

# Managers' Identities: Solid or Affected by Changes in Institutional Logics and Organisational Amendments?

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## Abstract

This paper studies doctors in Norway and Finland to compare how identities among professionals in managerial positions were expressed after changes in management in the aftermath of 'New Public Management' (NPM) reforms. Studying shifting identities provides a basis for investigating how institutions have changed and illuminates how agents within an organisation have implemented NPM-inspired reforms. Data from both countries revealed three groups: the majority of doctors/managers, who had a strong managerial identity; a smaller group who mainly identified as doctors; and a few doctors who displayed hybrid identities. Work experiences have a strong effect on how identity is perceived. Doctors who hold on to their professional identities seemed uneasy with their skills and ability to perform the tasks related to their new position. Many of the doctors were found to have altered their identities due to organisational amendments and the expanded focus on management-related issues. Hence, this paper concludes that a strong intervention in the sector from central government, as seen in Norway, has resulted in implementing general management to a larger degree than in Finland, but in a more hybrid manner. This is expressed through a focus on management, the institutional logics at stake and doctors' identity formation.

## Introduction

In this paper, we address changes in management by studying how the introduction of new institutional logics through public sector reforms has influenced the professional identity of doctors in management positions. We compare doctors in management positions in the hospital sector in two countries: Finland and Norway. Our aim is to study professional identities among doctors who hold managerial positions created by the 'New Public Management' (NPM) reforms.

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The reforms introduced new institutional logics, organisational structures and routines, prompting the question, ‘How do hospital managers who are also doctors interpret their professional identities?’

The concept of NPM was introduced to the public sector with the aim of improving quality, customer orientation and customer satisfaction whilst reducing administrative costs and increasing cost-effectiveness and productivity (Skälén, 2004). As in the private sector, the public sector requires extensive structural changes, and due to changes in the operational environment, it is facing major economic and political pressures to reach greater levels of efficiency (Mönkkönen & Puusa, 2015). Increased accountability (Christensen & Lægreid, 2011; Pollitt & Bouckaert, 2011) and strengthening managerial roles are two major solutions to achieving these improvements. These have been attempted by altering managerial structures and introducing new managerial logics with a greater focus on economy, efficiency, budgetary discipline and cost reduction.

Identities give actors a sense of who they are, what qualities are central and distinctive to the actors, who their colleagues are and how to function and act meaningfully within a certain context (Ashforth, 2016). Identity can be divided into individual identity, which is tied to a person’s perceived self, and professional identity, which relates to the experience, values, attitudes and beliefs of the specific profession (Hall, 1971; Spehar, Frich & Kjekshus, 2015). This study focuses on two sets of professional identities – that of doctor and that of manager. Identities are viewed as potentially fluid and on-going social constructions of the self. The process is not without direction (Andersson, 2015), and it can be viewed both in the light of identity tied to professions and the influence of identity through changes in institutional logics. Institutional logics explain how institutions can influence actors’ values, practices and sense-making (Friedland & Alford, 1991; Reay & Hinings, 2009). The connection between institutional logics and identity is that institutional logics also provide identities for the actors – the introduction of new institutional logics might disrupt actors’ identities (Sanders & McClelland, 2012). According to institutional theorists, a logic can dominate in an organisational field while also coexisting with other logics (Scott, 2008). How new logics are received in an organisational field depends on their relation to the prevailing logics (Fjeldbraaten, 2010). Changes in logics due to structural changes following reforms and the introduction of new managerial logics are challenging. The main source of these challenges is incompatible organisational cultures (i.e. conflicting identities) (Bartels, Douwes, de Joung & Pruyn, 2006; Puusa & Kekäle, 2015).

The number of studies focusing on doctors in managerial positions is growing (Andersson, 2015), and many have found that doctors have been reluctant to adopt new managerial roles and responsibilities (Spehar, Frich & Kjekshus, 2012). Still, by entering into these positions, they are combining medical and managerial leadership (L. N. Berg, 2015; L. N. Berg & Byrkjeflot, 2014; Jespersen, 2005; Llewellyn, 2001). Doctors’ leadership in hospitals is also connected to an identity challenge (Andersson, 2015). Professionals develop an identity throughout their education and socialisation (Scott, 2008), and according to

many scholars, this identity is considered to be relatively stable. Others, however, argue that identity can fluctuate when new roles are taken on (Hall, 1971; Spehar et al., 2015). According to some researchers, organisational members might perceive changes to be threatening '[when] it confuses the stability and endurance of their current identity conception' (Puusa & Kekäle, 2015: 432).

The argument for studying the nature of the professional identity phenomenon is that it is assumed to be fundamental to understanding how institutions have changed (Reay & Hinings, 2009). Changing deep structural factors such as identity and values is necessary for a successful transition to manager (Spehar et al., 2015). This is a way of investigating how actors within an organisation have implemented the NPM-inspired reforms. The research gap we address is how the identity of professionals in managerial roles reflects the NPM influence on management. Brown (2015) emphasises that there is a pressing need to increase our understanding of identity creation and the ways in which roles and identities co-evolve in organisational life. There is an increasing awareness for the need to improve scholarly knowledge on the meaning of identity in successful reforms, particularly regarding factors influencing professional identity (Dobrow & Higgins, 2005).

This paper contributes to the field in two ways: 1) it addresses identity construction related to career paths by focusing on doctors entering managerial positions, and 2) it studies the interplay between identity and institutional logics by examining the socialisation that has taken place through the introduction of NPM reforms and new institutional arrangements. By comparing a profession in countries that have chosen different types of NPM reforms, we can study how resilient identities are among doctors who work under different organisational structures and routines as well as how they reflect the logics that appear in the doctors' managerial work. According to Ashforth (2016), most studies of identity and identification use quantitative approaches. We address the research gap by applying a qualitative case study strategy and a comparative approach. Our aim is to understand the target phenomenon by analysing rich qualitative data in order to deepen our knowledge of identity among professionals entering managerial positions as well as to identify and introduce new theoretical insights (Piekkari, Welch & Paavilainen, 2009).

In the next section, we introduce the existing theoretical views on professional identity and institutional logics. Thereafter, we describe our methods and the recent reforms in each country together with an introduction of the case studies. In the analysis section, we highlight our findings according to the theoretical backdrop. We compare between the cases in the discussion section, and the paper ends with a conclusion and suggestions for further research.

