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STRATEGIC AND PROFESSIONAL LEADERSHIP: THE CHALLENGE OF ROLE DUALITY

A Study of the Role of Clinicians in Management in the National Health Service in England

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ABSTRACT

In 1983 the National Health Service in England moved from a functional to a general management philosophy. This fundamental change gained momentum with the introduction of NHS Trusts in the early 1990s. Since this period, clinicians have taken a greater role in the strategic leadership of their organisations.

This research considers the role of senior doctors (consultants) who have taken up a strategic leadership role alongside their clinical role (role duality). This is a qualitative study centred on the perceptions of individuals in this role in three NHS Trusts. A new understanding of the dual role is developed through a methodology linked to frameworks from existing research. The role is viewed through a role theory perspective and put into context by understanding existing research on the role itself and relevant areas of the career, strategic leadership and management literatures. The uniqueness of this research is to understand how individuals take up the challenge of role duality; there is a need to comprehend how individuals perceive the clinical role and the strategic leadership role in equal measure. This approach drives the methodology and the design of interviews as the main source of data.

The findings are many with new insights and confirmation of some existing understanding of how role duality is taken up and the differences and similarities between the two main elements of the dual role.

The different approaches to taking up the dual role within and across the trusts are seen as clustering around two dimensions, taking charge and managerial alignment. Consequences of the different approaches range from a possibility of failure or being ineffective, to a gradual development of the service and the development and delivery of the organisation's strategy.

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1 INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

This research is a study driven from a personal interest in the research subject. Many years of my career have been spent working with individuals who are at the centre of this research. I believe it is this interest that has sustained me through the long journey and personally uncharted territory of a doctoral programme. My sense of ownership of this research leads me to my decision to write it in the first person.

The research is centred on the role of clinicians in management in the National Health Service (NHS) in England. For the purposes of this research, clinicians are defined as doctors and not any of the other clinical disciplines. This subject occupied my time as a senior manager in the NHS and continues to interest me in my current position as a lecturer at Cranfield School of Management. Also, I recognise there is something about my own ontology which leads me down this path of enquiry and the type of research I undertake.

The research focuses on a role which is central to the delivery of health services in England. It is given the title of a strategic leadership role, for reasons that are explained later. The role is often more generally referred to as a management role. It is combined with the professional clinical role, hence the title of the thesis 'Strategic and Professional Leadership the Challenge of Role Duality'.

The thesis is ordered as follows:

Chapter 1 Sets the scene and focus of the study. There is a discussion of the importance of the role to be studied and a review of the context of the NHS and the role of clinicians in management.

Chapter 2 The literature review equips me with an understanding of how I can add to the existing body of knowledge concerning the role of clinicians in management in the NHS. The chapter concludes with the research objectives and questions.

Chapter 3 Describes the research strategy and methods. The phenomenological approach, which is driven by my view of the world is described, with the rationale for the approach in this particular study. This is followed

by the research method, the design of the interviews, the research sites and details of the research participants. The chapter concludes with a description of how the data is coded and analysed.

Chapter 4 Displays the data by grouping it to show the richness of the individuals' understanding of their role in the context of the research design.

Chapter 5 Analyses and regroups the data from the interviews into themes.

Chapter 6 The findings and discussion are explored and links made to the literature review.

Chapter 7 Describes the contribution to knowledge and the contribution to practice. The limitations of the research are explored. The thesis concludes with suggestions for further research and the implications of emerging changes in the NHS on the role of clinicians in management.

1.2 PERSONAL HISTORY AND RESEARCH FOCUS

My career in the NHS spanned 16 years. During this time I progressed through a number of finance, administrative and general management posts. I left the NHS in 1990 as a Unit General Manager with responsibility for managing a range of health care services for the local population. This part of my career history leaves me with a continuing interest in exploring management issues through management development, consultancy and in particular research in the social sciences. On leaving the NHS, I undertook a research MSc at the Health Services Management Centre, University of Birmingham. This research titled 'Success and Organisational Structure: An approach to seeking a link in the National Health Service' emanated from my experience of seeing many reorganisations and major change programmes dominated by structural change. I had always questioned the contribution that searching for and implementing new structures made to the success of the organisation. My findings indicated that there were many complex contextual issues that contributed to perceptions of success and the design of an organisation's structure was not dominant as a determinant of success. This academic experience leaves me motivated to explore another question which as a practitioner has challenged me and others in the NHS for many years.

The subject of my doctoral research is the role of doctors, especially senior doctors in the provision of health services. At a strategic policy level we can debate issues, such as the role of the doctor in influencing the health of the population. We can also argue the balance between the doctor's role in promoting health and treating ill health. However, the role many of us can envisage the senior doctor in, is a powerful figure in a white coat sweeping down a hospital corridor with an entourage of followers in tow. This image has been characterised in books, films and television and accords with the reality of many people's experiences, whether as patients or employees of the NHS. While this role can still be seen in some settings, the role of many senior doctors has changed in the last 15 years.

As a result of the NHS reforms, of the 1980's and the 1990's, there are opportunities for senior doctors, who are known as consultants, to be involved in key areas of management. Consultants are involved at a senior level in the local management of

the NHS. Some act as an executive director on health trust boards which provide services for, primarily a local population. Others are responsible for areas of the service within the trusts and in most cases are in the role known as a clinical director or lead clinician. In both these roles, the consultant continues their professional career and takes up the additional responsibility of what is described as a strategic leadership role. This complex dual role is now a fundamental part of the management structure in the NHS.

This experience informed me that consultants take on this dual role for a variety of reasons. The management element of the role was also understood in a number of different ways by consultants. Some obtained the role because their colleagues were not interested in management. Others were encouraged by their colleagues to take on the role as their colleagues felt they would not interfere with what they wanted to do. Some wanted to contribute to and influence the direction of the service. The way consultants managed their role with me ranged from coming to see me with a check list of items to 'report on', to developing a genuine dialogue about leadership issues, how to influence and motivate staff and how to analyse situations and behaviour. Understanding information systems and budgets was usually easy for them. Individuals who reach consultant status are intelligent and have the ability to learn quickly. However most struggled with the competing demands of the professional role and the strategic leadership role. The development of the clinical director role has progressed and strengthened since I left the NHS.

My experience during the 1990s working at Cranfield as a lecturer has heightened my interest in understanding individuals who combine their professional role with a management role. My experience working with clinical directors in a management development setting confirmed my practitioner experience that this dual role is worthy of academic research. Of course, I am not alone in this belief and research into the involvement of clinicians in management has been undertaken by academics and students.

My own interest was heightened delivering the lead module of a national management development programme for clinical directors in Scotland for two consecutive years. The lead module addressed the subject area of strategic leadership and in year two

included a module specifically on influencing strategies and more personal work with clinical directors. During the modules it became quite apparent to me that similar issues to those present in my practitioner experience still exist. It was so stimulating to observe and to try to understand the nature of the challenges and the personal effort that was required to manage the dual role. My discussions with the person who developed this programme, herself a psychologist, revealed that she was equally fascinated by the discussions during the module. She commented that it was the first time she had seen clinical directors emotionally and intellectually engaged in this subject matter.

To me, it felt like quite a breakthrough with some individuals recognising that leadership and management were subjects that could be intellectually challenging. A realisation that you could seriously engage clinicians in a rigorous and constructive debate about management was a further motivator to undertake research in this area. This research will progress my and others anecdotal evidence to a more meaningful and rigorously researched level of understanding. The literature review will identify where my research can make a contribution to knowledge concerning the role of clinicians in management.

At the outset of this research it was considered that this study, although in the context of the NHS, might progress the academic debate and stimulate further research to be undertaken into other dual roles, for example, lawyers in the Crown Prosecution Service, an organisation with whom I have worked. The legal profession has long been likened by researchers to medicine in terms of their career characteristics (Carr-Saunders and Wilson, 1933).

