatively autonomous fellow professionals – is being played out in similar fashion elsewhere, such as in settings in which the management of lawyers (LOMAR, 2000), academics (Gioia and Thomas, 1996) and consultants (Covaleski *et al.*, 1998), to choose three prominent examples, takes place. Management in each of these domains has likewise been sparsely investigated. Fourth, Stewart (1989) has suggested that more focused empirical research on managers is desirable, perhaps centred on particular types of managers instead of "general" managers. In some respects this paper is a response to that call. It utilises findings from a range of research studies carried out by the author to develop an empirical model of clinician-managers' behavioural routines.

The development of a model for clinician-managers' activities

Research foundation of the model

The research program from which the model was developed follows the methodological principle of triangulation. Arguments for pluralist research designs and interpretations of them include that the integration of perspectives or multiple data sources can produce rich accounts (Campbell and Fiske, 1959; Denzin, 1989; Jick, 1983). Privileged, harmonising and complementary levels of credibility and validity could be said to be facilitated this way. However, cross-paradigm approaches or multi-method research programs are not without their critics. Some hold that there can be no integration of perspectives or methods: distinct paradigms, and even data from differing sources, are incommensurable (Burrell and Morgan, 1979). Resolving this issue would go beyond the remit of this paper, and involve mobilising and weighing ontological, epistemological, and meta- and micro-theoretical arguments of considerable complexity. Instead, to cut through an otherwise potentially disabling impasse, we can create intellectual space to allow Schultz and Hatch's (1996) argument to the effect it is possible to proceed with a discussion of multi-paradigms by promoting interplay between the paradigms. In the logic of interplay:

> ... the researcher moves back and forth between paradigms so that multiple views are held in tension ... this interplay allows for cross-fertilisation [across paradigms] without demanding integration.

This circumvents the incommensurability problem, at least for now. In what follows, the paper criss-crosses over positivist and interpretivist approaches. It traverses data drawn from three methodological sources: participant ethnography, focus groups, and non-participant observational work. Data were analysed using content analytic tools and triangulation techniques including expert panelist interpretations of them. In another tradition, this might be labelled "bricolage" (Levi-Strauss, 1962).

Research studies: methods and findings

The major contribution to the empirical model developed is the results of three Australian studies sequestered from a program of quantitative and qualitative work conducted over the past decade to investigate the major interests and concerns of

hospital clinician-managers (Braithwaite *et al.*, 2004). The first consisted of extensive participant-observational work examining teaching hospital clinical directors ethnographically in one teaching hospital over a five-year period, between 1989 and 1994. This ethnographic immersion took place during a time when clinical directorates were forming, and hence the behaviour of newly appointed clinician-managers was surveyed longitudinally, from the point at which their positions were first being conceptualised, through to their initial recruitment to their posts and then as they increasingly gained experience (Hickie, 1994; Braithwaite, 1995).

The second study involved the content analysis of the discourse of 64 clinician-managers in four focus groups held in 1996 and 1997. The focus groups were confidential, participants were asked to be open and truthful and to explore issues. Transcripts were de-identified. The 10,830 words spoken by participants were content analysed two ways: by using the software tool Textpack version 5.0 to interrogate the words, phrases and sentences spoken, and by asking an expert panel to interpret the transcripts. This work created various categories of interests and concerns of participants (Braithwaite *et al.*, 2004). Clinician-managers were embedded in webs of complex relationships. There were 222 mentions of roles and positions in the focus group text, for instance (see Table I).

The third study mapped these categories to field notes created through non-participant observational work following four experienced clinician-managers in two discrete case-study hospitals (labelled cases A and B) over six months in 1997 and 1998. The field notes related directly to the 14 categories, with only socially-oriented, non-managerial material – the informal talk of the participants – left over (Braithwaite *et al.*, 2004). Table II shows the 14 categories of clinician-management activity and the relative proportional emphasis on each category[2].

Developing the model

It was evident from this research that these 14 categories are thickly interwoven. In one sense it is artificial to force them apart because there are levels of overlap and interaction across the categories. Yet in another sense it is necessary to disaggregate them. This is what classification is about – the delineation of phenomena to identify meaningful patterns and permit description and analysis. Moreover, the grounded nature of their construction, emerging as they do from real-time social science data, suggests that this classification of clinical-management work is less synthetic than other social science contributions such as data elicited from the administration of questionnaires, the items of which in many cases effectively come out of the researcher's frame of reference or interest. In any case, there is less uncertainty about the categories themselves than there might sometimes be in the case of qualitative studies, given that there is a strong correspondence across the data sets over the 14 categories[3]. Nevertheless, there is always the challenge of Popper and the problem of induction, the status of empirical findings and theoretical models, and the falsifiability principle (Popper, 1963; 1959). We will deal with these later.

