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The complex work of the hybrid manager

A qualitative study on how hybrid managers in healthcare respond to competing demands in their day-to-day activities

Abstract

In this thesis, hybrid managers' responses to competing demands are studied, in order to build an understanding of how they handle institutional complexity in their day-to-day activities. Thirteen managers with backgrounds as healthcare professionals participate in this qualitative study. In order to understand how hybrid managers respond to competing demands, theory on institutional logics and individual-level responses to institutional complexity is used. The findings show that hybrid managers mostly retain their professional logic in their managerial role and that most of the managers in balanced ways adhere to both the professional logic and the managerial logic in their daily work. The degree of adoption of the managerial logic varies from defiance, compartmentalization and combination. This thesis builds an understanding of how healthcare professionals act in managerial roles, which has implications for the potential outcomes of hybrid management.

Keywords: Hybrid management, Institutional complexity, Healthcare, Professionalism, Managerialism

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Definitions	
Medical operations manager	A medical operations managers is responsible for their own clinic (4 kap. 2 § Hälso- och sjukvårdslagen 2017:30) with the objective that the patient's need for safety, continuity, coordination and safety in healthcare is satisfied (Hälso- och sjukvårdsförordning 2017:80).
Hybrid manager	Hybrid managers are individuals with professional backgrounds managing co-professionals and other employees (Fitzgerald & Ferlie, 2000). In this study, all medical operations managers have professional backgrounds and thus qualify as hybrid managers according to the chosen definition.
Institutional logic	Institutional logics can be defined as 'the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality' (Thornton & Ocasio, 1999, p.804).

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1 Introduction

1.1 Background

Hybrid managers are operating in the intersection between the clinical and managerial spheres of healthcare (Kippist & Fitzgerald, 2009), where they face competing demands (Glouberman & Mintzberg, 2001). In Swedish healthcare organizations, the competing demands originate from the introduction of New Public Management-principles (from here on NPM) in the 1980's, a reform with the objective to improve economic efficiency in the public sector with inspiration from the private sector (SOU 2018:47). NPM has influenced the management of healthcare, with an increased focus on cost reduction and efficiency (Kippist & Fitzgerald, 2009). The NPM-principles regulate the work of healthcare professionals with market mechanisms, i.e. client and purchaser demand, and increased managerialism, i.e. managerial control and standards of performance (Ferlie, Ashburner, Fitzgerald, Pettigrew, 1996). These management principles conflict (Jonnergård, Funck & Wolmesjö, 2008) with medical professions' traditionally high degree of self-regulation (Freidson, 2001). Thus, the NPM-practices have created a divide between practice of healthcare and business of healthcare, where management principles may challenge the values of healthcare professionals (Kippist & Fitzgerald, 2009).

The tensions between traditional professionalism and the increased managerialism and market logic resulting from the NPM reform, represent competing institutional logics in healthcare (Bode, Lange & Märker, 2016). Accordingly, the healthcare sector is subject to institutional complexity; healthcare organizations face 'incompatible prescriptions from multiple institutional logics' (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011, p.318). This has implications for members of healthcare organizations, since institutional logics function as organizing principles (Friedland & Alford, 1991) that guide interpretation and behaviour in social situations (Greenwood et. al., 2011). A proposed solution to the fragmentation of healthcare that has been caused by the NPM reform are hybrid managers (Byrkjeflot & Kragh Jespersen, 2014), who have the purpose to combine clinical knowledge with managerial competence (Ferlie et. al., 1996). These managers have dual roles as they represent both a professional logic and a managerial logic, and they presumably keep them balanced (Sirris, 2019). However, when professionals enter hybrid management, they have to learn how to incorporate the managerial perspective (Ferlie et. al., 1996). The fact that hybrid

managers' inherent professional logics may compete with managerial demands, raises a question about how they balance institutional logics in their work. Therefore, there is a research interest about how hybrid managers can integrate competing demands.

1.2 Purpose and research question

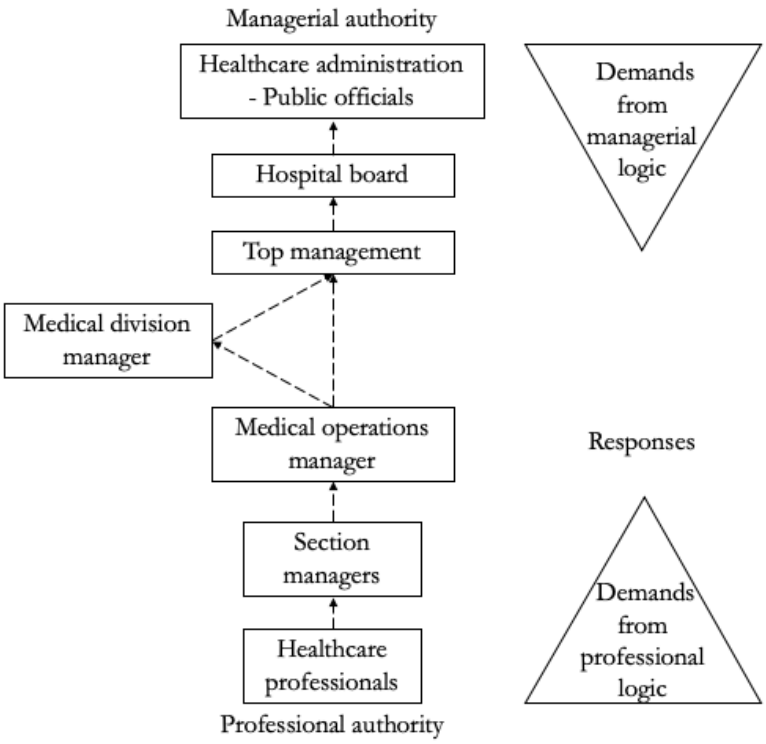
The purpose of this study is to understand how hybrid managers, individuals with backgrounds as healthcare professionals currently developing management experience, can handle an institutionally complex context. We aim to understand how hybrid managers respond to competing demands, in order to find out how they operate in between the clinical and managerial spheres of healthcare. Thus, our research question is stated as following:

How do hybrid managers respond to competing demands in day-to-day activities?

1.3 Delimitations

This study is limited to medical operations managers working at public acute hospitals in Sweden, as we found this environment to be subject to institutional complexity. The study is focused on the perspectives of medical operations managers, as they seemed especially interesting to study, since they are positioned in between top management and operational levels. We decided to focus our study on acute hospitals rather than community care. Glouberman and Mintzberg (2001a) distinguish between acute hospitals and community care and argue that acute hospitals are more isolated from public control than community care instances, that they are becoming increasingly specialized on advanced interventions, and that they are problematic to control. Furthermore, healthcare has a hierarchy that rather reflects status than authority (Glouberman & Mintzberg, 2001b). Considering the seemingly isolated practices of acute hospitals, potential difficulties in controlling them and the dual authority, this context was deemed as interesting when studying hybrid management in an institutionally complex environment.