1.3 THE SIGNIFICANCE OF THE ROLE

Taking up and developing in a role can be described as a type of negotiation process that operates consciously and sub-consciously. Researchers have viewed the process of negotiation from different perspectives. There is the economic term of satisficing. Other descriptions used by researchers, which give a sense of the interaction and exploration that is used in role making are words such as social moulding (Biddle and Thomas 1966), reciprocal determinism, reciprocal influence process (Bartlett and Ghoshal 1995) and mutual adjustment (Mintzberg 1973).

The rate and pace of change is quickening for individuals taking up organisational roles and for organisations themselves acting as systems in complex environments. At the heart of the response to change are people. Understanding the individual and their response to change and changing roles is important to researchers and practitioners. Organisations that are successful in transforming themselves in times of change have developed the ability to change employees behaviour. They have reduced top management's reliance on strategic planning systems by developing and deploying key people (Ghoshal and Bartlett, 1995). Certainly, clinical directors and doctors are key people in the NHS and their actions and behaviours are important to the successful delivery of the health service. Research has shown that while Parliament allocates resources and Chief Executives have responsibility for expenditure at hospital level, approximately 80% of all health expenditure is distributed by the medical decisions of doctors (Dohler, 1989). The performance of doctors in how they manage and commit resources is therefore a key role and critical to the NHS.

Identifying and developing key people, demands some in-depth understanding of the individual and the significant aspects of their previous development which has informed their current thinking and actions. My range of experience working with clinicians in management leads me to believe that their development has been highly influenced by the specific characteristics of their professional career. Their personal identity has evolved through a long period of training in a highly respected profession. They possess competence and confidence in their ability to carry out their professional role. The strategic leadership role, taken up when they have reached a

senior position in their professional role, is full of uncertainties. What does a strategic leadership role really mean? Is management a real career? Some of these seemingly fundamental questions pose issues of contrast between the professional role and the strategic leadership role.

The leadership role in this study is relatively new in organisational terms and is a consequence of the change in philosophy introduced into the NHS by the Griffiths Report (1983). Since this time, clinicians have been able to take on a broader management role. However, few have chosen to seek Chief Executive posts. A move to the new dual role which encompasses more than managing the individual's own profession colleagues brings a new set of challenges. The role of continuing to deliver core business as an individual professional, while taking the additional strategic leadership and broad general management role is not common. Many professionals supervise and manage fellow professionals as they progress in their career. Professionals may also be asked to make a contribution to planning the strategy of the organisation from their professional viewpoint. It is the nature of performing a professional clinical role and a strategic leadership role where the individual is asked to think and act within a much broader framework than their own professional expertise or profession, that makes this research of particular interest. With the changing nature of the services in the NHS and the constant pressure on resources, individual professionals are increasingly being required to work as an equal member of a multidisciplinary team to provide high quality efficient and cost effective services. This is a concept not familiar to doctors, particular many of those in acute hospitals. The nature of the medical career, with no common curriculum or shared learning with other professions is a long solitary journey. This is starting to change and has parallels with many other professions. However, particular characteristics set the medical profession apart from many others. These include the status of the profession and the concept that hospital doctors are continuously in training until they become a consultant.

At an organisational level, additional value from this research will be gained as the context of the research is in a highly complex organisational setting. One dimension of complexity in the NHS is size. It employs approximately one million staff and effecting change can seem like turning around a fleet of tankers. Tony Blair (1999),

the current Prime Minister angered many public sector workers by openly declaring that, in his view, the private sector has transformed itself over the last 50 years, but in the public sector little had changed. The NHS is highly political, it has a high profile nationally and locally and is a clearly visible organisation which is under constant scrutiny. This is an additional reason for interest in research into key aspects of its management.

The importance of the role in this study has been recognised and attention given to providing training and development for doctors in management. There have been national and local initiatives for all NHS board members, which include a medical director, and specific national and regional initiatives for clinical directors organised by, for example, Regional Health Authorities, British Association of Medical Managers (BAMM) and the National Health Service in Scotland (NHSiS). Generally, doctors appear to prefer to undertake training and development with other doctors, but some have undertaken development with a wider peer group. However, management qualifications are not popular. A survey (BAMM, 1997) of 702 doctors who manage clinical services revealed that only 6% reported holding a management qualification and only 5% were studying for one. Asked if they were interested in studying for a management qualification, the large majority (73%) were not. Publications (Simpson and Smith, 1995) have offered insights into management for doctors as it is recognised that much of the current training for medical students still prepares them for hierarchical, control based structures and does not equip them for team based processes. It is commented that many doctors lack communication and negotiation skills and have a poor understanding of, and little training in, leadership skills and teamwork (Riordan, and Simpson, 1995).

This move from a functional to a general management philosophy has attracted much interest from practitioner and academic communities. The significant potential this change brings, by enhancing this enormous organisation's strategic management capability has been strongly argued (Harrison and Miller, 1999). In the US there has also been a movement of physicians into formal management roles within a variety of health care settings. American researchers have identified the need to know more about the way individual doctors in a medical management see their roles and themselves in it (Hoff, 1998).

This research seeks to provide a deeper level of understanding about the challenge of role duality in a clinical and strategic leadership role.

1.4 NHS RESEARCH CONTEXT

This section explores the development of clinicians in management to provide a context for understanding the role at the heart of this research. The relevance is because, irrespective of the nature of changes affecting doctors, they are severely influenced by the history of the medical profession and the development of their place in the NHS.

The NHS was born in 1948 out of a rather chaotic system that existed prior to the Second World War, which was a mixture of the voluntary sector mostly providing adult care and the local authority sector providing mostly chronic care (Abel-Smith, 1964). When viewed as one organisation, the NHS is the largest employer in the western world and few individuals will escape experiencing the service it delivers, at some time in their lives.

Doctors' entry into the NHS was via an interesting series of events. In 1944 the British Medical Association (BMA) surveyed its members on the Government's proposals that were to become the NHS Act 1946. Much to the surprise of the BMA leaders, the members voted for the Government's ideas. The BMA sad they had not understood the proposals and would have to vote again. This time the members voted against the proposals. The Minister of Health was then faced with resistance from the medical profession. (Allen, 1995). To overcome this problem, Bevan, the Minister of Health in his own words "stuffed the mouths of the doctors with gold" (Abel-Smith, 1964). The most famous outcome of this, which lives on today, was that doctors were allowed to have private practice. Another less famous, but important concession was that doctors in hospitals were to have the same managerial arrangements as existed in the voluntary sector. In the local authority sector doctors had worked for and been directed by a Medical Superintendent, a system many doctors disliked. This was not what they wanted in the NHS. They were granted a system similar to the 'honorary consultant' status that existed in the voluntary sector, only they were to be paid. This system meant they had the status as head of a team, one among a group of equal consultants, not answerable to another. This has had a long-lasting effect on the NHS and been a status to be strongly guarded (Allen, 1995).

This type of arrangement is rare in organisational life and only seen in partnership arrangements such as lawyers, accountants and general medical practitioners (GPs). In these cases partners have to generate their own income, which has not been the case for hospital doctors. The consultants negotiated a rather unique position for themselves and owed a lot to the BMA for drawing them back from agreeing to the original proposals. This status allowed consultants to treat which patients they wanted in the way they wanted. This meant that ultimately the Secretary of State had little control over consultant led aspects of the NHS, over the costs and levels of output. Local medical staff's committees were involved in the advertising of consultant posts. The appointment of consultants was largely in the hands of peers. Strong professional representation is still a part of consultant appointments today. The appointment process is unusually enshrined in statute. This professional dominance was not challenged or possibly did not seem to matter when there was no real conflict between politicians, as guardians of public expenditure, and the service that was being delivered. Attempts were made to involve consultants in management with the Cogwheel Reports of 1967-1969, but their involvement was usually fairly 'gentlemen like' as there was change in the balance of power and no pressure in the system to challenge existing ways of working.