The largest proportion of words in the classification of focus group data clustered in the financial, people, organisational/institutional management and customer orientation categories and the smallest proportion in the data management, quality management, process management, strategy and planning and external relationships

Role or position	Times mentioned	Per cent of total roles and positions mentioned
Executive/organisational		
CEO	4	1.8
General manager	9	4.0
Executive	7	3.2
Managers	49	22.0
Administrator	4	1.8
Employer	1	0.5
Bureaucrat	2	0.9
Subtotal	76	34.2
Middle level/divisional		
Divisional head	3	1.4
Director	15	6.7
Nurse manager	3	1.4
Business manager	9	4.0
Clinician manager	7	3.2
Subtotal	37	16.7
Workers and professionals		
Clinician	31	14.0
Doctor, physician	18	8.1
GP	1	0.5
Employee	2	0.9
Specialist, VMO	8	3.6
Nurse	23	10.4
Non-clinician	1	0.5
Allied health	4	1.8
Surgeon	1	0.5
Secretary	3	1.4
Subtotal	92	41.7
Patient/client		
Customer	1	0.5
Patient	15	6.8
Subtotal	16	7.3
External		
Politician	1	0.5
Subtotal	1	0.5
Total	222	100.4[a]

Note: [a]Exceeds 100 per cent due to rounding

Table I.
Roles and positions most frequently mentioned

categories. The field notes which captured the ethnographic accounts largely verified this pattern, and the time spent on different categories of work activity was largely in proportion to the focus group discourse.

The focus group transcripts and field notes have now been interrogated further, and this paper reports the analysis. Five dimensions of the research materials were examined: how subjects' interests and concerns were prosecuted (i.e. how clinician-managers practised, and how they enacted their work), how work was

Activity	Exemplar words and concepts	Approximate per cent of talk and behaviour involved
People	Staffing, motivating, assigning work, delegating, disciplining	26
Organisational/institutional	Buildings, beds, equipment, reports	14
Structure and hierarchy	Decentralising, departments, directorates, restructuring	12
Financial	Budgeting, revenue, accounting, resource management	10
Customer orientation	Complaints, compliments, customer queries and needs	8
Education and development	Training, teaching and learning, education	7
Achievement orientation	Objectives, goals, priorities, results, successes	6
Change	Inertia, rapid, new ways of working, resistance	4
Processes	Systems, processes, procedures	4
Decision making, problem resolution	Deciding, decisions, problem resolution, consensus	3
External relationships	Suppliers, external agencies, outside companies	3
Strategy and planning	Longer-term planning, strategic goals, plans	1
Data	Information, data, information technology	1
Quality	Continuous improvement, TQM, quality	1

Table II. Major clinician-management interests and concerns

mobilised (i.e. how they did what they did), the time frames for subjects' activities, organisational relationships of clinician-managers, and aspects of power and control.

Model

Clinician-managers' behavioural routines

Re-analysis of these data sets suggested that the 14 categories of managerial interests and concerns shown in Table II could be reconfigured into three clusters. Nine of the 14 managerial interests and concerns reflected the managerial tasks or functions (labelled pursuits) of clinician-managers, and the remaining five were modes of achieving these pursuits (referred to as modes of operating). Four of the nine pursuits, (primary pursuits) were those on which clinician-managers spent most of their time and effort. The remaining five were those which were pursued but not to the same extent, in terms of subjects' time or effort, as the others (secondary pursuits). Figure 1 depicts this framework graphically.

The model suggests that clinician-managers' core pursuits – the task activities they are primarily engaged in – is the management of finances, staff, organisational/institutional matters and customers. They are also engaged in the management of data, quality, processes, strategy and planning, and external relations, but these are secondary to their major pursuits. The key modes of operating – the ways they undertake their work – are by adopting an achievement orientation, through the structure and hierarchy, and by managing change, in taking decisions and solving problems, and educating and developing self and others.