Figure 1. The context of medical operations managers



2 Theory

2.1 Previous research

A variety of research has been conducted on hybrid managers' responses to the institutional complexity they are facing in their roles in healthcare organizations, in the light of NPM (Van den Broek, Boselie, Paauwe., 2013). McGivern, Currie, Ferlie, Fitzgerald, & Waring (2015) found two types of hybrid managers in their study of medical professionals in managerial roles; 'incidental hybrids' protected the professional logic in temporal hybrid roles, while 'willing hybrids' developed enduring identities based on both a professional and a managerial logic. Studies have found that hybrid managers try to manage conflicts between competing logics by mediating between them (Llewellyn, 2001; Doolin, 2001). Moreover, Byrkjeflot and Kragh Jespersen (2014) argue that hybrid managers' competing professional logic and managerial logic characterized by NPM influences coexist, and that hybrid managers most often mediate between the logics. Indeed, Kippist & Fitzgerald (2009) argue that the hybrid manager role calls for navigation between managerial and medical objectives. Studies have also found that hybrid managers combine different logics rather than mediate between them. Blomgren and Waks (2015), have found that hybrid managers in Swedish health care organizations combined elements from the corporate, market, democratic and professional logics and Kurunmäki (2004) found that hybrid managers in Finnish healthcare hybridized by adopting accounting practices introduced in the organizations.

Furthermore, research concludes that hybrid clinician managers remain committed to their professional identity when entering management (Montgomery 2001; Byrkjeflot & Kragh Jespersen, 2014). However, previous research also states that professional backgrounds play an important role in shaping managers' identities (Connolly & Jones, 2003). Research indicates that an individual's type of professional background shapes adaption to the managerial role. For example, Skjøld Johansen and Gjerberg (2009) have concluded that hybrid nurse managers are more identified as managers than hybrid physician managers, and that nurses mainly understand their hybrid role as managerial, while physicians instead are more committed to clinical work.

Kippist and Fitzgerald (2009) argue that it is worth conducting more research on hybrid clinician managers, as healthcare organizations constantly aim to make practices more efficient and to reduce costs. Furthermore, they argue that one must question in what way these hybrid managers mediate the clinical and managerial roles. Byrkjeflot and Kragh Jespersen (2014) state that research is needed on different ways that institutional logics are combined in relation to hybrid management. In order to understand how hybrid managers respond to institutional complexity in their roles, theory on institutional logics is used.

There is thorough research on organizational responses to competing institutional logics (e.g. Oliver, 1991; Meyer & Rowan, 1977; Greenwood, Díaz, Li, & Lorente, 2010; Pache & Santos, 2010). However, individual responses to competing institutional logics have been studied to a lesser extent (Pache & Santos, 2013a). Organizational responses are guided by the concern for organizational survival (DiMaggio & Powell, 1983), while in contrast, individual responses are primarily guided by concerns for social acceptance, status and identity (Pache & Santos, 2013a). Organizational responses to institutional complexity have functioned as a base for frameworks on individual responses (Pache & Santos, 2013a), indicating similar behaviors on the individual level, and thus, a variety of individual responses to institutional complexity has been suggested. Studies on individual responses suggest that responses to competing institutional logics vary under the same context (Lok, 2010). Suggested responses to competing institutional demands include compartmentalization (Creed, Dejordy, & Lok, 2010; Lok, 2010), defiance of a competing logic (Glynn, 2000), hybridization (Powell & Sandholtz, 2012; Blomgren & Waks; Meyer & Hammerschmid, 2006) and 'hijacking' of logics from other members in the organization that do not correspond with their own professional background (McPherson & Sauder, 2013). Furthermore, research shows that individuals' responses to competing demands in institutionally complex environments are influenced by their identification to institutional logics (Pache & Santos, 2013a), which is affected by experience from education (DiMaggio & Powell, 1983), work (Pache & Santos, 2013a), organizational memberships, and society (Friedland & Alford, 1991).

As previously mentioned, research on individual responses to competing demands is less developed than research on organizational responses. McPherson and Sauder (2013) state that there is a lack of empirics on how individuals' logics form their actions in day-to-day activities. Furthermore, Goodrick and Reay (2011) argue that there is a lack of research on how professional work is influenced by institutional complexity. Considering these suggestions for

further research, this study is focused on individual responses in day-to-day activities of managers with professional backgrounds.

2.2 Theoretical framework

2.2.1 Institutional logics

In society, there are six principal institutional orders with inherent institutional logics; market, corporation, profession, state, family and religion (Thornton, Ocasio, & Lounsbury, 2012). This builds on the theory of the interinstitutional system in society by Friedland and Alford (1991). Institutional logics consist of symbolic constructions and material practices that shape organizations' and individuals' actions (Friedland & Alford, 1991). Institutions, organizations and individuals are interrelated, and thus individual behavior is shaped by institutional logics in organizations and institutions (Friedland & Alford, 1991). Individuals are influenced by institutional logics through their social interactions (DiMaggio & Powell, 1983), which affect their identities and practices (Lok, 2010). In healthcare organizations, the medical professional logic and the managerial logic are central, since both logics are employed by powerful actors (Reay & Hinings, 2009); physicians are in control of the operations and public authorities and managers are in control of funding (Scott, 1992). Accordingly, these logics stand in contrast to one another, entailing competing demands.

According to the professional logic, work is ideally organized solely by professionals, allowing their knowledge to control organization of work. Ideally, healthcare professionals practice medicine without being restricted by contract of employment or government regulations (Goodrick & Reay, 2011). The work of a professional entails a high level of discretion, as the professional uses their own judgement to define what is professional work, compared to common standards. Thus, the professional logic entails individualized trust and professional expertise belonging to the professional association as a source of authority (Iedema, Degeling, Braithwaite, & White, 2003). The view on what is anticipated as good professional work is closely related to the definition of the profession, and the mere existence of a profession relies on such standards (Ahlbäck Öberg, Bull, Hasselberg, & Stenlås, 2016). Accordingly, as DiMaggio and Powell (1983) state, professional norms originate from formal education, which enables such norms to be produced and legitimized in the individual's experience of institutional logics. Also, they define the development of a profession as a collective issue of

professionals when it comes to defining their work conditions and methods. In the context of compromising with nonprofessionals, such as managers and regulators, professionals form legitimation for professional autonomy (DiMaggio & Powell, 1983). Furthermore, the medical profession is referred to as the ideal prototype of professionalism and has traditionally had a high degree of self-regulation (Freidson, 2001). The medical profession demonstrates a strong identification with and high degree of adherence toward the professional logic (Gadolin, 2016). On the other hand, the nursing profession has a subordinate status to the medical profession (Currie & Spyridonidis, 2016). The degree of control over work, which is the essence of ideal professionalism, is lower. Thus, the nursing profession shows weaker identification with and degree of adherence toward the professional logic (Gadolin, 2016).

The corporate and the market logic, related to NPM influences, characterize the managerial logic in healthcare organizations (Currie & Spyridonidis, 2016). The market logic uses competition and market signals for cost control and organizational improvement (Martin, Currie, Weaver, Finn, & McDonald, 2017). This logic advocates the availability of professional knowledge, and ideally there is free competition regarding preferences and choices of the consumers (Goodrick & Reay, 2011). The corporate logic uses managerial techniques to control professionals' behavior (Martin et. al. 2017). This logic entails administrative control performed by managers, in a context of hierarchy and routinized work. Managers evaluate performance of professionals and determine quality of products and services (Goodrick & Reay, 2011). Practices associated with the managerial role are for example proceduralization, evidence-based decision-making, and budget work and appropriateness (Iedema et. al., 2003). In short, in line with Currie and Spyridonidis (2016), the market logic and the corporate logic are combined as a managerial logic in this study, since it is focused on individuals with professional backgrounds in managerial roles.