The situation changed during the 1970s with 'stagflation' and the pruning of government expenditure. No longer was the NHS receiving 3-4 % real increases in funding each year. With big loans taken from the International Monetary Fund the increase for the NHS had reduced to virtually nothing. Also, technology was developing rapidly and there was a capability for more costly services to be delivered. Conflict between service delivery and the resources available was in evidence and the government of the day needed to take action. The distribution of funds across the country was reviewed through the Resource Allocation Working Party (RAWP) set up in 1975 (DHSS, 1976). This was the first challenge to powerful consultants in the richest parts of the country. A second challenge followed quickly with the Priorities Document (DHSS,1977) which required that money should be shifted away from the acute sector towards long-stay services. Long-stay services were seen as less attractive and often referred to as 'Cinderella' services and included mental health and mentally handicapped services, the latter is now known as learning disabilities. These services had few consultants working in them and were seen by their peers near the

bottom of the hierarchy of the medical profession. From this point on, governments have felt the power of the medical profession and struggled to deliver a mission that is in conflict with the profession's interests. The reorganisation and reforms of 1974 (DHSS, 1972), 1982 (DHSS, 1979), the Griffiths Report (DHSS, 1983) and the introduction of the internal market (DOH, 1989) can all be seen in part as attempts to control more directly the activities of hospital consultants (Allen, 1995).

With an increasing pressure on resources in the 1980s and although the NHS had become known as the most cost-effective health service in the world (NAHAT report, 8th edition), renewed pressure for additional funding prompted the Thatcher government in 1988 to initiate the radical review (DOH, 1989) which led to the NHS and Community Care1991 Act.

Leading up to this change the 1983, reorganisation marked a watershed in the approach to NHS management. It brought a shift from the administration of services to a more proactive style of management. This heralded the end of 35 years of the consensus method of decision making. In its place a general management structure was created at every tier of the management structure in the NHS.

This change had particular relevance to doctors and particularly consultants. Prior to 1983, the NHS was organised along functional lines with organisational structures and lines of accountability in functional and professional hierarchies. Within the structure doctors were accountable to doctors, nurses were accountable to nurses, physiotherapists were accountable to physiotherapists etc. Planning the direction of services in line with national policy, co-ordinating the services and the management of many of the budgets was the responsibility of administrators who had their own functional hierarchy. This structure created a long managed tension between the professions, in particular the consultants who, by their actions, determined the spending patterns of the service and the administrators who managed the budgets. It was rare for this tension to be managed in a helpful and creative way that benefited the service. This reorganisation was the strongest effort to date to deal with the conflict in the system.

The fundamental change to a general management structure was decreed by the Secretary of State for Health following an inquiry led by Sir Roy Griffiths, who was then the Deputy Chairman and Managing Director of the food retailer Sainsburys. It was quite apparent that the Thatcher government believed that practices from the private sector could be transferred to the public sector to improve efficiency. One major criticism of the NHS was that if a member of the public walked into a hospital it would be impossible to identify who was in charge. The Griffiths Report (DHSS 1983) addressed this issue and general managers were appointed to "units" (hospitals or defined services). Key to this change was the involvement of clinicians in management. Clinicians were the key drivers of the organisation and as such were to be given a strategic role and made accountable for managing resources. Clinicians, generally consultants, were given the lead role for managing services within a specified area of the service within the "units". These areas were, and still are, referred to as directorates. The new role for the consultant as general manager of that directorate was, and often still is, called clinical director. This role is taken up by consultants in addition to their clinical role.

Various models of the general management structure developed across the country. There was resistance from some professions, particularly nurses, who saw their professional hierarchies being eroded. There were mixed views amongst the consultants, because although they were in a more influential role, there were responsibilities that came with the new role. However, the consultants professional body the British Medical Association (BMA) became preoccupied with the next radical change that was being planned by the government.

The next reorganisation, often referred to as the NHS reforms, led to the NHS and Community Care Act 1991 and embedded the role of the doctor in management by continuing the development of clinical directors. A doctor was also appointed as an executive director of the new NHS boards which were designed to reflect practices from the private sector. The idea of competition driving efficiency was also encouraged through the division of services into purchaser and provider roles. Many, including the BMA, saw these reforms as a route to privatising the NHS. Nevertheless, the Thatcher government, with Kenneth Clarke as Secretary of State for

Health, showed their determination to drive the reforms through by having no pilot, schemes, thereby refusing to test the feasibility of the changes.

The role of doctors in management has continued to develop with approximately 3,500 consultants in the role of clinical director or a similar role. The commitment to involve clinicians in management has been sustained with the change from a Conservative to a Labour government in 1997.

This discussion about the historical context of the role of clinicians in management should not be left without reference to the broader context of public sector change and the emergence of New Public Management (NPM). The NHS has not changed in isolation. All public services have experienced considerable change and NPM is synonymous with the emergence of the new economy in which the old distinctions between the public and private sectors seem to be disappearing. The old economy may be characterised as public administration and the new economy as NPM (Butler, 2001).

Ferlie (1999) summarises this movement as; from the 1940s to the late 1970s, we used to think that markets would give way to the state (public administrastion); in the 1980s and 1990s, we thought that the state would give way to markets (NPM). He views the current talk of a 'third way','modernisation' and public/private partnerships 1980s. Butler (2000, 2001) discusses the rise and rise of NPM and operationalises Ferlie et al's (1996) four NPM models by separating their deconstruction with a wider literature review. Within this detailed review, the emergence of the changing role of clinicians in management can be seen in a much broader context. Some relevant examples with implications for this research are; the introduction of a stronger management by control and command culture; a more results oriented focus; the construction of general management; new forms of corporate governance; managing through contracts; encouraging competition; using the language of the customer and monitoring service standards. The modernisation agenda is part of the new language of the NHS and brings with it a raft of changes that are currently being implemented. The implications of these for clinicians in management and the findings from this research are discussed in chapter 7 of this thesis.

The research objectives and questions will evolve through the development of the literature review.

2. THE LITERATURE REVIEW

2.1 INTRODUCTION

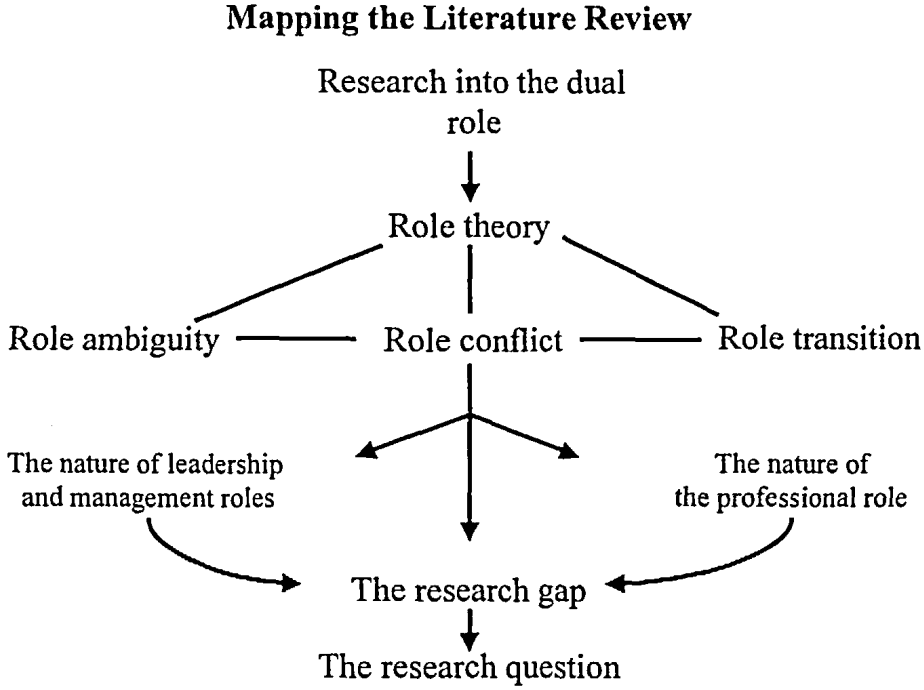
At the heart of this research is the role of the individual, who as clinical consultant takes on an additional role described here as a strategic leadership role. How to understand a role can take many forms, but a starting point has to be, to put some boundaries around the approach to the literature review. My ontology leads me to take a sociological and psychological perspective. Role theory claims to be a vehicle for integrating anthropology, sociology and psychology into a single discipline whose concern is the study of human behaviour (Biddle, 1979). As understanding individuals in a particular role in a particular context is the essence of this research the relevance of role theory resonates with me. In addition, role theory lies at the intersection of individual and organisational behaviour makes it useful for considering both the influence of expectations on managerial behaviour, and the effect of individual actions and preferences on behaviour (Hales, 1986). The importance of understanding how individuals form an understanding of their performance in a role, and the expectations others have of them in a role can only be heightened by knowing that managers spend a large percentage of their time engaged with others (Mintzberg, 1973).