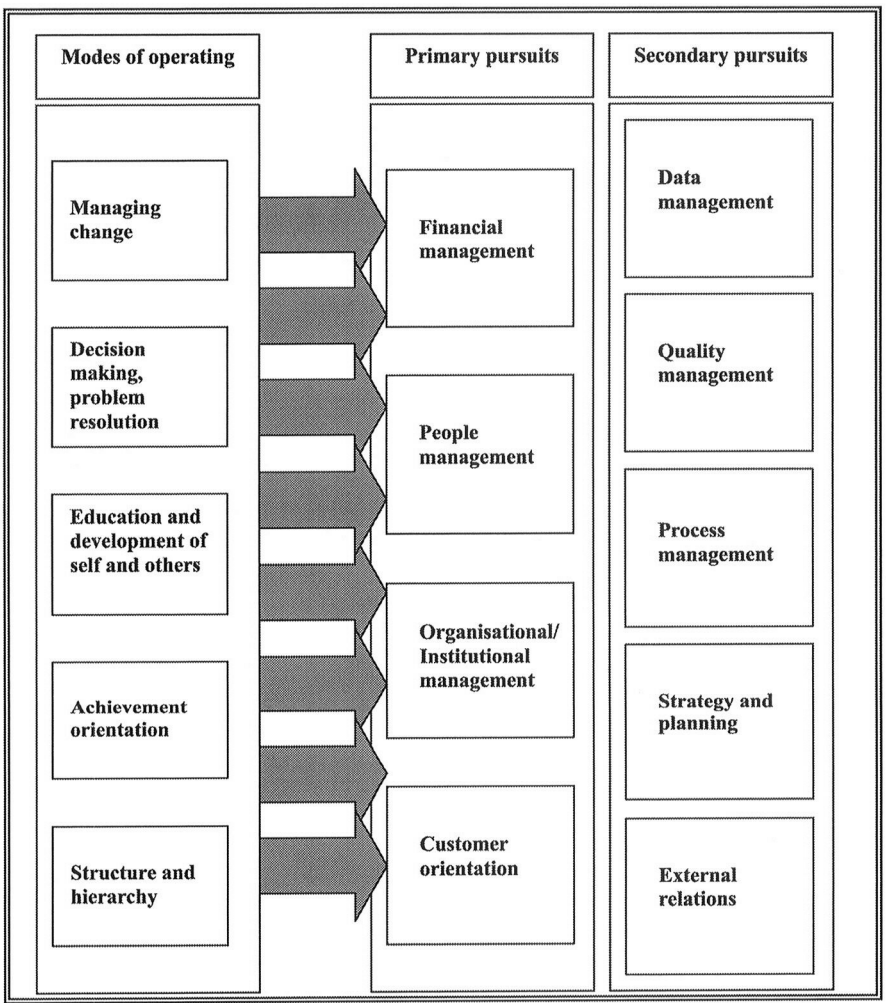

Figure 1.
Clinician-managers' behavioural routines: major modes of operating and primary and secondary pursuits

How work gets mobilised

The findings from the studies under discussion highlight that the majority of clinician-management work was conducted through formal and informal managerial vehicles, recognisable immediately to everyone: meetings. Viewed broadly, these are formal and informal encounters of two or more people where conversations, discourses, dialogues, and non-verbal exchanges – in short, social intercourse – takes place. There are thousands of such occurrences in a large health service every day.

There were essentially four types. First, regular hospital committees took place (e.g. the hospital executive meeting, the drug committee). Second, regular meetings for defined management purposes were held (e.g. the clinical directorate management meeting, the monthly meeting of a clinician-manager with all staff in his or her unit).

Third, *ad-hoc* meetings scheduled for specific management purposes were convened (e.g. a meeting with the information technology manager regarding the redesign of a data management system, meeting with the unions and the human resources manager about the disciplining of an errant employee). Fourth, *ad-hoc* unscheduled meetings emerged (e.g. chance encounters with someone in the corridor, opportunistic meetings with one or more people before or after a scheduled meeting).

Time frames for clinician-management work. We can further reflect on the modes of operating of clinical-managers if we look at the chronological nature of the talk as reflected in the four focus group transcripts (study two) and the field notes from the two case study hospitals, cases A and B (study three). Figure 2 suggests the time frames to which the talk and behaviour refers. It is thus a window into the temporal orientation of clinical managers as they go about their work.

The Figure shows how clinician-managers' operating modes can be located on a time continuum. Past, present and future are represented. Increasingly distant chronological time forwards and backwards from the present has been captured by a schema reflecting the immediate (temporally close to the present), the proximal (mid-range from the present) or the distal (furthest removed from the present).

Managing change is less in its focus about the past and more about the present and the future. For instance, we hear general talk like "how are we going to do X differently and better next time", "what's the approach for dealing with Y", and "in relation to Z, let's get moving". This discourse relates to intention, it is aspirational, and has a time frame from the present to the proximal future. It is rarely concerned with the far future.

Two specific examples extracted from the focus groups and case studies can be adduced. Change in both examples can be seen to occupy a time frame of now to the immediate future. Participant three in focus group 1, a nursing clinician-manager in a clinical directorate, said:

> It has been an interesting challenge to try and find the courage to change the process because the people that you're working with don't approve, agree and support the change. There are one or two groups which are totally against the concept of change and that has been a very challenging experience to try and work through.

On occasion, change had to be forced through, although there was some discomfort about this. A clinical nurse manager in case B from study three argued:

> Sometimes ... and I don't like this, sometimes you just have to direct rather than consult, especially to [medical department heads].

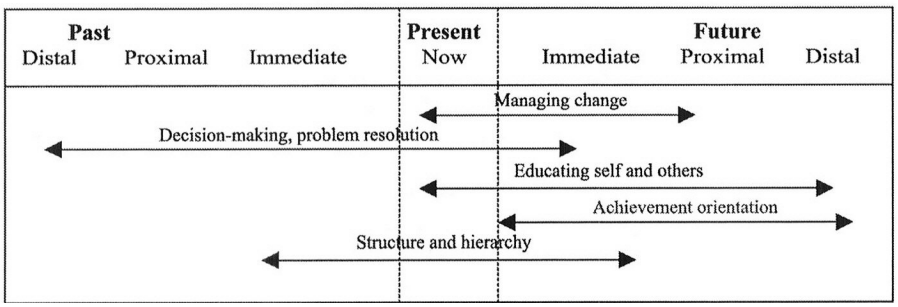

Figure 2.
Past, present and future orientations of clinician-managers

By its nature, decision-making and problem-resolution activity tends to be centred on past and extant issues. These are matters that are hard to bring to closure (e.g. ongoing budgetary problems), or keep resurfacing over time (e.g. chronic personality conflicts), or are consistently emergent (e.g. shifting political coalitions with differing views and behaviours trying to reshape the organisational agenda). For example, in case B a nurse lamented a number of false starts to a set of decisions about the assignment of beds:

> We just recruited, trained and . . . nurtured . . . new staff for renal/urology and this time is lost.