Table 1. Elements of the institutional logics; profession, market and corporation

	Profession	**Market**	**Corporation**
Root metaphor	Relational network	Transaction	Hierarchy
Source of legitimacy	Personal expertise	Share price	Market position of the firm
Source of authority	Professional association	Shareholder activism	Top management
Source of identity	Quality of craft, personal reputation	Faceless	Bureaucratic roles
Basis of norms	Associational membership	Self-interest	Firm employment
Basis of attention	Status in profession	Status in market	Status in hierarchy
Basis of strategy	Increase personal reputation	Increase profit	Increase size of the firm

**Derived from Thornton et al. (2012)*

2.2.2 Individual responses to competing institutional logics

In order to analyze individuals' responses to competing demands, we use Pache and Santos' (2013a) framework of individual-level responses to competing logics as a guideline for our analysis. The framework considers individuals' degree of adherence to competing logics, and the degree of hybridity in the organizational context. Pache and Santos (2013a) present five types of responses to institutional logics in contexts with competing institutional logics, based on findings in previous research.

Ignorance is an unconscious response, due to lack of awareness of the logic and its demands, individuals simply do not respond to it. This can occur when adherence to another logic is so strong that it keeps individuals from seeing other perspectives (Pache & Santos, 2013a). In addition, they state that *defiance* to the contrary of *ignorance*, is a conscious response in which values, norms and practices associated with a logic are actively rejected. *Compliance* can be both a conscious and an unconscious response, and it implies complete adherence to the values, norms and practices associated with a logic (Pache & Santos, 2013a).

Compartmentalization is an active response in which the individual separates the competing logics, and adheres to different logics depending on the situation. Creed et. al. (2010) found that individuals in institutionally complex environments compartmentalized their behavior by adjusting it to the organizational context. Lok (2010) suggests that individuals not necessarily have to physically separate the logics to different context in order to use them parallelly. One specific type of compartmentalization is decoupling. Meyer and Rowan (1977) state that decoupling is used in situations when control and coordination of practices fail, leading to conflicts and loss of legitimacy. Legitimacy can be secured through decoupling (Pache & Santos, 2013a; Pache & Santos, 2013b).

Combination is an active response implying that values, norms and practices from competing logics are blended (Pache & Santos, 2013a). One way of combining logics is selective coupling; intact elements are selected from each competing logic and thus combined (Pache & Santos, 2013b). Pache and Santos (2013b) further state that selective coupling is used for hybridization of competing demands by combining elements from different logics. Svenningsen-Berthélem, Boxenbaum, & Ravasi (2018) define hybridization in line with Voronov, De Clercq, & Hinings (2013) and their research on institutional logics; engaging in multiple logics with the aim to solve contradicting elements between them. Individuals do so by combining selected features of the involved logics.

2.2.3 Factors influencing individual responses

Individual responses to competing institutional logics depend on the degree of adherence to each logic (Pache & Santos, 2013a). Individuals are more likely to adhere to a logic if they have knowledge about it, if the logic comes to mind and if they actually use it when acting. In other words, if the logic is available, accessible and activated (Thornton et. al., 2012). Pache and Santos (2013a) build on the work by Thornton et. al. (2012), and suggest that adherence to a logic is related to the degree of identification with it; if individuals have a low degree of identification with a logic, they are likely to ignore demands from the logic and if the degree of identification is high they are more inclined to comply with the demands. Pache and Santos (2013a) suggest a degree of identification ranging from novice, familiar to identified. According to Pache and Santos (2013a) a *novice* lacks knowledge of values, norms and practices associated with a logic, while *familiar* and *identified* individuals have this knowledge about the logic. Individuals that are *familiar* with a logic are aware of the demands associated

with the logic, but they do not automatically use this logic. Individuals that are *identified* with a logic derive their identity from adhering to it, are committed to it and motivated to see it prevail. Pache and Santos (2013a) also argue that a logic that is identified is taken for granted and likely to be used while it also can blind individuals from seeing other logics. Finally, adherence to a logic depend on if individuals' experience from adhering to it is positive or negative (Pache & Santos, 2013a).

Individual responses also depend on the degree of hybridity in the context. The hybridity is high if the competing logics are of equal strength. A high degree of hybridity indicates that individuals can resist influences of a logic without critical sanctions (Pache & Santos, 2013a). Organizations that are embedded in moderately centralized and fragmented fields, groups of organizations with similar values, goals and practices (Pache & Santos 2013a), are likely to face long-lasting competing demands (Pache & Santos, 2010). According to Scott (1992), the healthcare field is moderately centralized since there is dual authority with public authorities and management controlling funding in favor of centralization, and professionals in control of operations in favor of decentralization. Furthermore, a field is fragmented if it depends on critical resources from uncoordinated actors (Meyer, Scott, & Strang, 1987). Swedish healthcare organizations do not depend on uncoordinated actors, due to the central role of public authorities in controlling the field. However, they can still be considered fragmented, since their actors adhere to competing logics with competing demands (Nilsson, Stjernquist & Janlöv, 2016).[1] Since healthcare organizations face competing demands of similar strengths, there are multiple logics present and the degree of hybridity is high. Consequently, the model is adjusted to responses given a high degree of hybridity.

[1] Similar reasoning by Pache and Santos (2013b) in their study: despite that the state controls access to the field, the field remains fragmented since actors adhere to logics with competing demands on the organizations.

Figure 2. Individual-level responses to competing logics

		Logic A		
		Novice	Familiar	Identified
Logic B	Novice	**Ingenuous member** Ignore A and B	**Disengaged coalition member** Comply with A and ignore B	**Challenger** Comply with A and defy B
	Familiar	**Disengaged coalition member** Ignore A and comply with B	**Intermediary** Compartmentalize A and B	**Advocate** Compartmentalize A and B
	Identified	**Challenger** Defy A and comply with B	**Advocate** Compartmentalize A and B	**Hybridizer** Combine A and B

*Derived from Pache and Santos (2013), adjusted for contexts with high hybridity

2.3 Theory discussion

Specifically focusing on the competing logics that hybrid managers are exposed to, the framework of institutional logics has been adjusted to this research context, in accordance with how Thornton et al. (2012) stress that the most prominent institutions and elements of institutional logics depend on the research context. Thus, the institutional logic elements 'informal control mechanisms' and 'economic system' were excluded due to lack of applicability to our analysis.

Furthermore, the model is limited to the professional logic and managerial logic influenced by the corporate and market logics. However, working at public hospitals, hybrid managers are subject to a type of a state logic, a democratic logic (Blomgren & Waks, 2015). As stated in the theoretical framework, hybrid managers are more or less subject to all principal institutional logics in society; corporate, market, profession, state, religion and family. Since this study is focused on hybrid managers' responses to competing demands in their daily activities at work, the competing demands in this local context are the most valuable for our analysis. The hybrid managers in this study have a healthcare professional logic associated with their initial and

primary expertise, and a managerial logic from an additional expertise in management (Blomgren & Waks, 2015). Thus, the central competing demands in their roles stem from their professional background carrying a professional logic, and their current manager role associated with a managerial logic.

3 Methodology

3.1 Choice of method and research approach

3.1.1 Research strategy

When conducting this study, we had a constructive ontological position. We made the assumption that the realities of the respondents were not primarily formed by formal organizational elements, but mainly formed by the individual on a daily basis in the organization; the respondents' viewpoints were affected by how they developed experience and attitude towards their role. This corresponds with constructive assumptions that social phenomena are produced through social interaction and that these assumptions change continually (Bell, Bryman & Harley, 2019, p.27). Moreover, we believe that a hospital as an organization displays order, between physicians, nurses and others, that provide meaning of individuals' behaviors and points of view, which is in line with symbolic interactionism (Bell et al, 2019, p.27). With this in mind, we believe that the individual is socially constructed and that their perceptions form their view of the world.