The strategic leadership role, more commonly known as a management role is to be explored through a review of the literature that allows the role to be grounded and conceptualised in the literature as the research evolves. The complexity of the subject area and the scope and scale of the conceptual bases from which to explore it have attracted numerous researchers. Research spans the spectrum from rigorous academic research to the thin paperback to be found in airports for the aspiring leader to read on his or her business trip. However, there is some consensus amongst academic researchers that 'leadership matters' (Hambrick and Mason, 1984) It is leadership qualities, not just plain old management that is required for the fast changing environment of the 1990's. Researchers have continued to believe that the pursuit of knowledge to deepen our understanding of leadership will prevail to the millennium and beyond (Kotter, 1990). A reduction in the leadership and management literature for this review was undertaken as the findings evolved to confine the thesis to what is relevant for this study.

A brief discussion has argued that the career of the individual in this research has been particularly influential in the individual's development. As with the leadership and management literatures, the literature on careers and the professional career will be reviewed to provide an understanding and conceptual base to augment the research as it develops. Careers have been the subject of interdisciplinary study. Psychology, sociology, anthropology, political science, economics have all contributed to the understanding of how careers unfold. Interest in the concept of careers has progressed since the work of Bailyn, Hall, Schein and Van Maanen at the Massachusetts Institute of Technology (MIT) in the 1970s. As valuable as this still is, the old picture of jobs for life, stable employment and associated organisational careers is fading fast. A new dynamic employment and boundaryless careers calls for attention. Interest now lies in how careers are linked to evolution, strategic positioning, learning networking, and alliance building of organisations (Arthur, 1994). One meaning of the boundaryless career occurs when organisational career boundaries, notably hierarchies and reporting systems are broken. In management roles in the NHS this change has been seen for sometime. In contrast, the medical profession remains largely unchanged with strict hierarchies, and for doctors in the NHS there is still relative stability and jobs for life.

The literature review looks at and critiques studies into the dual role that in many organisations in the NHS in England is called the clinical director role. Fig. 2.1 below maps the domains of the literature review. The literature review begins by considering the particular role in this research. Reviewing this literature first brings an early understanding of the breadth and depth of research in this particular context. Literature relating to role theory follows. The review concludes the relevant literature for the leadership and management and careers.

Fig. 2.1 Mapping the Literature Review



2.2 CLINICAL CONSULTANT AS STRATEGIC LEADER – THE DUAL ROLE

2.2.1 Introduction

As described in the introduction to this thesis, the research is set in a particular historical context of the NHS and the changing role of public services. The changes over the last decade has seen the increasing emphasis on ensuring that consultants as key drivers of the organisation are involved in the management of heath services and are given responsibility for the use of resources (Department of Health, 1989). Organisational effectiveness and success is seen to derive from the development of key people and less reliance is now placed on strategic planning systems (Ghoshal and Bartlett, 1995). This is particularly relevant in times of change when key individuals are asked to lead and deliver new services and ways of working. Change now seems to be the normal, rather than the unusual, state in the lives of most organisations. With this has come an increased interest in the attitude and behaviour of key individuals. It is viewed by Ghoshal and Bartlett (1995) that the difference between organisations who successfully transform themselves and those who fail to adapt lies in the organisation's ability to change its employees' behaviour. Consultants are not renowned for their readiness to embrace change as evidenced later in this research. This is a characteristic of professionals for whom recent research (Fitzgerald and Ferlie, 2000) suggests are adept at retaining power, but frequently through adaptation and in new forms. These researchers see considerable evidence of policy driven or managerial changes diverted in unintended directions, due to the interventions of individual powerful actors.

The drive for change and an increase in the efficiency and effectiveness of the NHS through the involvement of consultants in leadership and management roles continues to attract much interest and the next section describes research in this area. This section provides an understanding of what is known and what is not known.

2.2.2 Areas of Research into the Dual Role

The involvement of NHS consultants in management with general management responsibilities has been the subject of much commentary and many research studies in the UK (Fitzgerald and Sturt, 1992; Burgoyne and Lorbiecki, 1993; Cowling and

Newman, 1994; Fitzgerald, 1994; Dawson et al, 1995; Ashburner and Fitzgerald, 1996; Willcocks, 1996; Buchanan et al, 1997; Gatrell and White, 1997; Thorne, 1997, Ong, 1998; Harrison and Miller; 1999, Hearing et al, 1999; Kakabadse and Kakabadse, 1999.). The dominant organisational model for the involvement of consultants in management is the clinical director (CD) model, with consultants having responsibility for a specified area of the service which is known as a directorate. Being a new organisational role in the second half of the 1980s and gaining momentum in the early 1990s a number of the research studies centred on this new CD role and several were linked to management development initiatives.

Lessons to be derived from the US experience of involving clinicians in management are to recognise the unique aspects of a health care organisation and the need to build collaborative management structures using clinicians and managers. This means developing the clinician manager roles, which include strategic and financial decision making, and not marginalising clinician managers (Schneller, 1989). UK research concurred with this point and urges support as well as incentives for clinician managers (Fitzgerald and Sturt, 1992). From research in US hospital systems the four keys to success in managing strategic change are defined as: developing integrated continuums of care; behaving like a system; developing effective partnerships and strategic leadership (Shortell, Morrison, Friedman, 1990). Being part of an organisation that behaves like a system and taking and feeling ownership of corporate decisions is seen as long overdue for mangers in medicine in the UK (Dawson et al. 1995).

While there is encouragement for the involvement of medical consultants in management, the question of what that involvement should be is still the subject of national and local debate and research. Driving change in any organisation is aided by an incentive for change to take place, this is often a crisis and referred to as a 'trigger'. Ellis and Moffat (1989) give six examples in England, USA, Canada and Holland where the successful involvement of clinicians in management has been helped by a crisis. It may well be that when the NHS is experiencing increased pressures nationally and locally the engagement of clinicians in management would become more active and more meaningful. The need for a 'trigger' to encourage

action has a common sense logic which is backed up by the change and strategic management literature (Kotter, 1990, Johnson and Scholes, 1999).

Key research papers which explore the role of the clinical director are reported here. These papers are reflected in some detail where they have direct links with this study. The areas where this study substantiates previous findings or comment, adds to or disputes previous findings or comment are discussed in chapter 6. A summary of the findings from this area of research are summarised in section 2.2.3.

Early research by Fitzgerald and Sturt (1992) urged caution in following the clinical director model, but proposed that collaborative working between doctors and general managers was essential. They looked at a sample of job descriptions and found the most common tasks for clinicians in management roles were:

Managerial roles
e.g. select subordinates
assign work and resources
appraise performance

Co-ordinating/Liaising Roles
e.g. propose actions
communicate to group
overcome problems

Representative roles
e.g. present views, advocate position

Monitoring roles
e.g. standard of quality
expenditure
output

Developing Service Relationships
as service givers and receivers with other collaborating agencies
e.g. social services

Fitzgerald and Sturt, 1992

Fitzgerald and Sturt saw most of these roles reflecting those of any manager in a service organisation, with the possible exception of developing service relationships. They believed there was a tendency towards reverting to the old medical representative role with little and, in some instances, no emphasis on decision making.

These researchers argued for this new role, as it was then, not to be seen as any other part-time manager. They believed the clinicians skills and expertise should be built

on by paring the role down to a minimum and focusing on the decision making tasks of:

Service Strategist: developing the service profile.

Allocating Resources: within the directorate depending on and agreeing specific budgets and developments.

Improving the Quality of Care; monitoring the quality of service outcomes and processes, setting standards and methods of improvement.