## Professional identity

There is increasing scholarly interest in professional identity construction; this refers to people's professional self-concept, which is based on attributes, beliefs, values, motives and experiences that influence how they define themselves in a

professional role (Ibarra, 1999; Slay & Smith, 2011). At work, actors display and make sense of who they in many ways. Here, we focus on professionals who have entered into managerial roles after practicing their original profession as doctors. The professionals in question have experiences from both professional and managerial roles in their 'home' institutions.

A role is viewed as an external attribute and is linked to social positions within the social structure. Identity is internal, consisting of 'internalized meanings and expectations associated with a role' (Stryker & Burke, 2000: 289). Ibarra (1999) created a three-task model of adaptation describing the process of constructing a professional identity. The model deals with meaningful issues in adaptation and is comprised of observing role models, experimenting with provisional selves and evaluating results according to internal standards and external feedback. The role of self-evaluation and personal interpretation depends on how well or poorly one performs the tasks. Medical professionals go through a long education and extensive training that sets high standards. This inevitably shapes their ideas of self and sets high standards for individual levels of performance. In managerial positions, when doctors perform other tasks, they enter into a different role and need to socialise into a new set of institutional logics. Managers cannot simply 'be themselves' at work – they have to act as representatives of the organisation, which might influence their sense-making. We are interested in how this process of adaptation affects their identities.

Two ideal types of identities frequently used in organisational theory to describe professionals and managers are 'cosmopolitans' and 'locals' (Gouldner, 1957). Cosmopolitans are characterised by a strong commitment to professional values and skills, a strong outer reference group and weak loyalty toward the organisation. Locals tend to be less committed to professional skills, have a local reference group (e.g. other leaders) and show greater loyalty toward the organisation.

Evetts (2009) contrasts two ideal types of professionalism: 1) occupational professionalism and 2) organisational professionalism. Occupational professionalism is evident as a discourse within different occupational and professional groups. This type of professionalism emphasises aspects related to ownership of the expertise and the power to define both the nature of problems and their potential solutions. Mutual relations, assistance and support between colleagues rather than managerial control and hierarchy are emphasised. Collegial authority also depends on strong occupational identities that are developed through education and work cultures (ibid). Evetts (2011) further writes that while the notion of professionalism is appealing to occupational groups, the reality differs. Remedies have been introduced due to fiscal crises and the rising cost of welfare states. For example, under the influence of NPM, cutbacks and an increased focus on economy have been implemented by emphasising discipline among professionals. By increasing the focus on budgets, bureaucracy and management, the state is redefining professionalism into a more organisational form (Kuhlmann, 2003). Whereas occupational professionalism emphasised relation-

ships between professionals, formalised structures are of higher importance in organisational professionalism (Evetts, 2009).

### **Institutional logics**

Following professionalism, the logics of professions and management can relate to different types of institutional logics. These logics originate from different institutional orders or groups – within the order, there are specific practices and symbols that are taken for granted. Examples of institutional groups that are central to hospitals are the ‘state’, ‘professions’, and following the NPM’s influence, the ‘market’ (Vrangbæk, 1999). Different logics can work side by side in an organisation, yet logics are often conflicting and competitive (Greenwood, Raynard, Kodeih, Micelotta & Lounsbury, 2011). Despite this, and within a given local setting, institutional logics serve the critical function of binding together the work undertaken by different professionals (Byrkjeflot, 1997). By linking the concept of logics to management, different types of logics can appear in pure forms or as combinations. The latter case is described as ‘hybridisation’. Different types of logics can be connected in new ways to form a new, hybrid logic (Battilana & Lee, 2014). In relation to managerial roles in hospitals, we focus on two types of logics: managerial and professional (see Table 1 for a brief overview).

#### **Managerial logic**

This logic is influenced by the market and was introduced through NPM reforms. Here, the main focus is on efficiency (Flynn, 2002) via managing resources and economic control (Pollitt, 1993; Strand, 2007). There is an emphasis on the division of labour and hierarchical relations (Rost, 1993). Rational planning and the distribution of tasks from the leader to the follower are seen as crucial processes (O’Reilly & Reed, 2010; O’Reilly & Reed, 2012). Management by objectives (MBO) (Pollitt & Bouckaert, 2011) and managerial accountability (Christensen & Lægheid, 2011; Pollitt & Bouckaert, 2011) are also central. Indicators of the managerial logic in the Norwegian and Finnish health sectors are their focus on efficiency, economy MBO and the strategic management of human and financial resources. Decision-making is top down and emphasises hierarchy and line management. Managers show loyalty to and identify with the organisation – these public bureaucracies in turn identify with the state.

#### **Professional logic**

The professions can be viewed as an institutional order with a specific clinical-professional logic. The work of professionals relies on discretion, trust, autonomy and collegiality. Different types of professionals advocate distinct ideals of how to practice management (Abbott, 1988; Freidson, 1994). A common feature is planning daily activities and strategic work that are rooted in the platform of knowledge from education and training (Byrkjeflot, 1997). There is a strong focus on preserving the interests of the profession in a manner that aligns with

the priorities, identities and values of the professional group. Indicators of this logic can include focus on planning daily work for the professional group (e.g. creating shifts and schedules), focus on the quality of the services offered and continuing professional development. Decision-making is consensus-oriented, collegial and bottom-up.

*Table 1: Overview of the key elements in managerial and professional logic*

	<i>Managerial logic</i>	<i>Professional logic</i>
<b><i>Institutional order</i></b>	Market	Professions
<b><i>Emphasis</i></b>	Accountability	Autonomy
	Efficiency	Trust
	Resource management	Professional work
	MBO	Preserving professional interests
	Hierarchy	Collegiality
	Organisational identity	Professional identity
<b><i>Indicators</i></b>	Economy focus	Planning professional work
	MBO	Focus on the profession
	Line management	Consensus

We developed our research questions based on this theoretical backdrop. Following the unresolved debates regarding the nature of the professional identity phenomenon comprised of either relatively stable identities (Scott, 2008) or fluctuating identities (Hall, 1971; Spehar et al., 2015), we address the research gap by asking the following questions: 1) ‘How do managers interpret and make sense of their identities?’ In research question two, we follow Pratt et al. (2006) in their emphasis on the importance of understanding what managers are doing as a means to understand who they are: 2) ‘Are identities expressed in accordance with the dominant logics that managers emphasise?’ In the next section, we highlight our methodological approach.