Furthermore, we had an interpretive epistemology, as our objective was to understand rather than explain how hybrid managers handle competing demands (Bell et al, 2019, p.31). Also, this viewpoint is supported by the idea of phenomenology; how hybrid managers make sense of their role reflects how they handle competing demands. Furthermore, we believe that the study reflected a hermeneutic-phenomenological tradition; we tried to understand the positions of hybrid managers from their points of view, by entering into their shoes, and attempting to understand how and why they perform their role (Bell et al. 2019, p.31). Considering our interpretive epistemology, a qualitative research strategy was adopted, since we believed that qualitative data would better facilitate understanding of the realities of the respondents.

When doing our thesis project, we used an inductive approach (Bell et al., 2019, p. 23). We saw a phenomenon in real life, i.e. hybrid managers facing competing demands, that we wanted to understand in the theoretical world. Also, we needed empirical data to define further what theory was needed in order to analyze the phenomenon. Indeed, our process was iterative, as theory and empirical data formed each other, mostly when it came to thematic coding of empirical data. However, as we did not create new theory from theoretical data, we do not

propose that we have used a grounded theory approach, but rather applying theoretical elements in a less explored context.

3.1.2 Research design

When conducting this study, a cross-sectional research design was used. The cross-sectional research design is characterized by the collection of data on more than one case at a certain point in time. Since this study was focused on general findings rather than a comparison of unique contexts, the study is rather regarded as a cross-sectional study than a multiple-case study (Bell et al., 2019, p. 58). In our study a variety of cases were included; small and large clinics with different specializations located at different acute hospitals. However, such contextual variations were not the focus of our analysis.

3.2 Selection of respondents

There were two criteria for the selection of our sample: 1) They must be employed as medical operations managers and 2) they must work at public acute hospitals. The medical operations manager role was chosen to target managers with similar work descriptions working in similar hierarchical levels of their organizations. This far, the sampling was purposive, with the goal to target participants relevant for our research question (Bell et al., 2019, p. 391). However, the sampling within the acute hospitals was classified as a convenience sample, since we interviewed all respondents we got access to (Bell et al., 2019, p. 197).

This selection of respondents yielded a sample of medical operations managers with professional backgrounds as physicians, nurses and one other healthcare profession. The medical operations managers had zero to 18 years of experience as medical operations managers, both men and women were included and lastly, managers of different types of clinics at three public acute hospitals were interviewed. Managers matching the criteria were contacted via email, either directly or the email was forwarded via a superior manager or an assistant. In total, 57 medical operations managers were contacted whereof 20 responded and 13 were interviewed.

Table 2. List of respondents

Respondent	Hospital	Years of experience*	Sex	Professional background	Clinical work
A	Hospital 1	10	Male	Physician	Yes
B	Hospital 2	4	Male	Physician	No
C	Hospital 2	4	Female	Physician	Yes
D	Hospital 1	5	Female	Physician	Yes
E	Hospital 2	13	Female	Physician	No
F	Hospital 2	8	Female	Other healthcare profession	No
G	Hospital 1	9	Female	Physician	No
H	Hospital 1	15	Female	Physician	No
I	Hospital 2	8	Male	Physician	Yes
J	Hospital 2	1	Female	Nurse	No
K	Hospital 3	5	Female	Nurse	No
L	Hospital 2	0	Female	Nurse	No
M	Hospital 2	18	Female	Nurse	No

*As medical operations manager

3.3 Collection of empirical data

We chose to conduct semi-structured interviews (Bell et al., 2019, p. 436), as we thought that open questions would capture each respondent's point of view, while allowing us to cover the topics we aimed for. Before conducting the interviews, we prepared an interview guide.

Our interview guide was formed with consideration of our phenomenon of interest to generate useful material for our analysis. As we used an interpretivist epistemology for our study, we thought that open questions would be interpreted differently depending on which respondent answered. In this way, we aimed to capture each individual's thoughts on how to deal with competing demands in an environment with institutional complexity. Also, we thought that questions that were too closely related to our phenomenon of interest would incline the respondent to certain answers. Thus, we chose to ask questions that would allow the respondents to emphasize the competing demands they thought were most apparent in their everyday activities. In line with the formalities of semi-structured interviews, we started with

general questions about their backgrounds and their experiences of healthcare management, saving more specific and potentially sensitive questions for later (Bell et al., 2019, p. 219). We believed that this structure would prevent feelings of discomfort among the respondents and thus provide more honest answers. The probing questions and order of topics covered differed between the interviews. For example, we found that some respondents had more to say than others, and thus the probing questions differed, as well as the order of questions in our interview guide. By following the flow of each interview we tried to make the interviews feel more informal and conversation-like and less like a questionnaire. Moreover, after the first interview we removed a few questions that did not provide meaningful answers with regards to the research question. We also did some minor adjustments to formulations of questions that were not completely understood after the first interview, in order to avoid having to provide examples, since that can yield biased answers. All interviews were conducted in person.

During the interviews, one of us was responsible of asking the questions written in the interview guide and one of us was responsible of the recording of the interviews, asking probing questions and taking notes. However, the interviewer asking the questions from the interview guide asked probing questions when it was necessary and took notes as well during all interviews. In addition to recording, we chose to take notes of particularly interesting statements, with the purpose of comparing potential recurring themes in our observations in discussions and analyzes after the interviews. The interviews lasted between 27 and 77 minutes, for details see appendix 1.

3.4 Analysis of data

All interviews were transcribed within a few days after each interview. Parallelly to the interviews, we started to analyze the data, aiming to get an overview of reoccurring themes in the data, in line with our inductive approach. This initial analysis was based on a comparison of the questions in the interview guide. After all interviews, we conducted a thematic analysis in line with the definition made by Bell et al. (2019, p. 519). The interviews were empirically coded by both of us individually. The codes were divided into empirical themes. Together, we compared our themes that were derived from our empirical codes and included the themes that were the most relevant to our research question.

For example, the empirical code *the essence is knowledge in a clinic* belonged to the theme *the profession should manage healthcare*. This theme then corresponded to the final theme *a strong profession*. More specifically, the final themes were; *a strong profession*, *conflicting goals* regarding patient safety, employees and economy, *perceived scope of action* and *personal attitude*. In the next phase of the analysis, the empirical themes were inductively connected to theory on individual responses to competing logics. Minor changes were made to the empirical data when the quotations were translated from Swedish to English, in order to ensure that they were as understandable and close to the original meaning as possible. Thus, we translated the essence of the quotations, rather than the exact wording.

3.5 Discussion of methodology

3.5.1 Trustworthiness

To make our study as trustworthy as possible, the four criteria for trustworthiness suggested by Guba and Lincoln (1994) were considered. In order to attain credible research findings, we shared the quotations used in the final report with the respondents for validation. By using respondent validation, we aimed to make sure that our empirics corresponded with the respondents' experiences. Furthermore, we recorded and transcribed the interviews to make sure that our understandings of the data were distorted to the least possible degree in our analysis of the data.