From the Fitzgerald and Sturt's understanding of the NHS they acknowledged the following hurdles needed to be overcome in this approach.

- learning to operate from a non-expert position (at least initially)
- developing a strategic approach and vision
- learning a new language and understanding new orientations and ideologies
- being critically dependent on others such as a business manager and staff manager
- managing nursing and paramedics as an integral part of medical care
- developing skills in team building and teamwork
- maintaining credibility with clinical colleagues ('only poor doctors become managers')

This research asked the question, about the clinical director role "what are the main tasks being performed?" The question was addressed by reviewing a sample of job descriptions. However, we obtain no understanding of how much the job descriptions reflected the tasks that were actually being performed. Some of the hurdles to be overcome embrace, but add little to the general management philosophy that was being promoted at that time. These include developing a strategic approach and vision, something which is difficult for many individuals moving from an operational role to a strategic role; managing other disciplines and promoting teamwork. This study, although restricted to job descriptions, does show an intent to involve clinicians in a strategic role.

A study Burgoyne and Lorbiecki, (1993) around the same time collects empirical data to provide an understanding of the experiences of clinicians who were becoming involved in management was obtained through interviews with 60 clinicians in 1991

and 1992. The clinicians involvement was often, though not exclusively in the clinical director or related roles. These individuals were receiving help as part of a 'Consultants into management initiative'. The roles as experienced were seen as more complicated and strategic than the ones described from job descriptions by Fitzgerald and Sturt (1992). However, as advocated by the Fitzgerald and Sturt the roles in this research had moved away from conventional 'management tasks' which looked inward towards the needs of a clinical specialty, to ones which stepped outside and incorporate the need for a sense of vision and leadership for the direction of the unit as a whole. It is interesting that these papers were written from data obtained at approximately the same time, with one paper advocating what was already in place elsewhere. The differences could be explained by a diversity in the roles across England or the difference between the role as defined in job descriptions and the role as actually experienced, or some combination of the two.

The clinicians experiences of becoming involved in management from Burgoyne and Lorbiecki's research were summarised into the following broad areas. While understanding the macro and micro issues in the NHS, the link between them was less clear. The group in this research viewed themselves as experimental and therefore could retain their place in the medical culture and keep their 'lines of retreat' open. The link between service and remuneration applied to the clinical and managerial elements of the role, seeing both as needed by society. This was another study where there were sensitivities around the interpretation that clinical managers are failed clinicians and the strove to disprove their own case. However, there was a challenge and some stress in learning to shift from short term to long term decision making and from acting alone to working with others.

With regard to decision making, this research confirmed the views expressed by Ham and Hunter (1988) that consultants face high levels of stress and anxiety when faced with the legitimate (inherent in their ethical codes of practice) conflict of making choices which serve to enhance the overall and longer-term interests of the population they serve, but which could penalise the service on offer to presenting patients. Research discussed later (Thorne, 1997) also reinforces the levels of stress experienced in both elements of the role.

Burgoyne and Lorbiecki's (1993), research concluded that clinicians were becoming involved in management without changing medical culture in a major way. The transition required new skills and ways of learning, but these were viewed as possible. The limitation on the transition of clinicians into management was seen as the maintenance of their credibility and esteem, to themselves, their medical colleagues and the public. This was viewed as being firmly determined by the medical culture, which if left intact, would preserve this important characteristic of the clinical role.

From this research Burgoyne and Lorbiecki believed the clinical director model to be sustainable if:

- the medical culture and the professional self image of doctors can adjust to this model common for other professionals (accountants, solicitors, lawyers and indeed private practice doctors) or professional groups in a free market,
- a way of dealing with the reconciliation of medical need and available resource is found elsewhere in the system, without passing this problem onto hospitals and clinical directors.

Indeed, adaptation of the medical culture and the professional self image of doctors to the model is a major consideration not merely for the model to be sustained, but for it to deliver a meaningful change in attitudes and behaviours. The model may be seen as common to other professions, but as recognised in research (Schneller, 1989) there is a need to understand the unique aspects of a health care organisation. Also there are specific issues relating to the NHS system operating in a highly political environment, nationally and locally, with a complex set of many different professional relationships. This distinguishes it from many other professions, even doctors in private practice.

Some change regarding the second point made by Burgoyne and Lorbiecki concerning reconciling the medical need and the available resources elsewhere in the system has been made. The National Centre for Clinical Excellence (NICE) now makes decisions nationally on such issues as the prescribing of new drugs. The medical profession has viewed this as a possible erosion of their freedoms rather than a supportive measure of removing the conflict between medical need and money available. The conclusion of finding a mechanism of dealing with the conflict of

reconciling medical need and resources outside the system may provide a solution. It appears, however, to signal a layer of command and control which is not a style that consultants readily respond to. The problem of management at a local level will probably remain.

Slightly later research began in 1992 (Dawson et al, 1995) examined the role of clinical directors as part of a broader study. The data collected from eleven provider organisations was used in this study. Data were in the form of self completed questionnaires and semi-structured interviews with 59 doctors with management responsibilities, 50 were CDs or equivalent and 9 Medical Directors, plus some insights came from a further 15 CDs who participated in a management development programme run by the researchers. Dawson et al found that many clinical directors felt catapulted into the job. Even the most enthusiastic were somewhat daunted as they discovered the extent of the task to which they somehow found themselves 'volunteered'.

A similar sentiment was expressed in a recent study (Cavenagh and Dewberry, 2000) that updates the discussion on doctor's views of management and why consultants choose or choose not to take on clinical directors roles. This research was conducted in two stages, the first through semi-structured interviews with consultants, clinical directors and other stakeholders. Themes from the interviews for taking or not taking on a management role were used as the basis for a questionnaire to test the validity of the themes and identify their significance. It was found that clinical directors believe significantly more than consultants that the role of the clinical director is attractive because of the opportunity to contribute to their organisation in a broader sense and to add value and make difference. Consultants, however, see the role as more attractive than clinical directors purely because *"it is their turn"*.

We cannot understand from Cavenagh's study if the positive view of clinical directors making a broader contribution to the organisation is a case of conversion, with consultants changing their minds once they have some experience in the role or they had this view before taking the role. Consultants and clinical directors in this study agreed the role was unattractive because of the time taken for the role and the opportunity cost of personal time. A cultural shift in attitude is claimed with

consultants and clinical directors stating they would not find the clinical director role unattractive because of a belief that doctors should treat regardless of cost or that management values contradict clinical values. This information from survey data could be added to by further research to establish if behavioural change accompanied this shift in attitude.

Dawson et al (1995) found the key issues for the clinical directors in meeting the managerial challenge were as follows:

- The main barriers that prevented them doing the job were operational overload (40%), internal management problems (33%) and financial constraints and a lack of resources (31%). There was a good awareness of the challenges within their own organisation, but they had began to grapple with the issues in the wider marketplace.
- Clinical directors were concerned about the time taken in managerial activity encroaching on their clinical activity, in terms of keeping up to date clinically and maintaining their earning capacity in private practice.
- Succession was something that concerned them. Here it was a mixture of some feeling trapped as choice was limited, others feeling they may be unhappy to give it up.
- The thing clinical directors found most difficult was to manage, direct or cajole their colleagues whom previously they could ignore if they encountered major areas of disagreement. The 'election' of clinical directors was a complex balance of acceptability to the chief executive and other executive directors and the consultants. The differences in expectations between these two groups were recognised. However, some of the newer younger clinical directors, perhaps from relatively 'unfashionable specialties' that previously were not high in the 'pecking order' of hospital consultants, were eager to embrace what they saw as an alternative source of power in the organisation. It is not clear if this was evidence from the research or interpretation or extrapolation.

Willcocks (1996) made a similar point in his research by concluding that directorates that embraced managerialist perspectives may do so because they belong to specialties that have more to gain politically from being a managerialist culture. For

example they were specialists that for historical reasons have been perceived as less glamorous, have lower status and prestige and so forth.