## Research methodology and case presentations

In order to study the influence of organisation and changes in identities, we examined the same professions in different countries via a comparative case study approach. In case studies, it is typical to study subjective phenomena that are bounded by time, context and activity (Creswell, 1994; Yin, 2014). The comparative design is well-suited to develop a theory by investigating theoretical patterns that are not well-described in existing theories (Lijphart, 1971).

Here, we used purposeful, criterion-based sampling (Morrow, 2005). Participants were selected with the aim of providing the most information-rich data possible. We selected managers with medical backgrounds by following professional groups that dominated in management in their respective countries. In the

Norwegian context, doctors and nurses dominate jointly (Kjekshus & Bernstrøm, 2013), whereas Finnish hospitals seem to be more doctor-lead, with nurses increasing their influence through new professional tasks and improved multi-professional collaboration (Ensio, Lammintakanen, Härkönen & Kinnunen, 2016, forthcoming). To limit the bias related to different professions, we narrowed our study to only compare doctors in the two cases.

Qualitative data were collected from semi-structured interviews with seven Norwegian doctors and seven Finnish doctors in managerial positions. We purposefully selected the participants in both cases. In the Norwegian case, we studied the organisational chart and chose managers from different levels in the hierarchy. Four chief physicians (middle level) and three clinic directors (top level) from three clinics (medicine, surgery and psychiatry) were included. The gender division was five men and two women. In the Finnish case, the sample was chosen from a group of medical doctors in a management programme at a university. The sample included four female doctors and three male doctors. Five of them were chief physicians, one was the director of health services and one was a clinical teacher managing a research group; their fields of specialty varied.

We used a focused comparative method to parallel our findings (George & Bennett, 2004) and looked for patterns matching our theory and our empirical findings (Collier, 1993). We systematically analysed the interview transcripts in order to understand the inherent meanings in the data. We then conducted a thematic analysis to identify, analyse and report patterns forming themes within the data (Braun & Clarke, 2006). As for identities, the doctors were asked specifically how they identified themselves. The institutional logics were analysed according to the long list of work tasks and keywords related to management that the interviewees mentioned. Their tasks and attitudes were placed into groups based on similarities, were further analysed and then were divided again, ending in dimensions of different logics.

Qualitative data are not statistically generalisable, and other cases might have produced other findings. We sought analytic generalisability (Kvale & Brinkmann, 2009: 262) by exploring little-studied patterns that were not well described in earlier theorisations. We explored our data in the light of the theoretical interpretative framework and sought a deepened understanding of the identity and identity construction (Andersen, 2013). Other cases might have produced other findings, but comparisons to similar studies increase the validity of our study (Thagaard, 2013).

In both countries, the hospital sector has undergone organisational and funding alterations after national reforms that commenced in the 1970s but were fully implemented from the early 1990s onward. We focus especially on the reforms that introduced the NPM system and study how these reforms have created identities. In the following section, we present the central reforms and describe our cases in relation to them.

### **Reforms in the Norwegian hospital sector**

The medical profession has historically had a strong impact on both development and management in the Norwegian health sector (O. T. Berg, 1996). By the 1970s, doctors were gradually losing the self-evident dominant position that they held, while nurses were strengthening their position. Dual management with shared responsibility between nurses and doctors was introduced in this period, but doctors were still in charge (Torjesen, 2008). This model was controversial for politicians and the public due to unclear responsibilities and lack of transparency, and it led to the introduction of unitary management (HOD, 1999). The unitary positions became profession-neutral and were available to doctors as well as nurses, bioengineers, radiographers, physiotherapists etc. – not without protests from the medical profession (Johansen, 2005). Structural changes were made to support the management reform and stronger centralisation through the hospital reform introduced in 2002 (HD, 2001). Due to mergers and shutdowns, the number of hospitals was reduced from 80 to around 20 (Kjekshus & Bernstrøm, 2013), and there was a desire for stronger governmental steering of the sector (Byrkjeflot & Guldbrandsøy, 2013; Christensen & Læg Reid, 2002). The hospitals came under ministerial control and were converted into enterprises. The sector was divided into five (later revised to four) health regions connected to the university hospitals. Hospitals changed from professional bureaucracies to divisions of medical specialties such as clinics for medicine, surgery, psychiatry, etc. (L. N. Berg & Byrkjeflot, 2014).

### **The Norwegian hospital case**

The studied managers come from a mid-sized public hospital. The hospital has 5,000 employees and both general and specialised functions. Unitary management was introduced to the middle management level, and both nurses and doctors hold professional neutral management positions. This implies that the managers are responsible for all of the professionals employed in the unit; further, doctors are responsible for doctors, nurses and other professions. After the reforms, several hospitals were merged and reorganised according to medical specialties at different geographical locations. At the clinic level, management is a full-time job, whereas middle managers combine clinical work with management. Only two of the doctors have managerial educations.

### **Reforms in the Finnish hospital sector**

The Finnish health care sector is one of the most decentralised in Europe (Jakubowski, Saltman & Duran, 2013). There is a strong tradition of local democracy secured by legislation. Municipalities have a considerable degree of freedom and are responsible for the provision of primary health care; they also have the authority to allocate provisions and the financing of services, while the central government defines general conditions (MoSAH, 2013). The municipalities lack influence over the costs spent on running the hospitals. The small size of the authorities seems to make it difficult to develop competitive health care markets (Magnussen, Vrangbæk, Saltman & Martinussen, 2009). A major social welfare



and health care reform is underway and will be gradually implemented in the coming years. In this reform, the sector will be restructured, including the provision of services and financing as well as the duties of the regional governments. The goal is to provide social and health services in a more integrated manner with a markedly reduced number of service providers (MoSAH, 2015).