In case A, a medical head of a clinical directorate, talking about how hard it was to influence external decision making in the Department of Health, indicated:

> It's a constant challenge for us to influence what goes on in corporate office.

Educational initiatives and prospective, achievement-oriented talk and behaviour are both more clearly and obviously future-oriented (about the immediate and proximal future) and are sometimes about longer-term, distal matters. These respectively are centred on satisfying future staff development needs (arranging computer training, or encouraging someone to embark on a master's level programme in management or public health, for instance) or pursuing initiatives expressed by reference to longer-term goals, objectives and priorities. Participant 12 in focus group 4, a nurse manager of a clinical directorate, said:

> I made a definite choice to continue in a management role and undertook the appropriate training therefore to facilitate my performance within that role.

But not everyone agreed on the importance of training people for the future. The chief executive in case B was a clinician who had been promoted through the ranks and did not value highly or really see the need for managerial training for himself or others. Instead, he viewed management as largely common sense, and acted as if it was about command and control. This stance was viewed unfavourably by many organisational stakeholders, and seemed to contribute to his unpopularity.

Navigating through the formal organisational arrangements which constitutes the structure and hierarchy occupies a relatively large amount of time and effort. Participant two in focus group 1, an allied health practitioner, indicated:

> You are moving across boundaries and you are trying to do away with boundaries and what other people are doing is they're making the boundaries matter. Managing the care process is extremely difficult in such a circumstance.

Participant 18 in focus group 4, a business manager, queried:

> I wonder if you couldn't actually have achieved the same levels of efficiencies with the old structures that we previously had and if we just take good communication mechanisms, participation and whatever. I don't know whether we might do a full circle eventually.

A participant in case B argued:

> . . . the structure sometimes . . . got in the way of patient care . . . and created boundaries.

Talk and action in this frame is thus mostly present- and future-oriented (e.g. working on, or proposing to alter the formal organisational structure, or talking about or trying to decentralise services or tasks, re-organise work, or reassign responsibilities)

although it is sometimes about the immediate past (e.g. how we are coping with the most recent management restructuring). In case A, for instance, a senior manager said:

> ... structure is a means to an end rather ... than the end itself, and this needs to be made ... clear.

Relationships beyond the clinician-management role

Clinician-managers were embedded in webs of complex relationships, as highlighted in Table I. It suggests that the focus group talk concerning roles and positions is classifiable into five types – executive/organisational, middle level/divisional, workers and professionals, patient/client and external. The most frequently occurring words related to workers and professionals (41 per cent of the total), executive/organisational (34 per cent) and middle level/divisional (17 per cent). An analysis of the relationships of clinician-managers with people in these roles and positions, drawn from the transcripts and field notes, shows that there are demands and pressures on clinician-managers on both the vertical and horizontal organisational planes. It seems that clinician-managers, to use a colloquialism made popular by Porter (1985) in another context, are stuck in the middle. Figure 3 seeks to realise graphically a depiction of this phenomenon.

Figure 3 suggests that, although clinician-managers are in a recognisable position of power *vis-a-vis* subordinates in wards, departments and units, they are subject themselves to challenging expectations from subordinates below. Clinicians below want their unit clinical-managers to represent them and their interests, lobby for more

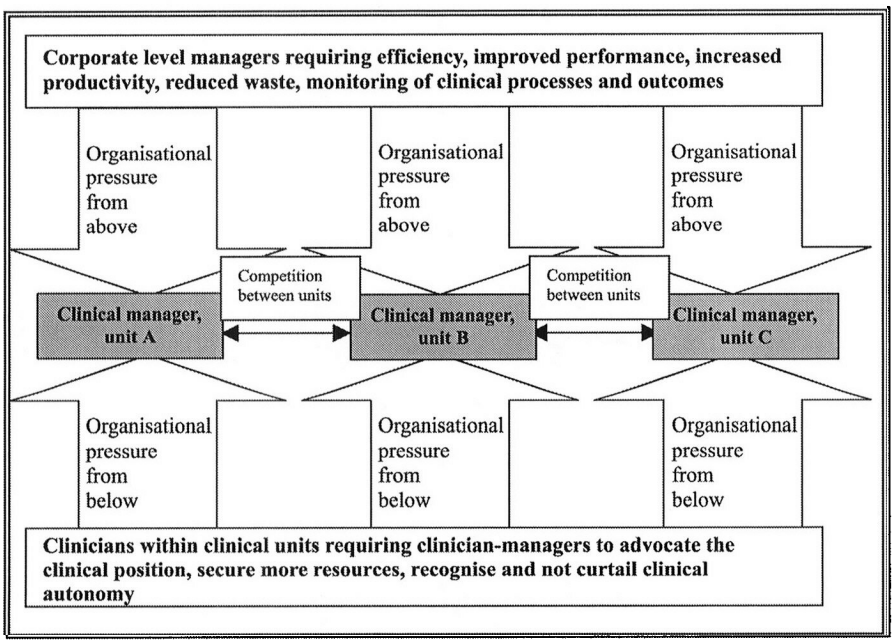

Figure 3.
Schematic diagram of some lateral and hierarchical power and relationship issues facing clinician-managers