The degree of transferability depends on our ability to produce thick descriptions of the researched phenomenon. Our sample only consisted of 13 respondents and although we experienced that responses during the interviews were repeated to some extent during the last interviews, we probably did not reach empirical saturation. Although the experiences from a limited number of respondents were presented in the study, we tried to present as detailed descriptions as possible about the respondents.

Some degree of dependability was achieved through participation at seminars, as our supervisor and peers followed the progress of our thesis project. However, a significant part of the work and the finalization of our analysis was conducted without our supervisor or peers involved. However, all our work has been documented and saved throughout the process and is accessible for possible auditing.

Lastly, we tried to make the study as confirmable as possible by comparing our interpretations of the findings throughout the project since the respondents' answers could be interpreted in several ways. Therefore, we discussed our interpretations of the respondents' experiences after each interview and produced empirical codes on the interviews individually, which we compared and modified before analysis of the data.

3.5.2 Ethical considerations and implications

Throughout our thesis project, ethical considerations with regards to the participants were taken into consideration. In order to ensure that we did not disregard any principal ethical aspects with regards to the participants, the four main ethical principles by Diener and Crandall (1978), cited in Bell et. al. (2019, p. 114), were considered; harm to participants, lack of informed consent, invasion of privacy, and deception. Prior to the interviews, we granted anonymity to the respondents with regards to their names and clinics. However, throughout the interview process we realized that additional measures to secure anonymity were necessary in order to avoid potential harm and invasion of privacy from recognition of their statements. Consequently, we anonymized the names of the organizations. In order to avoid any deception and to enable informed consent, we made sure that the respondents were aware of the purpose of the study in broad terms prior to the interviews, by explaining our interest in their roles as hybrid managers, considering the complexity of the environment they operate in. However, to avoid potentially biased answers, we did not specifically mention our phenomenon of interest; their responses to competing demands. In addition, we aimed to ensure informed consent by being transparent about that the interviews only would be used for the purpose of this bachelor thesis, asked for allowance before recording the interviews, and informed them that the interviews would not last for more than one hour.

4 Empirics

4.1 A strong profession

Most respondents emphasize the centrality of professionals and high expertise in the hospitals. The professionals are the ones knowledgeable about the operations, as D expresses it: "*The clinic has best specific knowledge regarding what we need*". The professionals are also inclined towards questioning decisions, as E describes it: *"That is in part what governing of healthcare is about, that it is a little, the dilemma indeed, that professionalism is really strong and people have quite a lot of objections"*. This has implications for their roles as managers, in that they adjust their behaviors to what suits the employees and value employees' acceptance. Acceptance is in many cases gained through their educational backgrounds, as C explains: *"One has to have completed a Ph. D. and done research if one is going to be a person that people like".* Acceptance is also gained through clinical work, as D explains: *"And I think that it provides a certain credibility if people see that I can contribute, I can roll up [as in roll up their sleeves], and that I can do things, [...] So I am almost always changed [to scrubs] and ready"*. Several respondents also emphasize the importance of building relations with their employees, as L explains: *"And I think that it is important that one is close to the operations, partly so that I understand what is happening and partly for the others to know who I am and have faith in me".*

With regards to the managers, a few mention that they never had the intent of becoming managers. For example, B explains:

> *"And then, because I was not very interested in being a manager, but very interested in that the clinic is functioning. Thus, I decided to take on the role, and now I have been manager for four and a half years. And have tried to protect the clinic so that it can continue its operations."*

Even after fifteen years as a manager, H wears scrubs and explains that she would have liked to work clinically if she had the time: "*Now I do not work clinically anymore, which I would have liked to do."* On the other hand, several respondents with backgrounds as nurses have another attitude to the managerial role. As M mentions: *"As for me, the nursing role and*

healthcare part has faded away, and, I would rather say that I am a manager these days". K describes how her managerial practices were not always appreciated:

> *"They are so tired of me when I say that we have to create a business plan for this, and at top management level, all the physicians sitting upstairs. 'Business plan, that is what one does in the business sector'."*

Also, many respondents describe an informal hierarchy of competence in healthcare, as hybrid managers who have backgrounds as physicians emphasize the importance of their professional background in the managerial role, while hybrid nurse managers rather emphasize how physicians' views on their professional background might challenge them in their roles as managers. M says the following:

> *"There is a hierarchy that one needs to take into account. So my, I would not say that I have any strategy, but one must think rather, if one wants to get through with certain decisions. So it is about, which it always is, preparing oneself, finding out, what people you need on board."*

4.2 To be a professional in a managerial role

Although a majority of the respondents highly value professional competence in the managerial role, two of the respondents are to a higher degree than the others guided by their own and their fellow professionals' competence in their role as managers. Respondent A expresses the important role of the professionals: *"One cannot overrule people here. There is no wish to do so either one can say".* B highly values the consideration of the professionals:

> *"But the challenge is, if one pictures that I work with people that have 15 to 20 years of education they can, indeed, my challenge is that, and that is the case really regarding leadership in general, I can give orders, but it will not work if I cannot motivate it, that the order is in line with what the people who work want to achieve."*

Furthermore, respondent B prioritizes acting in line with his values, above following directives from the hospital management:

"But if some middle manager somewhere gets angry with me because I have not delivered something the hospital says one has to deliver, that I do not put a great strain on, I do some sort of moral hierarchy regarding what is important and what is less important and what is completely unimportant."

Accordingly, it is clear that not all directives are followed by B:

"And that is somewhat the role as manager, and what I have been taught from a management course, it is to protect the clinic from stupid directives. So one always has to carry out something that is called confidentiality assessment or impact analysis for a directive, so. To determine whether it is feasible or not."

Both these managers express dissatisfaction in their managerial roles, since organizational demands make it difficult for them to lead their clinics as they wish. Respondent A explains a situation in which he does not agree with the cost efficiency measures proposed by public officials:

"They think it is expensive to have it [the clinic] at the hospitals. And we argue that this clinic is needed at a hospital in order to take care of patients who have [organ]-diseases at the hospital [...]."

It appears that A thinks that public officials in charge of funding do not have a proper idea about the ideal solution: *"And the arguments they came up with, they were bad, they were weak. And we had strong arguments to keep it [the clinic]".* However, A manages to keep his clinic open, although closing it would have been more cost efficient. On the other hand, B is overwhelmed by bureaucracy and centralization: *"That was why I gave notice, I was given responsibility for two clinics, but did not get the authority to reorganize the way I wanted".*

4.3 To be both a professional and a manager

Many of the respondents have a more balanced approach, in which they are also guided by managerial directives in their work. M explains her role as a hybrid manager as: *"Because one has, the political organization and also our own organization. And the aim as a manager is to unite these two worlds.".* This way of thinking is reflected in the actions of a majority of the

managers. It appears that they not only consider the professional perspective, but also the managerial perspective. G explains:

> *"[...] it can be different stakeholders that think one thing is more important than another, and thus one must reach consensus such as compromise. That is how it is, and I also think that it is very difficult if one is black-and-white."*

Overall, the work of many respondents is characterized by elaborations to enable cost efficiency demanded by superior managers, while not intruding on healthcare practices that would jeopardize patient safety. J expresses how she works in such manners: *"They rather want to achieve efficient processes so that the patients leave faster so that we can accomplish more care events (vårdtillfällen), then we might not have to save money. Sometimes one can work in smarter ways".*

A common behavior among the hybrid managers is to adjust their behavior to the situation, in order to both satisfy needs of their managers and their employees. Respondent I satisfies managerial demands in some situations, such as delivering on budget, but ignores them in situations when directives are deemed to have serious consequences: *"Sometimes I am given directives from my manager like 'now you must do like this' and then I go out of the room and do not tell anyone about it, because it is wrong, and it will not fall through".* Similarly to respondent B, respondent I sometimes ignores implementing decisions. However, respondent I also puts emphasis on adherence toward senior managers:

> *"And if my manager thinks it is most important to deliver exact numbers of production every week the last two weeks, like this or that, then one has to deliver that and explain why and preferably come up with a plan, one must be able to handle, one must play their closest manager in a good way."*

Several other managers share this type of behavior regarding behavioral adjustments to the situation, although they are inclined to being more loyal toward directives. For example, D says:

> *"And we try, evaluate, does it work? Yes, but then it is just to adjust, that was that. Or we must modify something to make it work, then we do that, and then we evaluate again. Or*

also one says 'this was not good, this we do not do', because, that happens. Everything we come up with does not happen, that is the case."