Doctors have traditionally had a strong foothold in the management of Finnish hospitals and policy-making (Jespersen & Wrede, 2009). Starting in the mid-1990s, attempts to introduce a 'multi-professional' managerial role have met resistance from the country's medical organisations. Finnish doctors have kept their positions due to decentralised implementations of reforms; they appear to have succeeded in maintaining and expanding their former managerial positions (ibid). This has impacted the managerial structures and cultures within Finnish hospitals. Finland has kept its traditional department structure to a larger extent than Norway has (Kjekshus, 2009).

### **The Finnish hospital case**

The managers from the Finnish hospital case come from two public hospitals that have not been reorganised lately but are facing increasing demands to focus on management. The case includes one middle-sized central general hospital with approximately 3,000 employees and one university hospital in charge of the demanding specialised medical care of nearly one million patients. This latter hospital employs more than 4,000 professionals. The hospitals are organised with parallel hierarchies for doctors and nurses. All of the participants from this hospital combine their clinical work with management duties, and they are responsible for both doctors and nurses. Some simultaneously hold a part-time professorship at the university. The doctors come from the managerial levels below the CEO. The Finnish hospital managers were undertaking management education at the time of this study.

## **Analysis of data according to the theoretical framework**

### **Identity**

In our first research question, we asked 'How do managers interpret and make sense of their professional identities?' Based on the analysis, the data were categorised into two types: one group with a strong identity connected to their health care profession and the other group who identified primarily as managers. In what follows, we present some quotations from the data in order to provide a more vivid, collective picture of the construction of meaning.

### **Doctors with a professional identity: cosmopolitans**

Managers with a strong professional identity did not actively seek managerial positions – looking at the Finnish case, the doctors did not actively wish to become managers. In addition, they interpreted the fact that they held managerial positions as more of a coincidence or a matter of convenience (other people regarded them to be the most suitable for positions that opened up).

I was chosen because the opportunity presented itself in a sad way. The prior head doctor passed away and I happened to be the only surgeon in our unit with a PhD degree. However, during [my] studies, I had only planned on becoming a clinical doctor. (Doctor, Finland)

Besides their long formal training and practical experience, they are intellectually and emotionally committed to being doctors. Doctors in this group can be viewed as ‘reluctant managers’. Practicing medicine has been their desire ever since they applied to medical school, and they have kept their medical identity: ‘I have never thought of myself as being a manager, but as a professional’ (Doctor, Finland).

Like the Finnish doctors, some of the Norwegian doctors had no intention of becoming managers, but they ended up as managers due to their wish to influence the development of their fields. For others, taking on the role was due to coincidence. The doctors in this group do have a strong identity as doctors, but it is combined with a managerial identity, and due to this, we label them as ‘doctor–managers’.

In a way . . . I do absolutely think that I am a clinician. That is what I feel I am. But I also feel that I am managing the department. I am quite often reminded that it is actually me who is the manager. (Doctor, Norway)

A couple of the doctors in this group reported that they did not want to become full-time doctors. Their management positions gave them more opportunity to influence the development of the field as well as more freedom to choose what research to prioritise.

For the Finnish participants, the manager’s role can be interpreted as ‘external’ (Stryker & Burke, 2000). It is a position that requires the interviewees to perform certain tasks, but it does not strongly construct their perceptions of themselves as professionals. Their loyalty lies with the profession, and they can be viewed as cosmopolitans (Gouldner, 1957). They do not regard their managerial roles as ‘natural’, whereas their health profession-related identities have become part of the interviewees’ personalities – an idea of who they are as people. For the Norwegian group, this identity is more hybridised (Battilana & Lee, 2014). They have a strong medical identity, but it is combined with a managerial identity.

#### **Doctors with a managerial identity: locals**

Doctors in this group primarily perceive themselves as managers and have adopted the managerial role as part of their professional identity. The identity

can be regarded as internalised (Stryker & Burke, 2000), and due to a stronger loyalty to the organisation, they can be viewed as locals (Gouldner, 1957).

Becoming a manager had been on the table for the studied Finnish doctors for a long time as an attractive or at least an intriguing possibility. When the opportunity presented itself in practice, they took it. They regarded the managerial position as challenging, but they seemed to have a realistic view of what it would entail. The doctors also faced pressure to make a managerial career move:

Another set of pressures is climbing from bottom to top within the organisation. Many of my former colleagues and even some supervisors are now my subordinates. On the other hand, it is regarded as a benefit as well since I know the organisation thoroughly. (Doctor, Finland)

To become a manager and then climb the managerial ladder was not highly regarded among doctors during the first few years after the reforms in Norway (L. N. Berg, 2015). Gradually, the medical profession realised the need for doctors in managerial positions at different levels in order to safeguard its interests. At this point, doctors who engaged in management felt more accepted for their choice. Most of the Norwegian doctors were unaware of management practices before entering such positions, but some of them could not resist the chance to enter positions with influence.

The doctors in this group emphasised the need to identify themselves as managers. They saw the managerial position as a way to implement their visions for development within their fields:

I had to choose. Earlier, I was in a temporary managerial position for some months . . . and I thought: I can never become a manager! . . . But then I realised that it was because I did not go in for it. That was useless . . . I came to a point where I realised, if I want to implement some of my ideas and visions, I have to become a manager . . . It is really because I want to do something bigger. (Doctor, Norway)

### **Logics at stake**

In our second research question, we asked 'Are the identities expressed in accordance with the logics that the managers emphasise?' Here, we have grouped the answers according to the logics that appeared. Whether there is a connection between logics and identities is continued in the discussion chapter.