resources for them and be generally supportive and collegial toward them, rather than autocratic and demanding of them.

Clinician-managers are also subject to accountability measures above from other corporate level senior managers, especially the chief executive officer (CEO) and other powerful stakeholders such as boards of directors, regional bureaucrats or governments. The expectations here are generally for clinician-managers to run efficient and effective services, be on top of things, and be able to control clinical work activity.

Thus there is considerable social pressure on them from above and below to respond in certain organisationally or clinically appropriate ways, as Figure 3 attempts to show. Clinician-managers have to face both ways simultaneously, and they are under scrutiny above and below, with differing and sometimes mutually exclusive sets of demands placed on them.

Aspects of power and control

There are other relational aspects of clinical-management work, centred on dimensions of power, control and interdependence, that inspection of the data sources reveals. One is in respect of the relationship between clinician-managers and corporate level managers. Over time, clinician-managers have been increasingly given or have taken on more duties and responsibilities, as Table II indicates. Because of the shifting patterns of hospital managerial and financial responsibility toward clinician-managers, there is a suggestion that some corporate level managers have become surplus to requirements. For example, under the traditional structure in hospitals there were positions of directors of nursing, medical and corporate or administrative services. In many hospitals these positions remain in place despite restructuring into clinical directorates up to a decade or more ago. At several points in the transcripts, the role of the occupants of these positions was explicitly or implicitly questioned by clinician-managers. These positions and others that supported them may now effectively be redundant, or in some cases the responsibilities have changed or been curtailed quite considerably.

There are prevalent accounts in the transcripts to the effect that although substantial power and decision-making authority has been handed over to or acquired by clinician-managers, insufficient resources are available to them. There are also suggestions that larger or more strategically important decisions are still made by corporate level managers, especially the CEO, or that these staff hold latent power in reserve to make such decisions. Moreover, the transcripts and their interpretation by expert panellists suggest that clinicians within clinical units, especially doctors, continue to remain relatively autonomous. Some clinicians view clinician-managers with suspicion, and vice versa. For example, Participant nine in focus group 3 said:

> ...we have a few medical clinicians on board ... and a large number who still have very different value systems where cost is not part of their value system.

Discussion

The scope of clinician-managers' behavioural routines

Conceptually clinician-management activity is being depicted here in terms of five principal modes of operating – through managing change, by making decisions and

resolving problems, developing self and others, trying to meet goals and targets and by attending to structural and hierarchical matters. Each of these has differing time frames, which is reflected in the talk and behaviour of the subjects in the studies. On the evidence profered, four primary pursuits of clinician-managers, defined by reference to those to which most time is devoted, are financial, people, organisational/institutional and customer orientation. Five secondary pursuits, according to this hypothesis, are data and quality management, process management, strategy and planning, and external relations. These findings extend previous work in "general" management reported by the earlier managerial empiricists such as Mintzberg (1971), Stewart (1967) Kotter (1982b) into a more specific, specialised domain. They offer a tight categorisation to complement the varieties of health system clinical management reported by Mintzberg (2002), Stewart *et al.* (1980), Brooks (1999), Kocher *et al.* (1998) and Thorne (2002).

Despite a cacophony of differing opinions in the literature as to what constitutes management for clinician-managers, and an even greater range of normative views about what should constitute management for clinician-managers and how to do it well (e.g. Rea, 1993; 1995; Sang, 1993; Smith *et al.*, 1989; Chantler, 1989), this model provides some observational underpinnings for these four primary and five secondary work activities. An empirically-based, bottom-up conceptualisation of clinical management, emerging from the words and behaviour of the participants themselves, has not been available in this way in the past. By classifying the text of managers in clinical settings and aggregating the words into 14 categories, a tentative, although seemingly comprehensive description of the scope of the management tasks facing clinician-managers, is tendered. These results appear to represent a step forward in providing a descriptive-analytic rather than normative-prescriptive account of clinician-management from the perspective of practicing clinical managers.

There are claims in the literature to the effect that important aspects of clinical managerial work include quality management (e.g. Fitzgerald and Sturt, 1992; Kirkman-Liff and Schneller, 1992), information systems development and data management (e.g. Bernstein, 1993; Abernethy and Stoelwinder, 1986), managing clinical pathways and attending to other process-oriented matters (e.g. Degeling *et al.*, 2000), formulating strategy and planning for future services (e.g. Corbridge, 1995; Allen, 1995). The evidence provided here quite clearly suggests that these are not of the highest concern to clinician-managers compared with the other primary aspects of management noted above.