To move away from this guarded approach of not naming these less attractive specialties, my experience tells me these would include pathology. Taking this assumption, it is interesting to contrast research (Ong, 1998) which compared clinical management in surgery and pathology. Here, in pathology, reasons of experience and having to compete externally were given for the awareness of the importance of strategic management. The existence of an internal coherence and collective perspective on their own service had not been achieved in surgery. While the new approach had been defined the cognitive shift had not been accepted by the surgeons.

Returning to Dawson et al budgetary responsibility was varied with some clinical directors having a broad range of responsibility with internal and external service contracts to others who were frustrated at being asked to deliver on financial and quality targets with no budgetary responsibility. Human resource management was less welcome than budgetary responsibility. Although seen as inevitable, responsibility for hiring, firing and developing members of the team was seen as an area where they lacked expertise and interest. Clinical directors were keen to see appropriate appointments of managers to support them.

This study showed that although clinical directors said in response to the question about job activities that strategic planning and marketing of their services were important aspects of their job, they had actually done very little work in this area.

Dawson et al argue that if clinicians are to continue as part-time leaders there will need to be considerably more investment in training, development and support. They also discussed the issue that the medical profession, as with other professions, had rarely been in the forefront of initiating organisational change. The discussion reminded us that monopoly suppliers of professional services with carefully controlled entry and prescribed forms of training, have enormous power in determining the form in which services will be supplied (Johnson, 1972; Friedson, 1988; Clarke and Lawry, 1988)

Staged processual research between 1990 and 1993 (Ashburner and Fitzgerald, 1996) suggested a number of dangers in the escalation of the new role for clinicians at that time. One was that as rapid change occurs, clinicians would assume roles that were ill-defined and not use them effectively. Another danger was seen that without training, in the stages of transition, the part-time management roles would not attract clinicians who were committed and had credibility among their colleagues, and the potential of the role would not be fulfilled. The cohort in this research was 31 clinicians who were already in or had assumed management roles. These were individuals who went to programmes of management training based in high quality business schools. This was probably not a cohort typical of the general population of clinicians in management many of whom undertook little or no training.

As said before, several studies are linked to training programmes, but there seems to be no evidence to link training and the attraction of committed individuals into the clinical director role and their credibility with consultant colleagues. In Willcocks (1996) the study had shown that clinical directors in the acute specialties are likely to reject conventional development routes. He also posits that the overall effectiveness of the clinical director may be seen as the extent to which he or she is able to influence, adapt, modify or change role expectations, reconcile conflicting expectations or live with multiple expectations.

Wilcock's research looked at the effectiveness of the CD role through a role theory perspective. He suggested that effectiveness in the role may be measured by the extent to which managers are able to meet the expectations of their role set, and that the overall effectiveness of the clinical director may be the extent to which he or she is able to influence, adapt, modify, or change these role expectations. Wilcock's research is more tentative than earlier findings by Tsui (1984) who also took a role theory approach to examine managerial behaviour and effectiveness. Her research concluded that "reputational effectiveness" was the extent to which the role sender (those who have an interest or stake in the individual's performance) had his or her expectations met.

Research which aimed to explore how doctors engage in hospital management processes (Buchanan et al, 1997) developed a model concerning the positive and

negative balances in the pattern of engagement in one NHS trust centred on a district general hospital. Here 6 CDs and 19 other members of the hospital management were interviewed. These researchers argued that an emphasis had been placed on identifying the 'skills deficit' of those who move into a CD role with less emphasis on how they actually engage in the management process. The most important qualities were seen as, the confidence of clinical colleagues, a corporate perspective, broad understanding of the management issues, leadership qualities and political skills. Positive influences were seen as CDs having an informed voice, bringing a patient-centred focus to decision making with an understanding of the resource implications of changes; having a range of social and interpersonal skills. Motivations for undertaking the role were seen by managers as power, ability to play a shaping role, influence, status and prestige and possible career progression. Managers viewed the main sources of dissatisfaction for CDs as time pressure, financial constraints, role conflict and pressure and conflict from colleagues. From the CDs perspective factors which reduced the attractiveness of the role were, was a general reluctance by their colleagues to take on the role, it was transient, there were no career benefits, it was a pressured lonely role. These researchers believed that the benefits to be achieved by further developing the doctor's engagement in the management process should encourage new and innovative approaches.

Recently published research by six medical doctors (Hearing et al, 1999) took an enquiry action learning approach to look at the problems doctors encounter when assuming a management role. They also focused on how the CDs felt the NHS could make undertaking managerial duties more attractive to doctors. Problem areas for doctors going into management were; the conflict between the focus on the individual patient and the use of resources for the benefits of patients as a whole; time pressure; potential loss of income if management responsibilities encroach on private practice; managers don't command the same respect and confidence as doctors and the attitude of colleagues. It was seen as important for doctors to be convinced of the relevance of their input to the management process. Also, the above problems need to be addressed to encourage consultants into management roles, although this research does not purport to offer solutions to these.

A case study approach at a large provincial NHS teaching hospital trust (Thorne, 1997) viewed the CD role through five themes, stress, identity, leadership, control and ambiguity. Here different kinds of stress were seen in both elements of the dual role. The CDs at this trust viewed their identity as living 'two separate lives' operating in a 'parallel reality'. Leadership rather than management was how the CD role was viewed, with the five themes operating in an internal and external world. CDs were resigned to external control and internally the tension between satisfying the Chief Executive and clinical colleagues placed them in a difficult situation. Ambiguity was high in the role, induced by the nature of the role and the lack of preparation for it. Approaches to the role varied and the lack of structured feedback on their performance from executives left a vacuum. Thorne believed this research raised three questions. Is the clinical director role valuable? Is the role in its present form 'doable'? How should it be recognised and rewarded? Ways forward were suggested as, understanding what level and type of support is needed, planning succession and exit, managers learning to work more effectively with doctors and doctors recognising the need to behave corporately and learning how to add value through the corporate decision making process.

The distinction between the operational role and strategic role of the clinical director appears to be unclear. It is argued (Harrison and Miller, 1999) from the experience of developing, running and evaluating a three year management development programme, the role of the clinical director is potentially of great significance in enhancing the organisation's strategic management capability. They believe this would be achieved by CDs acting as conduits for knowledge connectivity both inside and outside their organisation, by understanding and where necessary challenging the dominant logic of their organisation. By acting as link-pins in intra- and inter-organisational networks, they believe that CDs can make a valuable contribution to that capability. They made the interesting, subtle and yet important distinction between the CDs themselves having a strategic responsibility and contributing to the strategic capability of the organisation.

Being strategic, whatever the interpretation of the word 'strategic', and having a strategic leadership role has consistently been a feature of the CD role. The subject of strategic leadership has been an element of many of the training and management development initiatives delivered for consultants in management in the UK. This has

emanated from the identification of training needs which have often been one output from research studies (Harrison and Miller, 1999). However, earlier research showed a strategic element to the role was often an assumption and there was little agreement on the actual capability that was required (Cowling and Newman, 1994, Dawson et al 1995).

Embarking on research to understand the roles of consultants moving into management posts can be problematic. They are often sceptical of any research methods other than formal clinical trials and research which produces quantitative statistical data. They are used to scientific training with positivistic methodologies (Pope and Mays, 1993). The transition to management requires new ways of learning with which consultants are unfamiliar, much of the learning in a management role is experiential. Burgoyne and Lorbiecki (1993) acknowledge new ways of learning are required and see this as possible.

2.2.3 Summary

The transition to the dual role of clinician and strategic leadership has to be understood through acknowledging and understanding the individual. These studies leave us in little doubt that the role is a challenge for many of those in the population of the studies cited here. . Although there consistencies and confirmation of findings in some areas, the role is experienced differently amongst the population. Some common themes emerge from the studies, these are summarised below.

The role continues to attract research interest as it evolves in the changing nature of the NHS. Some the findings concerning the role remain unchanged across the last decade. The role is espoused as a strategic role, management role and a representative role. A more strategic role is urged to focus on decision-making tasks (Fitzgerald and Sturt, 1992). The perception of the strategic element of the role appears to vary in different studies (Burgoyne and Lorbiecki, 1993).