### **Managerial logic**

In both cases, there were doctors who were full-time managers and others who divided their time between management and clinical work. It is, however, demanding to stay current in their expertise in combination with management, and

they have had to adjust their expectations for themselves. They realised that they could not be experts in all areas, as expressed by a Norwegian doctor:

You have to cut a lot of the things you did earlier if you want to be a manager. You cannot be 100% a doctor and 100% a manager. You have to take management seriously. There is a squeeze . . . you should work clinically, but not too much. Some think you should not be clinically active, but then I am afraid you are losing focus. Because I have seen that before, I have seen that doctors who were not in the clinic had problems in leading the professional work . . . and even worse, they had no understanding of adding the professional terms of the work. (Doctor, Norway)

The economy was one of the elements that divided the groups in both cases. Some of the doctors were managers at units with good economies and were not concerned with finances, whereas others faced more challenges and even budgetary deficits. For the Finnish doctors, this was one of the motivations for enrolling in management education at the university. Doctors from the Norwegian case expressed a need for greater knowledge of economics through additional education, but they did not actually pursue it. One Norwegian doctor explained how the organisational structure did not give the doctors in the lower levels of the hierarchy the option to develop their financial skills:

Financial expertise is one of the things I feel I could have greater knowledge of. [What is] interesting, regarding doctors and management, is that doctors in first line management have no financial responsibility. You do actually run the business, but you have no responsibility for the economy. I used to say: I cannot even order a pencil, but I can order drugs for patient totalling NOK 20,000 in one hour without being responsible for the costs. This is one of the drawbacks of the way we are organised. (Doctor, Norway)

Throughout the interviews, the Norwegian managers explicitly referred to elements intrinsically associated with NPM and managerial logics such as MBO and strategy, resource management and line management (Byrkjeflot, 2011). This overall focus on management can be interpreted as a focus on organisational professionalism (Evetts, 2009). The case hospital was reorganised after the hospital reform in 2002 – here, the transverse clinical structure between different geographical sites formed the chain of command. This is also a central element of managerialism (O'Reilly & Reed, 2010). Another feature of the organisational divisions and clinic structure was an increased need for planning and coordination, resulting in large meeting activities. The changes in organisation and the new managerial roles can be interpreted as affecting the framework conditions for managers, influencing their daily lives (Christensen & Lægheid, 2002).

### Professional logic

Traditionally, the managerial role for the medical profession was divided between planning and engaging in medical work (Degeling, Maxwell, Kennedy & Coyle, 2003; Freidson, 1994). How the managers in this study arrange this depends on the size and characteristics of the units, the doctors' preferences and the types of professions they oversee. Some doctors do the planning themselves, but much of this work is institutionalised through procedures, resulting in delegation. The autonomous role of the professionals is stressed, and the managers facilitate work for them.

As a manager, I believe in participation and value the knowhow of my subordinates. I trust them and do not focus on micro managing . . . I set goals and deadlines and trust them to know how to reach them. My main motto is trust. I also feel it is important that professionals are allowed to actually use their expertise. (Doctor, Finland)

Following the autonomous role, the managers do not directly control the professionals' work – they trust their employees.

I am an engaged leader, everybody says that . . . I believe most of them perceive me as a kind person. I do not control much. I find that important . . . but perhaps I am too little controlling? I should perhaps be a bit more controlling. That is an ethical question – controlling too much or too little? (Doctor, Norway)

Trust and autonomy of professions is a central theme in profession theory (Abbott, 1988). Professional work is based on scientific and abstract knowledge, which the individual professional balances through autonomy and discretionary powers. The managers do not instruct, or 'micro manage', the professionals in their daily activities; instead, they organise the work.

Another characteristic of management performed by professionals is a focus on quality and developing the professionals' competences (Freidson, 2001). Managers in both cases emphasised this by giving the following examples:

In my opinion, it is important to take care of my closest subordinates [professionals], grant them room and opportunities to develop, to trust them. (Doctor, Finland)

. . . to make each person be able to develop to their maximum according to their job, be able to see the needs to make all levels work well. (Doctor, Norway)

This focus is expanded in the Norwegian case, and it is not solely linked to their own professions. After the influence of NPM and the introduction of the unitary management role, managers became responsible for different professions. Their role has expanded to focus on professional development for all types of employees in their unit. This can be interpreted as a hybridisation of the professional logic (Berg, 2015).

## Discussion and conclusion

In this final section, we focus on our findings from a comparative perspective, discuss implications for theory and offer suggestions for further research. Turning to the first research question, the managers from both countries experienced identity challenges, equal to managers in similar studies (Andersson, 2015). Two distinctive types of interpretations regarding the participants' perceptions of their work-related identities appeared. One group had a strong professional identity as doctors and one group had a strong managerial identity. However, there were also a few doctors displaying a more hybrid identity, identifying strongly as both a doctor and a manager. The identity challenge has been studied in relation to how the doctors ended up in managerial positions, and the findings from our study are comparable with other studies (Spehar et al., 2012). Some doctors entered management positions accidentally or even reluctantly, whereas others actively sought such positions. The doctors holding a managerial position while still maintaining a strong professional identity did not seek managerial positions. In other words, for those with a strong occupational identity, the managerial role was viewed as an external attribute, and it was not integrated into their internal identity. According to Slay and Smith (2011), professional identity is affected both by the present occupation and the organisation through social and relational influences. This supports our findings that the studied actors made sense of their professional identities in different ways.

Our findings concur with Järventie-Thesleff and Tienari (2016): roles and identities co-evolve over time. They argue that 'identity work involved in role transitions is affected not only by situational and cultural circumstances but also by economic ones' (24). As an extension, however, we argue that identity work in role transitions is also a matter of personality, motivation and skills. A professional identity can remain stable regardless of changes in roles (in our case, managers who have a strong doctoral identity) (Scott, 2008). Respectively, a role change can also completely alter a professional identity perception (in our case, managers who identify with their managerial position instead of their doctoral background) (Hall, 1971; Spehar et al., 2015). Lastly, a professional identity might increase as the field of responsibilities increases, appearing in a hybrid form (Battilana & Lee, 2014). This version is most visible in the Norwegian case.

Identity also manifests itself in practical matters, for example, in how people divide their and what type of work is being prioritised. There seems to be some coherence between identity and time management. Firstly, when the managers

with a strong professional identity described their daily work, they mainly discussed substance work related to being a doctor and feelings that they had too little time to carry out their managerial tasks. Secondly, for this group, management was associated mainly with administrative duties. Thirdly, some felt they lacked appropriate knowhow and skills regarding management, administration and economics mainly due to their lack of formal training. In the Finnish case, this acted as an incentive to participate in management and business courses organised by a university, while few doctors in the Norwegian case followed this path. This skill shortage might strengthen professional identity while simultaneously weakening managerial identity. Doctors with a stronger managerial identity spent more time on management issues and highlighted a broader range of duties. As a first conclusion, we argue that the expression of identity is complex and not solely related to professional background. Structural elements such as time division and tasks influence identity, but personality, motivations and skills also matter.