While these respondents are loyal to managerial directives, they also focus on satisfying professional needs, such as delivering high quality care, being autonomous and using their expertise in ways that do not interfere with the managerial objectives. Several managers provide a feeling of choice to the employees. J exemplified this matter:

"I had created that model which I thought was good and my employees thought was good, but now we would to change to the new one. And then, for me, it is very much about learning this new model and how I can pitch it in the best possible way."

L highlights that acceptance among employees is easier if they feel like they have the possibility to choose between options:

"In order to make it, one has to think, and that may be a shortcoming of mine, that much earlier, start the bureaucratic process first. The danger with that, is that things leak, and an employee group might overhear, 'you planned that we should move but we did not get informed'. Do you think they want to move then or do you think something else happens? [...] They do not want to move."

4.4 To be a professional manager

Most respondents express an acceptance of the organizations they operate in, and an adaptation to what is demanded from them as managers. Although most respondents actively try to satisfy both demands from their superior managers and the professionals, some appear to struggle more with conflicts between objectives than others. The following respondents not only think that high quality of healthcare and cost efficiency are compatible, but they also combine their professional expertise for managerial purposes. H reasons that, although she finds it difficult to make time for development, it does not only improve quality, but also cost efficiency: *"And if one were to calculate the costs for a resource, and what time costs and that you reduce costs regarding other aspects. Quality, better quality makes it cheaper."* C thinks that budget allocation based on production makes sense in healthcare:

"Money should follow the patient, I do not find that strange. I think it is right, how else would it be? It has not been, it was not like that three years ago. It was just a large budget. One received 97% of the money even if one did not produce according to plan. And I do not think we can work like that, and it might be so that I think like this because I have worked at [private hospital], it was another way of thinking."

E argues that improving cost efficiency can be seen as an opportunity:

"They treat way too few patients and they cost too much. Well, then one has the opportunity, one can see the opportunities as well, no but then one maybe also has to merge it with another unit. [...], how one chooses to see it."

F is another respondent that recognizes the possibilities of cost efficiency. She improves efficiency by carefully considering the quality of care:

"It may be the case that when evaluating treatment we see that between treatment five and treatment ten, not much is happening and then we conclude that five suffice. And then we give five, it would almost be unethical to give five additional. Because otherwise it would actually mean that some other patient would have to wait longer for their treatment."

These respondents combine different objectives without compromising any of them, as C explains it: *"All the time, and I think that I do not try to compromise with what we have to do, budget targets and so on, but it is very much about negotiating with different people."* However, when managerial demands are incompatible with the operations, they take the professional perspective to the managerial side of the organization. For example, K brings politicians and representatives from higher hierarchical levels closer to the operational work:

"Yes, we are governed by politicians and we have very good communication, I have all politicians here all the time. [...] So that is why they have to get down here, to the reality. So I work, since I have worked in the private sector as well, so I work, I lobby quite a lot, I work as a lobbyist."

With consideration of the patients, E presents well-grounded arguments to superior managers:

"This we can manage to save, but should we save more, well, then one has to shut down the [disease]-practice, or, one often takes the most drastic one. Well, then they say no to that and then somewhere one will get through with it. But then one has to, one needs to have quite good arguments, when one gives the proposal."

However, they also carefully consider managerial demands, and it characterizes their thinking and acting. K argues that she puts her own attitude aside:

"No, I think it is very important that, even if, I can express my opinion and why I do not think it is a good decision, but when I step out from top management and they have decided that we should do this, then I have to be loyal toward the decision, and that, then it is important that I do not forward my discontent downwards in the organization."

E reasons that it is important not to refuse adherence to decisions from higher hierarchical levels:

"I have a feeling that, if one owns the matter, not just sweeps in and says no, we are not, we are not going to do this, or we are not, well then it gets, then it usually happens anyways in a way one cannot control."

K is decisive, but at the same time leaves room for professional knowledge to change her mind:

"I am decisive, I want my employees to know that there is no hidden agenda, that is, if I say yes that means yes, if I say no, then it is actually a no. Then they have to prove me wrong, that it is a good idea, and then one can change one's mind of course."

Some of the respondents indicate a holistic view on their work and connect their work with the organization as a whole, as C explains:

"My subordinate managers, it can be easier or harder for them in different ways, and then you have to, well one might have to give some and the other take some, and then it is about talking to them, it is also lateral between us medical operations managers, that we have to, settle with each other."

5 Analysis

Generally, the respondents appear to be primarily guided by the professional logic rather than the managerial logic. This has implications for their responses to competing demands in their day-to-day activities. A majority of the managers are clearly identified with the professional logic. Their identification with the professional logic is expressed through their emphasis on the fact that professionals have the best knowledge about what the organization needs, which corresponds with the traditionally high degree of self-regulation in the medical profession (Freidson, 2001), and through their emphasis on medical professional expertise and quality of healthcare in their work as managers. The quality of healthcare is always prioritized, and the medical professional expertise is used as a source of legitimacy and is gained through PhD:s, clinical work experience and continuing to work clinically while still being a manager. The identification to the professional logic is generally apparent even after many years working as hybrid managers, as for example respondent A. This corresponds with previous research suggesting that hybrid clinical managers remain committed to their professional logic. (Montgomery 2001; Byrkjeflot & Kragh Jespersen, 2014). This phenomenon is more prominent among the respondents with backgrounds as physicians, than the respondents with nursing backgrounds.

The respondents with nursing backgrounds generally adapt more to the managerial logic, which is expressed through their identification as managers, acceptance of top management authority and not supporting the bottom-up hierarchy in the same way as the physician hybrid managers. This finding corresponds with previous findings suggesting that hybrid physician managers remain committed to their professional identities and clinical work, while hybrid nurse managers identify more as managers (Skjøld Johansen & Gjerberg, 2009). Furthermore, this observation can be supported by previous findings indicating that nurses' degree of identification with the professional logic is not as strong as physicians' (Gadolin, 2016). While a similarity among a majority of the respondents is a high degree of identification with the professional logic and adherence to the identified logic as suggested by Pache and Santos (2013a), the degree of identification with and adherence to the managerial logic varies.