Barriers for clinicians meeting the challenges of the dual role are many. The medical culture is seen as a barrier, it is thought to be so strong that reconciling medical need with resources may only be possible through a mechanism outside the system (Burgoyne and Lorbiecki, 1993). The practical barriers are seen as an overload of

operational work, time taken in the management role encroaching on other activities, internal management problems and a lack of resources and the problems associated with 'managing' colleagues (Dawson et al, 1995, Hearing et al, 1999).

Reasons why individuals take up the role are seen as varied with a host of concerns. Some feel they have little choice in taking up the role. The feelings are: they are volunteered for the role by others; it is their turn; they feel trapped because no one wants the role (Dawson et al, 1995, Cavenagh and Dewberry, 2000). For some, particularly young consultants in the less attractive specialties, a sense of power is interpreted as a reason for taking the role (Dawson et al, 1995, Willcocks, 1996, Buchanan et al, 1997). More positive reasons include an ability to play a shaping role and influence (Buchanan et al, 1997). The latter may still be related to having power.

Several studies have taken place in relation to the identification of training needs for the dual role. There are pleas for more training from researchers interested in management training and development (Dawson et al, 1995, Ashburner and Fitzgerald, 1996). Studies where the samples are those participating in training programmes may not be typical of the population where training has been patchy (Ashburner and Fitzgerald, 1996). Knowledge and skills have been identified for the role ranging from expertise to hire and fire, strategic planning and marketing, to the qualities of having the confidence of colleagues and being able to take a corporate perspective (Dawson et al, 1995, Buchanan et al, 1997).

Alongside the acquisition of knowledge and skills acquired through specific training, are the values and beliefs of the individual which will be challenged as difficult strategic choices have to be made which may divert resources from their own specialist professional area. The dominance of their own strong professional identity and specialism needs to be put aside to consider and make decisions within a broader frame of reference. The management role is perceived as stressful having to act corporately in the interests of the organisation where decisions may penalise the service offered to presenting patients (Ham and Hunter, 1988, Hearing et al, 1999). The power consultants possess from professional autonomy and the respect they are shown for their clinical skills does not automatically transfer and stay with them in performing the strategic part of their role. The strong medical culture reinforces their

concern to maintain their credibility and esteem to themselves and their medical colleagues (Burgoyne and Lorbiecki, 1993). The effect of medical training and socialisation on their attitudes and behaviours has often created problems between managers and management (Bennet, 1987).

Adding to this research, as a practitioner I have a personal understanding of the level of conflict that can be experienced between clinician and manager with chairs being thrown through windows with frustration and a gun club licence being left on a manager's desk by a clinician as a threat. This conflict, tension and stress which is acted out between manager and clinician has to be managed 'internally' by those who take up the dual role and become manager and clinician. Although not straying too far into a psychoanalytic approach this conjures up the picture of the inner drama of role taking (Triest, 1998) and the notion of the 'organisation in the mind' (Hutton et al, 1997). Another literature explores this approach to role analysis (Gould, 1991, Hirschhorn, 1985, Armstrong et al, 1994).

Research fairly recently still shows the concept of management being part of the doctors role is not generally accepted. There appears to be a 30:70 split between those who are receptive to the concept and those who are antagonistic to it (Gatrell and White, 1997), although this study covered all the medical grades including medical students, who had chosen medicine as a profession and possibly less likely to feel positive about seeing management as part of their role at an early stage of their career. But it may say something about doctor's attitudes towards management in general.

Dangers are seen by Ashburner and Fitzgerald (1996) that as rapid change occurs roles will be ill-defined and individuals not used effectively. A study partly using role theory believes effectiveness in the role is concerned with managing the role expectations (Willcocks, 1996).

There is a theme of a quest for and recognition of the clinical director role as one of significance in the strategic management of the organisation (Fitzgerald 1992, Harrison and Miller, 1999). The quest still appears to be how should this be achieved. Lists of competencies for strategic leadership roles are not in short supply, as

evidenced later in the literature review. Many of these studies concentrate on the skills and knowledge required to do the role and understanding some of the views of the role e.g. the barriers to performing the role.

Behind the reason for many studies one can see the search for individuals to be effective in the role, hence the link with training and development programmes. Delivering more training, defining the role clearly, managing expectations and other variables are offered as contributors to effectiveness in the role. Identifying the variables is an issue and finding causal links between them an even greater challenge. Acknowledging from these studies the role is taken up in different ways, there is no understanding why this is. What is different about the approach to the role by individuals? What looks different about how the role is taken up? Little regard is given to the recognition of where these individuals are coming from and how they actually take up the role. Acknowledgement of their professional career is discussed almost anecdotally, but no real evidence is produced on the individual interpretation of how both elements of the dual role are taken up.

To put the understanding of the clinical director role in a theoretical context, the next section explores role theory, the origin of roles and how roles are taken up.

2.3 THE TAKING UP OF ROLES

2.3.1 Role Theory Background

What is role theory? This question causes as much debate as the subject itself. Role theory can be defined (Biddle, 1979) as a science concerned with the study of behaviours that are characteristic of persons within contexts and with various processes that presumably produce, explain, or are affected by these behaviours (Biddle, 1979). A role orientation has evolved gradually from related interests in several social sciences, anthropology, sociology and psychology and merged into a single discipline whose concern is the study of human behaviour (Biddle, 1979). Others see role theory as partitioned into two contrasting fields, one stemming from symbolic interactionism and the other representing structured psychology (Heiss, 1968). Within other social sciences e.g. economics, political science and demography, human behaviour is viewed more as an independent variable than as a dependent variable. Role theory can contribute by informing these disciplines of behaviours which operate in various contexts. Helping the professions is more central to role theory e.g. teaching, psychiatry, social work and leadership training and development.

Role theory still lacks a propositional structure that ties the field together. However, there are several underlying propositions which have not been refuted and about which there still appears to be general, if informal, agreement. These are summarised by Biddle (1979) as:

1 Role theorists assert that 'some' behaviours are patterned and are characteristics of persons within contexts (i.e. form roles).
2 Roles are often associated with sets of persons who share a common identity (i.e. who constitute social positions).
3 Persons are often aware of roles, and to some extent roles are governed by the fact of their awareness (i.e. by expectations).
4 Roles persist in part, because of their consequences (functions) and because they are often embedded in larger social systems.
5 Persons must be taught roles (i.e. must be socialised) and may find either joy or sorrow in the performances thereof.

It has to be said that there would not be complete agreement on these propositions in the wider community of social scientists. Biddle's view is that radical behaviourists would tell us that the concept of expectation is unnecessary and confusing; and Marxists would focus more on economic matters and historical imperatives. Despite such arguments, role concepts are widely accepted within the social sciences. The pragmatism that can be seen in the five propositions probably contributes to its appeal.

Hales (1986) in his review of the role literature, suggested that role concepts could provide one suitable theoretical framework for research. He provided a general statement of the utility of role theory, arguing that its location at the intersection of individual and organisational behaviour made it useful for analysing both the influence of expectations on managerial behaviour and the effect of individual actions and preferences on behaviour. Researchers have proposed that a role framework is useful for the analysis of any set of persons whose common life situation is worth looking at sociologically (Goffman, 1961). It is especially useful for the analysis of occupational and quasi-occupational categories (Sarbin, 1968), where associated with any office or position is a set of activities or expected behaviours to be performed by any occupant of the position (Katz and Kahn, 1978). The emphasis on occupational and social positions, particularly those in complex organisations, makes a role perspective a logical choice for researchers analysing the behaviour of incumbents of managerial jobs (Fondas and Stewart, 1994). The attractiveness of a role perspective is further enhanced as so many management studies comment on the high percentage of managers' time spent in interpersonal contact with others. Hales (1986) and Fondas and Stewart, (1994) sighted numerous examples of these studies. As Mintzberg (1973) stated 'contacts are the manager's work'.

Considering the dual role of professional and strategic leader through this perspective offers an insight into how both elements of the role are made and enacted. The term enacted is defined here as what the individual actually does in the role. In the literature this is also be referred to as role behaviour and role interpretation. We now look at the origin of roles followed by the relevant research for this study.