How work gets mobilised: through meetings. Interaction is the social DNA of clinical management behavioural routines. Activity – doing things, exchanging views and mobilising influence – is heavily centred on discourse. Following Mintzberg (1971) the observations were of clinician-managers engaged continuously in conversations with others, striving to impose some sort of communicative order on, and make sense of, the world they inhabit.

In short, clinician-managers talk to others and listen to them in person. This is by far the major endeavour. E-mail and telephone (both mobile and fixed line) communications are used frequently, but the most dominant mode of working is through meeting with others. Meetings represent a large investment in time and effort, and are the main way ideas and issues are processed, sense making about

organisational events and issues occurs (Weick, 1995) and the negotiated order (Strauss *et al.*, 1963) is enacted.

Such dynamic managerial activity is not well explained by prior static, normative accounts and frameworks which have purported to advance representational assemblages of clinician-management work. Clinician-management work activity is centred on ongoing interaction, coordinating work with and through others, influencing people and the constant creation and dismantling of relationships and teams (see Firth-Cozens, 1998; Davies and Harrison, 2003). This is how the social structure emerges.

The time-orientation of clinician-managers: past, present and future

So far as the temporal orientation of clinician managers is concerned, these studies provide a first approximation of how differing functional modes of operating are time-bound. According to this research, decision making and problem resolution by nature are mostly past-oriented. Decisions and solutions or attempted solutions are largely applied to things that have already happened.

Discourse about the structure and hierarchy exhibited a different time-orientation. It is more immediate and present. People who had regard to the organisational arrangements did not discuss the distal, most likely because structure is about here and now issues.

The language of both change and education are future-oriented, as is achievement talk. Clinician-managers change things to try to create improvements, they educate people and they strive to meet various self- and externally-imposed goals, objectives, deadlines, targets and milestones. All of this is about dealing with issues in the present to improve the organisation and its services in the future. Whether this is accomplished effectively depends upon factors such as the capacities and skills of participants, quality of decisions, resources available, and other organisational and cultural variables.

Exploring relationships beyond the clinician-manager role: a sociogrammatic depiction

Table I and Figure 3 render a summary of how the clinician-manager is in the middle of a complex web of stakeholders, social pressures and influence. Managing the expectations of others, especially those of corporate level managers above and clinical and other subordinates below, is a constant theme in clinician-managers' work. Clinical units in this respect are intermediate organisational hierarchical arrangements between clinicians and other workers on the one hand and corporate level managers on the other. Clinician-managers are often appointed to the hospital executive ranks, and thereby necessarily assume dual and sometimes conflicting roles. They are first among equals with clinical colleagues, but also have executive responsibilities over them. Navigating through this testing milieu requires adroit skills, continuous strategic sense making and socially dexterous manoeuvrability.

However, to account for the influences and pressures on clinician-mangers by explaining only the vertical plane of relationships is incomplete. The ethnographic data, in confirmation of focus group evidence, show how there is competition across clinical units for resources, attention and status. These circumstances add to the pressure and demands on clinician-managers. They appear to perceive, quite rightly, that their performance against other clinical units is evaluated informally but

constantly by many organisational stakeholders. From a clinician-manager's standpoint, there is steady and at times seemingly relentless social pressure to outperform relative to counterpart clinical units on any number of criteria such as patient throughput, embracing the next change strategy and meeting budgetary targets. Competition is socially mobilised through organisational members' critical, judgemental observations and gossip. Stakeholder individuals and groups within and outside clinical units talk about the relative merits, performance and contributions of specified clinical units and clinician-managers responsible for them compared to others. In the process they create or lend impetus to clinical-managers' positioning, posturing and rival-regarding behaviour. Thus to amplify the earlier allegory, clinician-managers have to face not only two but multiple ways simultaneously.

In enacting their behavioural routines and in pursuing their managerial interests and concerns, managers in these present studies rarely gave commands, instructions or orders, but used the means to achieve their aims more subtly. Central to clinician-managers' behavioural routines is not only being subject to others' attention, pressure and influence, but in regarding, pressuring and influencing others. Clinician-managers constantly tried to shape others' opinions, fashion alliances and networks to achieve goals and objectives, frame and project meaning, re-orient agendas and make incremental and larger changes to policy or practices. Thus the pressure of organisational expectations, requirements and demands is not merely something that is experienced by clinician-managers. They exert pressure on others by mobilising their own expectations, requirements and demands.

In doing so, the evidence suggests that sometimes clinician-managers were trying to achieve beneficial outcomes or solutions for the organisation at large, sometimes for individuals or groups within their own unit and sometimes for themselves. Frequently, one or more of these converged. In other words, the talk and behaviour of these subjects was in progressing their strategic interests, sustaining momentum and, generally, influencing others in support of their goals and objectives. Some of these goals and objectives were organisationally defined, but others were central to their own interests. Contriving a path though the day under these circumstances is socially and politically challenging.