Two of the respondents, A & B, can be referred to what Pache and Santos (2013a) define as *challengers*; they actively defy the managerial logic in order to prevail their strongly identified professional logic. They emphasize the importance of professional expertise by expressing that

professionals know best and that top managers and public officials do not understand what their clinics need. These respondents have a hard time accepting top management authority and cost efficiency incentives in accordance with the managerial logic of healthcare. In their work, they protect their professional identity and try to defy the managerial logic. For example, B highly values the professionals' opinions, acts in line with his values rather than following organizational demands and protects the clinic from managerial demands. This implies that his professional logic, with emphasis on professional expertise and authority derived from the professional association rather than hierarchy, as suggested by the managerial logic, guides him in his role as a manager. Although protecting the clinic from managerial demands in itself is a practice of decoupling (Meyer & Rowan, 1977), B's practices are characterized by defiance of the managerial logic rather than symbolic adherence to it and co-existence with his professional logic. The defiance is further supported as B decides to quit when he cannot organize his clinic in line with his professional values due to decisions at higher hierarchical levels and bureaucratic rules, which secures adherence to the professional logic and protects his professional identity.

Moreover, A also distinguishes himself from the other respondents by being almost entirely guided by his professional logic. He expresses frustration towards authorities that want to improve cost efficiency by shutting down his clinic. Although it is possible that his action is partly driven by self-interest in this situation, it is clear that he is reluctant to how the organization is managed. He does not see the bigger picture of cost efficiency and he is prepared to act in order to maintain what he considers as high-quality healthcare. In arguments with public officials, he defies these managerial demands by using his medical professional expertise about the needs of the patients as a source of legitimacy, and manages to keep the clinic open and thus fully satisfy his professional demands of quality of care. In brief, A & B's defiance of the managerial logic can be explained by negative experiences of compliance with it (Pache & Santos, 2013a). These observations are supported by previous research findings on that hybrid managers tend to retain their professional logic (Montgomery, 2001; Byrkjeflot & Kragh Jespersen, 2014).

Several respondents resort to a strategy in which they generally compartmentalize the professional and managerial logics, D, G, I, J, L and M, and manage to comply with and resist both logics parallelly. Pache and Santos (2013a) refer to these individuals as *advocates,* as they are familiar with one and identified with the other. They use these logics in different contexts

in similar ways as found by Creed et. al. (2010) and Lok (2010). The compartmentalization is manifested through adherence to top management authority, while parallelly satisfying demands from the professional logic.

Some of them are identified with the professional logic and familiar with the managerial logic. Without actively defying top management authority and cost efficiency and control that compete with the professional logic in meetings with superior managers, they find other ways to comply with the professional logic of self-regulation (Freidson, 2001). Commitment to the professional logic in their managerial roles indicates that they derive their identities from this logic, since it enables them to maintain their professional identities. Respondent I exemplifies decoupling as a way of compartmentalization, as he emphasizes meeting demands from his manager, while ignoring what his manager tells him to do if he deems that the decision implies unwanted consequences violating his professional logic. This way, he secures legitimacy (Pache & Santos, 2013a; Pache & Santos, 2013b) by displaying adherence to the managerial logic without violating his professional identity. By adjusting his behavior to the context, he compartmentalizes as described by Creed et. al. (2010).

Compartmentalization is expressed in various ways. Some managers compartmentalize by parallelly adhering to both logics but not necessarily in different contexts, as suggested by Lok (2010). While being loyal to decisions made at higher hierarchical levels about cost efficiency that compete with the professional logic emphasizing self-regulation and high-quality care, they find other ways to prevail their professional identity by adhering to the professional demands parallelly to the managerial demands. One way of adhering to the professional logic parallelly to adhering to the managerial logic, is to emphasize collegiality and self-regulation in local contexts with fellow professionals. For example, respondent D manages to separate her professional logic and managerial logic. She accepts that she cannot control managerial demands and thus adheres to top management authority and cost efficiency. However, she also adheres to the professional logic locally at the clinic and this way prevails her professional identity. She gains legitimacy in the workgroup by working clinically and she emphasizes consensus with subordinate managers, as she highlights the importance of having them on board, which corresponds with the self-regulation of the medical professional logic. L emphasizes that she provides employees with a feeling of choice when there are managerial directives that have to be followed and similarly as D try to get the employees on board. Another compartmentalizer is respondent G, who explains that she finds it important to see

both perspectives and adjust to different stakeholders, indicating that she adjusts her behavior depending on the situation. Another way in which the respondents compartmentalize by parallelly adhering to both logics as described by Lok (2010), is to elaborate with solutions to ensure that the managerial directives do not affect daily operations negatively. They use their professional expertise to work in smarter ways, in order to satisfy cost efficiency demands, without violating self-regulation and value in quality of craft associated with the professional logic. This is exemplified by J when avoiding cutting down by working in 'smarter ways'.

Some of the respondents who compartmentalize rather show a stronger degree of identification to the managerial logic than the professional logic. Two respondents with nursing backgrounds, J and M, display understanding of the professional logic by using it to gain compliance from the professionals. They try to get the professionals on board and to provide a feeling of choice, proving that they acknowledge the professional autonomy. However, they indicate a stronger identification with the managerial logic. This line of reasoning corresponds with Gadolin (2016), who argues that nurses have weaker degree of identification with their profession.

Some managers, E, C, F, H and K, indicate identification with both the professional logic and the managerial logic and act as what Pache and Santos (2013a) define as *hybridizers*. They exhibit a strong desire to succeed from both a professional and a managerial point of view, indicating commitment to both logics. By using different methods to combine the two logics, they find ways to fully enact both. They differentiate from those who compartmentalize by combining both in the same practices and conceptualizing them as compatible. For example, C does not compromise with managerial demands and thinks that budget control based on production targets, in line with the managerial logic, is an evident way to govern healthcare. The combination of logics also appears in H's perceptions, when she links improved quality to cost efficiency to motivate development. Combination of logics in practices, is for example expressed when F balances how much patients are treated by using medical professional expertise when working on cost efficiency. All hybridizers, in comparison to the other respondents, express a holistic view of the organizations, considering the success of the entire organization in addition to the success of their own clinics. A holistic view, in which their clinics are part of the whole organization, implies that they identify as organizational members that try to contribute to the success of the organization as a whole in line with a managerial logic. Thus, they both take into account the managerial directives aiming to benefit the

organization as a whole, and combine this with their professional logic to ensure quality of care at their clinics.

Furthermore, *hybridizers* fully enact the managerial logic by adhering to the top management authority and organizational goals of cost efficiency. They also fully enact their professional logic by using their professional expertise as a source of legitimacy in order to influence decision making at higher hierarchical levels, when the quality of care is at stake. Thus, they use both logics in the same context. When using their professional logic in meetings with superior managers they find it important to have well-grounded, evidence-based arguments. This way, they combine the logics by making use of the professional expertise, but simultaneously adjust to the managerial logic of evidence-based decision-making rather than relying on the individualized trust of the professional logic (Iedema et. al., 2003). This behavior corresponds with the concept of selective coupling (Pache & Santos, 2010). The identification with both logics that Pache and Santos (2013a) refer to as hybridization, is common among respondents with extensive experience of the managerial logic, either through long experience as hybrid managers, or through work experience in the private sector in line with how Pache and Santos (2013a) suggest that work experience influence adherence to institutional logics. This corresponds with Kurunmäki's (2004) finding that healthcare professionals introduced to another logic hybridized over time.

6 Discussion and results

6.1 Answer to the research question

With the purpose to understand how hybrid managers handle competing demands from the clinical sphere of health and the managerial sphere of health, we analyzed hybrid managers' responses to competing institutional demands in their organizational contexts. The analysis was conducted using theories on institutional logics and individual responses to institutional complexity, in order to answer our research question stated as following:

How do hybrid managers respond to competing demands in day-to-day activities?