Here, we discuss the second research question and whether the actors' identities are in accordance with the institutional logics that the managers emphasised. In the Finnish case, managers with a strong professional identity also worked as doctors and highlighted the professional aspects of their managerial roles. The rest of the Finns had a stronger focus on management according to NPM-influenced logics. The Norwegian group was to a larger extent influenced by organisational changes due to changes in clinical structure and new routines following the introduction of unitary management. This is in line with the intentions of the NPM reforms, which were to de-institutionalise traditional forms of management (L. N. Berg, Byrkjeflot & Kvåle, 2010) and to introduce management logics. NPM seems to have influenced the managers, but not in a pure way; instead, the managerial role has become more complex and hybrid. Most of the managers seem to act according to different logics, which we interpret as a hybridisation of management (L. N. Berg, 2015). As a second conclusion, we highlight the coherence between identity and the logics that the doctors expressed. Both countries featured managers with strong managerial identities who focused on managerial logics and organisational professionalism (Evetts, 2009), while a smaller group in both countries focused on occupational professionalism (*ibid*) and professional logics. The Norwegian case was more hybridised.

The strength of our study is that it compares cases from a similar profession from two countries that have chosen different paths in reforming management in the hospital sector. The medical profession has traditionally dominated both management and policy formulation of the hospital sector in both countries. The central government plays an increasing role in initiating and implementing reforms in Norway, leaving the local governments to enforce and manage the reforms. In contrast, Finland has a more decentralised model in both how policy actions are designed and implemented (Magnussen et al., 2009). Finnish doctors have kept their power positions due to decentralised implementations of reforms – they have succeeded in maintaining and expanding former managerial positions (Jespersen & Wrede, 2009), whereas nurses and doctors compete for the

same types of positions in Norway (Torjesen, Byrkjeflot & Kjekshus, 2011). Such competition with other professions in management might have influenced focus on management and contributed to its hybridisation (Kirkpatrick, Kragh Jespersen, Dent & Neogy, 2009). Three identity groups emerged from the Norwegian case; these can be traced back to changes after the NPM reforms. Many managers have altered their identities due to organisational amendments and expanded focus in management, some expressing a strong identity as managers, with others possessing more hybrid identities. A smaller group identifies as doctors even after entering managerial positions. There have been no changes in the structure of management in the Finnish case, but managerial logics have been introduced. This has affected identity in two ways: one group that identifies as managers and one group that identifies as doctors who have kept their professional identity. Both cases revealed coherence between the identities the doctors expressed and the logics they emphasised. Another strength of our study is that it shows how work experiences have a strong effect on how identity is perceived. Whether it is 'doctor'- or 'manager'-related is dependent upon personality, and particularly, on whether or not they are operating within their comfort zone. Ibarra (1999: 764) argues that in taking on a new role, one has to acquire new skills and, more importantly, adopt social norms and rules that govern how to conduct oneself. In our study, however, skills and knowhow were more relevant than the expectations of others. The people who held on to their professional medical-related identities rather than taking on managerial identities seemed uneasy with their skills and ability to perform the tasks related to their new positions. As a result of this identity conflict, they are faced with a need to reflect on their central and enduring preferences as well as their skills, talent and values (Hall, 1971; Spehar et al., 2015).

The title of the article asks whether professional identity is solid or is affected by changes in institutional logics and organisational amendments, and the answer to this is that it is both. Some doctors stick to their professional identity, while others expand their identity. As this study revealed, under the influence of NPM, the countries have chosen different reforms, which has impacted how management has altered and influenced identity construction. The stronger intervention from the central government, as seen in Norway, has resulted in implementing general management; it has taken a more hybrid form than in Finland.

We suggest that future researchers examine the boundaries of professional identity construction (Kreiner, Hollensbe & Sheep, 2006; Kreiner, Hollensbe & Sheep, 2009). One angle is to study the interface between individual identities and organisational identities. Another is to follow up on how work experiences influence identity formation through studying boundary-drawing tactics in relation to how the doctors prioritise their time management. Boundaries could also be studied in relation to other central professions in hospitals, such as nursing. Nurses have entered the doctors' territory in different ways in Finland and Norway. Due to the lack of doctors in the beginning of 2000, Finnish nurses have expanded their responsibilities into the professional field (e.g. as consultants for outpatients, tasks previously regarded as solely for physicians) (Koskinen, Aro-



maa, Huttunen & Teperi, 2006), while Norwegian nurses have a strong foothold in management (Kjekshus & Bernstrøm, 2013). Here, we suggest a study that compares how the jurisdiction between the two professions has developed and how this has influenced identity constructions.

## References

- Abbott, Andrew (1988) *The System of Professions*, University of Chicago, Chicago.
- Andersen, Svein S. (2013) *Casestudier: forskningsstrategi, generalisering og forklaring*, Fagbokforlaget, Bergen.[Case studies: Research strategy, generalisation and explanation]
- Andersson, Thomas (2015) The medical leadership challenge in healthcare is an identity challenge, *Leadership in Health Services*, 28 (2): 83-99.
- Ashforth, Blake E. (2016) Distinguished scholar invited essay: exploring identity and identification in organizations: time for some course corrections, *Journal of Leadership & Organizational Studies*, 1 (13): 1-13.
- Battilana, Julie & Matthew Lee (2014) Advancing research on hybrid organizing - insights from the study of social enterprises, *The Academy of Management Annals*, 8 (1): 777-799.
- Berg, Laila Nordstrand (2015) *Multifaglig ledelse - hybridisering av sykehusledelse etter NPM-reformer*, (PhD), Universitetet i Bergen, Bergen. Retrieved from <http://hdl.handle.net/1956/11604> [Multi Professional management - hybridisation of hospital management by NPM-reforms]
- Berg, Laila Nordstrand & Haldor Byrkjeflot (2014) Management in hospitals - a career track and a career trap. A comparison of physicians and nurses in Norway, *International Journal of Public Sector Management*, 27 (5): 379-394.
- Berg, Laila Nordstrand, Haldor Byrkjeflot & Gro Kvåle (2010) Hybridledelse i sykehus - en gjennomgang av litteraturen. *Nordiske Organisasjonsstudier*, 3 (2010). [Hybrid Management in hospital - a review of the literature]
- Berg, Ole Trond (1996) 'Meta-Medicine: The Rise and Fall of the Norwegian Doctor as a Leader and Manager' in Øyvind Larsen (ed), *The Shaping of a Profession*, Science History Publications, Canton, MA.
- Braun, Virginia & Victoria Clarce (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3 (2): 77-101.
- Brown, Andrew D. (2015) Identities and identity work in organizations, *International Journal of Management Reviews*, 17(1), 20-40.
- Byrkjeflot, Haldor (2011) 'Healthcare States and Medical Professions: The Challenges from NPM' in Tom Christensen & Per Læg Reid (eds), *The Ashgate Research Companion to New Public Management*, Ashgate, Farnham, Burlington.
- Byrkjeflot, Haldor (1997) *Fra styring til ledelse*, Fagbokforlaget, Oslo.[ From management to leadership]