Aspects of power and control

All managers are faced with the problems of control, and how to mobilise power and influence to get things done (Salancik and Pfeffer, 1977). The data from the studies suggest that control is neither easily exercised nor exercisable in professional settings. There is a considerable amount of evidence able to be adduced to uphold this contention. There is a prevailing view discernible in the experts' interpretations of the transcripts that clinicians' work cannot be readily controlled without clinicians' cooperation. Despite the expectations of managers at the apex of the corporate level that clinician-managers should control clinicians and their work, this does not, on the evidence of the data reported here, appear to have been accomplished by clinician-managers. Moreover, control is less than clear when responsibilities have not been clarified between clinician-managers on the one hand and corporate level officeholders, such as the director of nursing or director of medical services, on the other.

Control for most participants in these studies appears to equate almost exclusively with control of resources and their allocation. For example, the expert panel's consensus position on control was: "without financial control it is very difficult to control clinicians". Control is not expressed by focus group participants in terms of micro-management of clinicians' conduct, performance, outputs or outcomes. There is a strong suggestion that the "old boys' medical network" can not only allow doctors to remain unaccountable to a large degree, but also negates control processes or surveillance measures.

Perhaps this is definitional of how control works and relationships between clinical "subordinates" and clinical-management "superiors" are expressed and circumscribed in professionalised settings. Concepts of managerial control in the sense discussed by scholars of this subject such as Edwards (1979) and the labour process theorists (e.g. Braverman, 1974; Knights and Willmott, 1990) have been evinced in the past from analysis of environments where knowledge workers were not the prominent inhabitants, and hence these have not historically been the subjects. But with relatively autonomous, self-determining, control-resistant experts like hospital clinical specialists, older accounts of control can be seen as being anachronistic and perhaps irrelevant. Knowledge workers are people who have relatively high levels of discretion and expertise and autonomy, yet their work nevertheless needs to be coordinated. This requires fine-grained and sophisticated skills, and hence the contemporary clinician-manager is required to discuss, negotiate and persuade rather than require, insist or demand, in order to achieve objectives and get things done. Delicacy and diplomacy on the part of clinician-managers are needed to deal with powerful, autonomous and sometimes egotistical clinicians.

Analysing the world of clinician-managers: a synthesis

How can we summarise this complex world? Participant clinician-managers attended to a variety of tasks and issues, and constantly attempted to impose order on the messy, deceptive, imprecise social world that they inhabit. They acted within their social setting on organisational others by adopting various modes of working and socio-managerial roles as Mintzberg (1973) reminded us decades ago (e.g. resource allocator, social liaison with other hospital groups, information disseminator, disturbance handler). They constantly mobilised influence, creating organisational space, and spheres of influence for themselves, and developed networks and alliances and support structures within the negotiated hospital order. They did so in the light of demands and constraints made on them by others and through choices facing them, as empiricised by Stewart (1976) in the case of health services managers. Their work can be seen as intensely social and political, and involved complex navigational routines, with networking, agenda-setting and alliance-building, following Kotter (1982b), among their core strategies.

Seen in this light, in adopting five modes of operating and nine managerial pursuits, these clinician-managers were attempting to enact an understandable environment for themselves. In this respect the present studies provide an empirical verification of Weick's thesis (1979). According to this work, subject clinician-managers were constantly sense making of their environment. They were trying to make their way in a complex world, and attempting to fathom out what they could do, and who they could do it with, what was possible, and what was prohibited. As Weick predicted, they

constantly talked to justify past choices, for instance, and extracted cues from the streams of stimuli that confronted them, and they based options on feasible rather than precise data. In addition, they frequently tried to cast their clinical unit in a positive light, and favourably projected their own identity and their unit's role and place in their hospital to others.

Some implications of this model

The evidence reported above shows how clinician-management jobs are busy and difficult, and required the development of a range of competencies. In this respect managerial competencies for clinician-managers can be thought of as centring on the 14 interests and concerns summarised in Table II. For practicing clinician-managers one outcome of this program of research is an indication that they might concentrate on developing skills in five modes of operating and four primary and five secondary pursuits if they wish effectively to address the sets of demands placed upon them. In addition, prospective clinician-managers might look on the development of interpersonal skills at both the individual and group levels as being as important as the development of technical managerial or professional skills.

We have seen how management activity in clinical units is heavily social, centres on discourse, persuasion and negotiation, and involves working with and influencing individuals and groups, and in turn being lobbied and influenced. To be effective requires well-developed political and social skills and verbal ability and the capacity to cope with multiple issues, tasks, responsibilities and requirements within a richly textured, ambiguous, challenging and deceptive habitat. These suggestions are supported by earlier research: Luthans *et al.* (1985) found that successful managers in other industries tended to spend more of their time on conflict resolution and peace making and socialising/politicking than their less successful counterparts.