The findings show that hybrid managers face competing demands between the professional logic and the managerial logic. Their responses to competing demands are shaped by their generally strong identification and familiarity with the professional logic. It is clear that all hybrid managers do not respond in the same way to similar contexts. This corresponds with previous findings by Lok (2010) about how individual responses may differ in the same context.

A minority of the respondents respond to the competing demands by primarily being guided by the professional logic and defying the managerial logic. They highly value the professional expertise of their colleagues and are guided by their professional expertise in their daily work. Both respondents have negative experiences with the managerial logic and act in order to prevail their professional logic when it competes with the managerial logic. Primarily guided by the professional logic, they classify as 'incidental hybrids' (McGivern et. al. 2015).

Most of the hybrid managers adopt the managerial logic, and let it co-exist with the professional logic. These managers fit into what McGivern et. al. (2015) describe as 'willing hybrids'. However, the extent of adoption of the managerial logic varies as one group combines it with the professional logic to a higher extent than the other group, which rather lets the logics exist side by side. A common response is to primarily mediate between the logics by compartmentalizing the logics and adhering to competing demands from both logics parallelly. This type of response corresponds with previous of hybrid managers mediating between logics

(Llewellyn, 2001; Doolin, 2001). The compartmentalization is done through decoupling, adherence to different logics in different contexts or adherence to different logics parallelly in the same context. Some managers instead combine the logics by conceptualizing them as compatible and using both in the same practices, and thus indicate hybridization to a higher degree than the other respondents. The behavior of these managers corresponds with previous finding of hybridization among hybrid managers (Blomgren & Waks, 2015; Kurunmäki, 2004).

A factor shaping the responses is the professional background. Hybrid physician managers are more identified with the professional logic than the managerial logic, in comparison to hybrid nurse managers. Hybrid physician managers use their professional expertise as a source of legitimacy, acknowledge authority of the profession, and to a higher degree identify with their professional skills and education than hybrid managers with nurse backgrounds.

6.2 Discussion

6.2.1 Contribution and practical implications

This study contributes with insights on how professional work of hybrid managers in Sweden is influenced by institutional complexity. The findings indicate that individual responses of hybrid managers with strong professional identification compared to the identification with the managerial logic, might have challenges dealing with managerial objectives influenced by NPM. Hybrid managers have been proposed as a solution to integrate competing demands in healthcare. In theory, hybrid managers appear to be an evident and easy solution. However, in practice the role is tackled in numerous ways. It is clear that the many years of education and practice of healthcare characterize their responses to the competing logics they face in their managerial roles. Professionals being managers does not necessarily imply that they do not identify themselves as professionals anymore. Although the professional logic can be useful in many ways to essentially ensure that managerial directives are in harmony with clinical work, it appears that the work is easier done if the managerial logic is complied with rather than defied. Thus, this has implications for the efficiency of hybrid managers. Generally, this group of individuals can make use of their professional backgrounds in their managerial roles to more efficiently handle professionals and superior managers. However, their effectiveness as managers can be questioned if the identification with the professional logic remains strong and they defy the managerial logic.

6.2.2 Limitations

This study is focused on two main competing logics central to the hybrid manager role, the professional logic and the managerial logic, that were identified in the empirical data. A more thorough analysis of all institutional logics that appeared in our data could have yielded a more nuanced understanding of the logics at play. More specifically, we found features in our empirical data that could be connected to the state logic, but it was not included since it was not central in shaping their responses in day-to-day activities. The prominent competing demands originated from the professional and managerial logics. Thus, this study provides a simplified picture of the logics at play.

Our interpretive view of the world may have resulted in biased findings, since we from the start of this thesis project anticipated finding major conflicts in their work as hybrid managers. Another limitation is that a few interviews were short, approximately thirty minutes long. This limited our understandings of their responses, and there is a risk that not all competing demands and their true responses to them were captured during the short interviews. However, since the responses differed among respondents working at the same hospitals, in the same role and approximately the same time, it seems like the interviews yielded material on particular competing demands they experienced.

6.2.3 Implications for future research

Since this study, and previous research, indicate differences in the logics used by nurses and physicians in managerial roles, more thorough studies of how the responses differ could be conducted. There could also be done more studies on how these two groups respond to competing demands in managerial roles with the purpose to produce generalizable findings, since this would have implications for their efficiency in the role and thus recruitment.

Since our findings indicate that the professional logic is prominent even when professionals have worked as managers for many years, research on other managerial levels could be conducted, in order to get an overview of how prominent the professional logic is in comparison to the managerial logic at different managerial levels. Such studies could gain insights on how responses are shaped by professionals' managerial experience. Lastly, studies with the purpose to investigate all institutional logics at play in healthcare organizations, largely conflicting or not, could be conducted in order to better understand their dynamics.

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8 Appendices

8.1 List of interviews

Respondent	Date	Interview length
A	14-02-2020	47:54
B	18-02-2020	77:47
C	18-02-2020	47:08
D	21-02-2020	39:22
E	21-02-2020	50:45
F	24-02-2020	53:37
G	25-02-2020	27:14
H	25-02-2020	42:38
I	26-02-2020	35:50
J	26-02-2020	29:34
K	27-02-2020	59:01
L	06-03-2020	38:10
M	11-03-2020	49:38

8.2 Interview guide

Interview guide

Ethical considerations:

- Participation in the interview is voluntary and you are free to cancel your participation at any time.
- Things mentioned during the interview will only be used for our bachelor thesis.
- In the bachelor thesis that this interview will be used for, your name, the name of the clinic you manage and the name of the hospital you are employed at will be anonymized. It will be mentioned that the study is conducted within Sweden.
- Do you allow us to record the interview, so that we can transcribe it?
- Do you have any questions before we begin?

Opening questions

What is your journey to the role as medical operations manager?

- If not answered, ask the following questions: Om vi inte får svar, ställ följande frågor:
    - For how long have you been a medical operations manager?
    - For how long have you worked within healthcare?

What do you do during an ordinary day at work?

What is your view on your role as medical operations manager?

What do you consider important in your role as a medical operations manager?

Questions about governing mechanisms
How do you experience governing from higher hierarchical levels?
What is your scope of action to influence the governing of the clinic that you manage?

Questions about the work as medical operations manager in relation to professionals
How does the decision-making at the clinic function? How are decisions made at the clinic?
How do you experience implementation of directives from higher hierarchical levels in the daily operations at the clinic?

- Higher hierarchical levels:
    - Politicians/public officials
    - The hospitals' top management team

How do you experience your possibilities to consider professionals' viewpoints about how the clinic is managed?
How is your relationship to the physicians/other professionals at the clinic, given your role as medical operations manager?

Questions about challenges
What do you find challenging in your work as a medical operations manager?
What situations emerge in your work in which you have to compromise between different goals?

- What is your experience of having to compromise?
- How do you make decisions when you have to compromise?
    - How do you consider different goals when compromising?

If it occurs that governing from higher hierarchical levels is not adhered to, why is that?
Do you experience that you have prerequisites to do what you consider is a good job, in your role?
Concluding questions:
What should we have asked that we did not ask, to really understand your situation?
Do you want to change any answer?
If we would have any questions, is it alright that we email you questions for clarification?
If we include any quotations or so, in the final thesis from this interview, you will get the opportunity to confirm them before we hand in the thesis.