- Byrkjeflot, Haldor & Kari Guldbrandsøy (2013) Både hierarkisk styring og nettverk. En studie av utviklingen i styringen av norske sykehus, *Tidsskrift for samfunnsforskning*, 54 (4): 463-492. [Both hierarchical management and networking. A study of developments in the management of Norwegian hospitals]
- Christensen, Tom & Per Læg Reid (2011) *The Ashgate Research Companion to New Public Management*, Ashgate, Farnham.
- Christensen, Tom & Per Læg Reid (2002) *Reformer og lederskap. Omstilling i den utøvende makt*. Universitetsforlaget, Oslo.[Reforms and leadership. Restructuring in the executive power]
- Collier, David (1993) The comparative method, in Ada W Finifter (ed), *Political Science: The State of Discipline II*: 105-119.
- Creswell, John W (1994), *Research Design. Qualitative & Quantitative Approaches*, Sage, Thousand Oaks.
- Degeling, Pieter, Sharyn Maxwell, John Kennedy & Barbara Coyle (2003) Medicine, management, and modernisation: a 'dance macabre'?, *British Medical Journal*, 326: 649-652.
- Dobrow, Shoshana R. & Monica C. Higgins (2005) Developmental networks and professional identity: a longitudinal study, *Career Development International*, 10 (6/7): 567-583.
- Ensio, Anneli, Johanna Lammintakanen, Mikko Härkönen & Juha Kinnunen (2016, forthcoming) 'Expanding Roles of Nurses in Finnish Health Care' in Reinhardt Busse, Anne-Marie Rafferty, Luk Bruyneel & Britta Sanders (eds), *Nursing in Europe*, European Observatory for Health.
- Evetts, Julia (2011) Sociological analysis of professionalism: past, present and future, *Comparative Sociology*, 10: 1-37.
- Evetts, Julia (2009) New professionalism and new public management: chances, continuities and consequences, *Comparative Sociology*, 8: 247-266.
- Flynn, Rob (2002) 'Managerialism, Professionalism and Quasi-Markets' in Mark Exworthy & Susan Halford (eds), *Professionals and the New Managerialism in the Public Sector*, Open University Press, Buckingham, Philadelphia.
- Freidson, Eliot (1994) *Professionalism Reborn: Theory, Prophecy, and Policy*, University of Chicago Press, Chicago.
- Freidson, Eliot (2001) *Professionalism: The Third Logic*, Polity Press, Cambridge, MA.
- George, Alexander L. & Andrew Bennett (2004) *Case Studies and Theory Development in the Social Sciences*, MIT Press, Cambridge, MA & London, England.
- Gouldner, Alvin W. (1957) Cosmopolitans and locals: toward an analysis of latent social roles, *Administrative Science Quarterly*: 2(3): 281-306.
- Greenwood, Royston, Mia Raynard, Farah Kodeih, Evelyn R. Micelotta & Michael Lounsbury (2011) Institutional complexity and organizational re-

- sponses, *The Academy of Management Annals*, 5 (1): 317-371. doi:10.1080/19416520.2011.590299
- Hall, Douglas T. (1971) A theoretical model of career subidentity development in organizational settings, *Organizational Behavior and Human Performance*, 6 (1): 50-76.
- HD (2001) Sykehusreformen, *Ot paper number 66 (2000-2001)*. [Ministry of Health; The Hospital Reform]
- HOD (1999) HOD: Lov om helsepersonell m.v. (helsepersonelloven).[Ministry of Health and Care services: The Health Personnel Act]
- Ibarra, Hermina (1999) Provisional selves: experimenting with image and identity in professional adaption, *Administrative Science Quarterly*, 44: 749-791.
- Jakubowski, Elke, Richard B. Saltman & Antonio Duran (2013) 'Country Governance Profiles' in Elke Jakubowski & Richard B. Saltman (eds), *The Changing National Role in Health System Governance* (Vol. 29), World Health Organization, European Observatory on Health Systems and Policies.
- Järventie-Thesleff, Rita & Janne Tienari (2016) Roles and mediators in identity work. *Organizational Studies*, 37 (2): 237-365.
- Jespersen, Peter Kragh (2005) *Mellem profession og management*. Handelshøyskolens forlag, København.[Between profession and management]
- Jespersen, Peter Kragh & Sirpa Wrede (2009) 'The Changing Autonomy of the Nordic Medical Profession' in Jon Magnussen, Karsten Vrangbæk & Richard B. Saltman (eds), *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges*, European Observatory on Health Systems and Policies Series.
- Johansen, Monica Skjøld (2005) *Penga eller livet? Lederutfordringer i det reformerte norske helsevesenet*, Rokkansenteret, Bergen.[The Money or Your Life? Leader Challenges in the reformed Norwegian health care]
- Kirkpatrick, Ian, Peter Kragh Jespersen, Mike Dent & Indareth Neogy (2009) Medicine and management in comparative perspective: the case of Denmark and England, *Sociology of Health & Illness*, 32 (5): 642-658.
- Kjekshus, Lars Erik (2009) 'Changing Demands for Institutional Management' in Jon Magnussen, Karsten Vrangbæk & Richard B. Saltmann (eds), *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges*, McGraw-Hill House, Open University Press.
- Kjekshus, Lars Erik & Vilde Bernstrøm (2013) *Helseforetakenes interne organisering og ledelse*, *Intorg 2012*, Oslo.[The internal organisation and management of health trusts]
- Koskinen, Seppo, Arpo Aromaa, Jussi Huttunen & Juha Teperi (2006) Health in Finland, *National Public Health Institute KTL National Research and Development Centre for Welfare and Health STAKES*, Ministry of Social Affairs and Health.
- Kreiner, Glen E., Elaine C. Hollensbe & Mathew L. Sheep (2009), Balancing borders and bridges: negotiating the work-home interface via boundary work tactics, *Academy of Management Journal*, 52 (4): 704-730.