Further, from the foregoing, it seems that a strategy of continually working on the inclusion of clinicians and organisational others in managerial processes, activity and decision making is likely to be more successful than adopting a top-down mode of control. Partnership rather than instruction appears more appropriate for professional-managerial relationships, given the networks of stakeholder complexity discussed here.

A core proposition which requires further work is that the focus group participants' patterns of talk corresponded quite tightly to the behaviour represented in the ethnographic field notes. This may be an important finding. If what managers or, more broadly, what social agents say (when they are asked to be honest, and guaranteed a safe, confidential, collegiate focus group environment) is related to what they do, then the structure of one may be able to be successfully read off against the structure of the other. Assuming that informants are not deliberately or unintentionally lying, then it should not matter to researchers whether they conduct focus group discussions or observational work *in situ*. Each mode offers other benefits and inheres with various shortcomings, and this does not suggest that one can supplant the other. But it may mean that structural patterning in the one can mirror and hence anticipate structural patterning in the other. Philosophically, if this is so, there may be work to do to consider what triangulation of methods means in regard to the contingencies of converging and diverging evidence.

Conclusion

A grounded model

The schema represented in Table II and Figure 1, based on both talk and behaviour, offers a grounded description of clinician-managers' behavioural routines not previously available. Figure 2 provides a temporal perspective on the way clinician-managers work, and Table I and Figure 3 attempt to model some of the issues central to the shaping of power, influence and key relationships.

Critics can point to a flaw in this type of research, noting that participants in each of the ethnographic, focus group and case study components may have acted as though they were front stage, and aware during the conduct of the studies that their behaviour was subject to observation by a researcher. As Goffman (1959) has shown, subjects' impression management is a perennial factor. This is likely to be especially so in circumstances in which human behaviour comes under the scrutiny of a researcher or external other. Nevertheless, the studies were conducted over extended periods and there were clearly many occasions when the subjects ignored the participant and non-participant observer and talked and behaved without explicit regard to an external presence. In the case of the focus groups, frankness was requested and seemed to be provided. Moreover, the triangulated evidence of the data sets – five years of immersion, 64 clinician-managers over four focus groups, and two separate in-depth case study reviews – suggests a pattern of behaviour and talk which is robust. The convergent nature of the findings lends support to the proposition that the results are sturdy and may be transferable to other settings.

Falsifiability and refutation

Whether or not they are is subject to falsification processes, following Popper (1959). In all work of this kind, we can never be rationally justified in asserting that some, or even extensive observational instances, are good grounds for believing in general propositions. This is because of the problem of induction: no matter how many observations are made, we can never conclusively "prove" anything (Scruton, 1994). One counter example can falsify, however. The classic example is the sun, rising each morning. We draw the general conclusion that it will do so tomorrow. It may well; indeed, it is almost certainly going to do so. But one tomorrow, relentlessly, according to the logic of physics based on the laws of thermodynamics (Hey and Walters, 1997), entropy will prevail, and the sun will burn out. The hypothesis – what Popper would label the generalised conjecture – will be refuted, radically and decisively in that case.

The evidence presented here is hence by no means submitted under a positivist agenda, and is in any event no more privileged than any other social science data, whether qualitative or quantitative. The results are tendered as interpretive rather than "definitive" data. The empirical contributive value lies in whether or not the findings resist refutation under criticism (Popper, 1963), and whether the model is a useful approximation of the behavioural routines of clinician-managers.

Consideration has been given to what it might be like for these data and interpretations to be false *in toto* or to a large extent. This would be hard to imagine, as prior management empiricists like Mintzberg (1971), Stewart (1967) and Kotter (1982b) have adduced findings about tasks, roles, functions and work activities of other kinds of managers which have some concordance with those drawn from the current collection of studies, as we have seen. In any case, the data on which these

clinician-management discussions are based have emerged from multiple research sources, and thus comprise many observations under different conditions. But neither Popper nor the problem of induction can be taken lightly. In the spirit of Popper's criterion of demarcation and his proposal that any empirical offering must be seen as conjectural in nature until new empirical evidence (and hypotheses based on these) come along which supplant them, criticism of these findings is welcomed, as are attempts to refute them.

Notes

1. This is especially prevalent in what we might label the airport bookshop literature. Highly normative in tenor, this genre of management writing aspires to teach the world's executives and managers how, using elegant, accomplished methods and strategies, to be a virtuoso leader. Among others he or she will run excellent organisations, master TQM, re-fashion successful organisational processes, manage change proactively, create learning organisations and do marvellously well by variously: centralising, decentralising, being nimble, outsourcing, downsizing or better still, rightsizing. The disordered, socially opaque, complex, ambiguous, difficult, experienced world of managers and executives is largely ignored.
2. Estimates of proportions of talk involved in various categories were accomplished by analysing transcriptions in study two; estimates of behavioural categories were derived from analysing the text of the field notes in study three. The percentages are based on a summing of these two sources.
3. This is by no means an attempt to over-claim the value of ethnographic or other qualitative data. There is a perennial problem of participant impression management. However, the studies were of sufficiently long duration that participants largely accommodated to being observed, and behaved and talked "normally". See the classic: Goffman (1959).

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