- Kreiner, Glen E., Elaine C. Hollensbe & Mathew L. Sheep (2006) On the edge of identity: boundary dynamics at the interface of individual and organizational identities, *Human Relations*, 59 (10): 1315-1341.
- Kuhlmann, Ellen (2003) 'Professions and Changing Societies - Case Studies from the Field of Health Care' in Lennart Svensson & Julia Evetts (eds), *Conceptual and Comparative Studies of Continental and Anglo-American Professions*, Göteborg University, Göteborg.
- Kvale, Steinar & Svend Brinkmann (2009) *InterViews. Learning the Craft of Qualitative Research Interviewing*, Sage Publications, Los Angeles, London, New Delhi, Singapore.
- Lijphart, Arend (1971) Comparative politics and the comparative methods, *The American Political Science Review*, 65 (3): 682-693.
- Llewellyn, Sue (2001) 'Two-way windows': clinicians as medical managers, *Organization Studies*, 22 (4): 593-623.
- Magnussen, Jon, Karsten Vrangbæk, Richard B. Saltman & Pål E. Martinussen (2009) 'Introduction: the Nordic Model of Health Care' in Jon Magnussen, Karsten Vrangbæk & Richard B. Saltman (eds), *Nordic Health Care Systems. Recent Reforms and Current Policy Changes. European Observatory on Health Systems and Policies Series*, Open University Press, Berkshire.
- Morrow, Susan L. (2005) Quality and trustworthiness in qualitative research in counseling psychology, *Journal of Counseling Psychology*, 52 (2): 250-260.
- MoSAH (2015) *Social Welfare and Health Care Reform*.
- O'Reilly, Dermot & Mike Reed (2012) "'Leaderism" and the Discourse of Leadership in the Reformation of UK Public Services' in Christine Teelken, Ewan Ferlie & Mike Dent (eds), *Leadership in the Public Sector. Promises and Pitfalls*, Routledge, London, New York.
- O'Reilly, Dermot & Mike Reed (2010) 'Leaderism': an evolution of managerialism in UK public service reform, *Public Administration*, 88 (4): 960-978.
- Piekkari, Rebecca, Catherine L. Welch & Eriikka Paavilainen (2009) The case study as disciplinary convention: evidence from international business journals, *Organizational Research Methods*, 12 (3): 567-589.
- Pollitt, Christopher (1993) *Managerialism and the Public Services: Cuts or Cultural Change in the 1990s?* Blackwell, Oxford.
- Pollitt, Christopher & Gert Bouckaert (2011) *Public Management Reform. A Comparative Analysis - New Public Management, Governance, and the Neo-Weberian State*, Oxford University Press.
- Rost, Joseph C. (1993) *Leadership for the Twenty-First Century*, Greenwood Publishing Group, Inc., Westport.
- Sanders, Matthew L. & John G. McClelland (2012) Being business-like while pursuing a social mission: acknowledging the inherent tensions in US non-profit organizing, *Organization*, 0 (0): 1-22.
- Scott, Richard W. (2008) *Institutions and Organizations*, Sage Publications, Los Angeles, London, New Delhi, Singapore.

- Slay, Holly S. & Demonize A. Smith (2011) Professional identity construction: using narrative to understand the negotiation of professional and stigmatized cultural identities, *Human Relations*, 64 (1): 85-107.
- Spehar, Ivan, Jan C. Frich & Lars Erik Kjekshus (2015) Professional identity and role transitions in clinical managers, *Journal of Health Organization and Management*, 29 (3): 353-366.
- Spehar, Ivan, Jan C. Frich & Lars Erik Kjekshus (2012) Clinicians' experiences of becoming a clinical manager: a quality study, *BMC Health Services Research*, 14: 421.
- Strand, Torodd (2007) *Ledelse, organisasjon og kultur*, Fagbokforlaget, Bergen.[Management, organisation and culture]
- Stryker, Sheldon & Peter J. Burke (2000) The past, present, and future of an identity theory, *Social Psychology Quarterly*, 63: 284-297.
- Thagaard, Tove (2013) *Systematikk og innlevelse: en innføring i kvalitativ metode*, Fagbokforlaget, Bergen.[Systematics and sensitivity: an introduction to qualitative methods]
- Torjesen, Dag Olaf (2008) *Foretak, management og medikrati. En sektorstudie av helseforetaksreformen og ledelse i den norske spesialisthelsetjenesten*, Universitetet i Bergen, Bergen.[Enterprise, management and medikrati. A sector study of health reform and management in the Norwegian specialist health service]
- Torjesen, Dag Olaf, Haldor Byrkjeflot & Lars Erik Kjekshus (2011) 'Ledelse i helseforetakene. En gjennomgang av norske studier av ledelse i sykehus' in Steinar Askvik, Bjarne Espedal & Hallgeir Gammelsæther (eds), *Kunnskap om ledelse - Festskrift til Torodd Strand*, Fagbokforlaget, Bergen.[Leadership in health trusts. A review of Norwegian studies of management in hospitals' in 'Knowledge of management - Festschrift for Torodd Strand']
- Vrangbæk, Karsten (1999) 'New Public Management i sykehusfeltet - udforming og konsekvenser' in E. Z. Bentzen, Finn Borum, Gudbjørg Erlingsdotir & Kerstin Sahlin-Andersson (eds), *Når styringsambitioner møder praksis. Den svære omstillingen af sygehus- og sundhedsvæsenet i Danmark og Sverige*, Handelshøyskolens Forlag, Munksgaard. ['New Public Management in the hospital field - design and consequences' in 'When management ambitions match practice. The difficult restructuring of hospital and health care in Denmark and Sweden']
- Yin, Robert K. (2014) *Case Study Research. Design and Methods*, Sage Publications, Los Angeles, London, New Delhi, Singapore, Washington DC.