2.3.2 The Origin of 'Role'

All the world's a stage,
And all the men and women merely players.
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages.

W. Shakespeare, As You Like It, Act II, Scene 7

The well known quotation from Shakespeare leads us to the analogy of role with the theatre, which is taken from Biddle, and Thomas' work (1966).

When actors portray a character in a play, their performance is determined by the script; the director's instructions; the performance of fellow actors, and reactions of the audience as well as by the acting talents of the players. Apart from differences between actors in the interpretation of their parts, the performance is programmed by all of these external factors; consequently, there are significant similarities in the performance of actors taking the same part, no matter who the actors are.

Taking this analogy into real life and using some of the terms of role theory (Biddle and Thomas, 1966). Individuals in society occupy positions, and their role performance in these positions is determined:

- by social norms;
- demands and rules;
- the role performance of others in their respective positions; by those who observe and react to the performance;
- the individual's particular capabilities and personality.

The 'social script' may be as constraining as the play, but it frequently allows more options. In organisational life there is usually a manager who has parallels with a theatre director and there is an audience who watch us. How well we play our organisational role is linked to how well we know our 'part', our personal history, our personality and the 'script' which others define for us in so many ways.

Although the word role was part of the English and various European languages for many years it does not appear to have been used to refer to a technical concept until the 1930s. Moreno (1960) summarised the interesting history of the word role and its usage as follows:

"Role" originally a French word which penetrated into English is derived from the Latin rotula (the little wheel or round log the diminutive of rotawheel). In antiquity it was used, originally, only to designate a round wooden roll on which sheets of parchment were fastened to allow them to smoothly roll ("wheel") around it otherwise the sheets would break or crumble. From this came the word for an assemblage of such leaves into a scroll or book-like composite. This was used subsequently to mean any official volume of papers pertaining to law courts, as in France, or to government, as for instance in England: rolls of parliament - the minutes or proceedings. Whereas in Greece and also in ancient Rome the parts in the theatre were written on the above mentioned "rolls" and read by the prompters to the actors (who tried to memorise their part), this fixation of the word appears to have been lost in the more illiterate periods in the early and middle centuries of the Dark Ages, for their public presentation of church plays by layman. Only towards the sixteenth and seventeenth centuries, with the emergence of the modern stage, the parts of theatrical characters are read from "roles", paper fascicles. From this each scenic part becomes a role.

We continue to use the language of the theatre in organisational life, with work being 'front of house' or 'on stage' when employees are 'performing' in front of customers or when those in leadership positions act as role models for those working with them. Also, we frequently use role-play to practice and learn behavioural management skills, such as negotiation and giving and receiving feedback.

2.3.3 Role Making

The concept of role is one that can be described as the summation of the requirements with which the system confronts the individual member (Katz and Kahn, 1966). Park wrote as early as 1926, that ' everyone is always and everywhere, more or less consciously, playing a role . . . It is in these roles that we know each other; it is in these roles that we know ourselves'. In common with the career literature, discussed

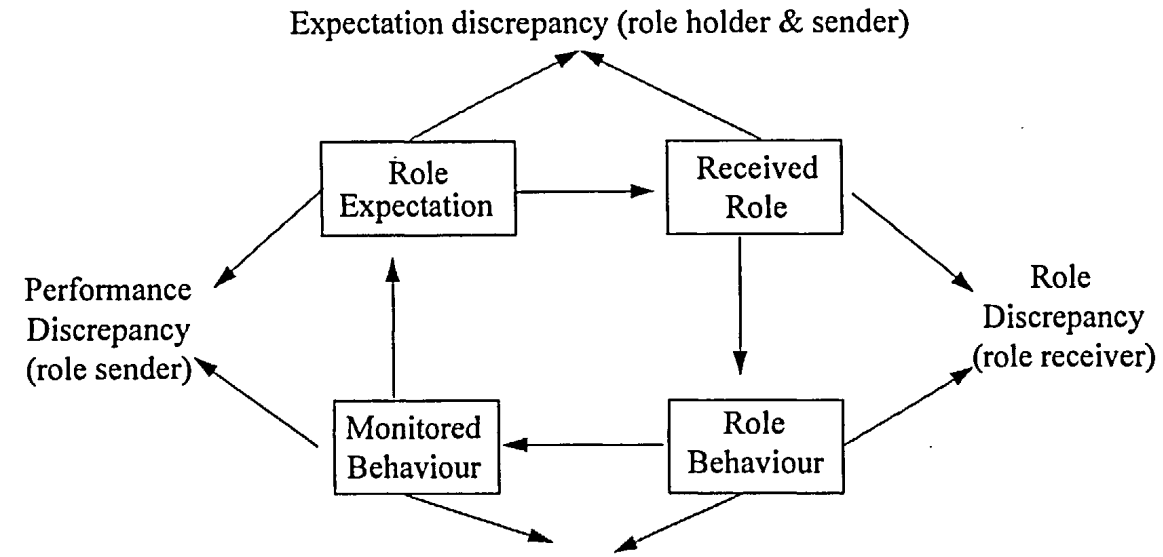
later in section, the concept of role has an early and continuing link with a range of social science viewpoints.

Role has been used to explain the origins of social behaviour (Mead, 1934) and as a concept in psychotherapy (Moreno, 1934). It has been made a key concept in social psychology (Newcombe, 1951) and given a central place on anthropology (Linton, 1936). Others consider it essential to understanding social action and social structure (Parsons, 1951; Merton, 1957).

Generically, role behaviour refers to the recurring actions of an individual, appropriately interrelated with the repetitive actions of others so as to yield a predictable outcome. Frameworks have been developed which consider role behaviour as a set of interdependent behaviours which comprise a social system or subsystem, a collective pattern in which people play their parts (Katz and Kahn, 1966).

The framework developed by Graen, (1976) through Fig. 2.2 captures the process of role making as a dynamic iterative process between individuals. This process is explained below.

Fig. 2.2 Role Making



NB. Model for one role receiver and one role sender

Graen (1976)

In the performance of a role (role making) there are other people around the individual who are referred to as the role set. The role set (Merton, 1957) consists of different people with whom the individual (role holder) has contact. In the role set are people who hold expectations about and have a stake in the person's performance in the role. They are also referred to as the role senders, and in the context of this research they could be the people with whom the clinical director works, who communicate their expectations during interactions with the role holder, the clinical director. The role sender will develop beliefs and attitudes about what the role holder should or should not do and how they expect them to behave and treat them. What happens between role sender and role holder is a psychological process consisting of that person's perceptions and cognition's of what was sent. Fig. 2.2 shows diagrammatically the interaction between the role sender and the role holder.

A role expectation is sent by a role sender (e.g. a nurse manager) to the role holder (clinical director), the role holder receives the expectation and is then labelled the role receiver in Graen's model Fig. 2.2. He or she interprets the role he has been sent and in turn behaves in a certain way, the behaviour is monitored by the role sender (e.g. nurse manager), who interprets this and reacts. Where a discrepancy is exists there is an opportunity for behaviour to be adjusted. First, the discrepancy has to be recognised and second, the behaviour has to be intended and capable of being interpreted positively. This model demonstrates the flow of role making for one role holder. This highlights the complex set of interpretations that individuals are required to make if they want to influence their entire role set towards a specific outcome.

The creation of roles is an ongoing, indeterminate process and not a quickly reached conclusion. Differences and ambiguities in demands from role senders will lead role occupants to make social comparisons with relevant others and enact their roles in a manner which reflects what they want as well as what others want (Smith, 1973; Weick, 1976). Several practical procedures have been developed from the Graen model to understand and negotiate role expectations between the sender and the receiver (Machin et al, 1984).

Stewart's studies into managerial behaviour included some research in the NHS, this concentrated on general managers. In her earlier work (Stewart, 1976) she distinguished between behaviours which the role demands, the factors which place constraints on the range of behaviours and the choices which enabled a specific manager to behave differently from someone else occupying a similar role. This is the framework for the first interview with the clinical directors and is explained later in chapter 3. The model started from a desire to describe jobs and to understand what a study of behaviour could tell one about the nature of jobs. Stewart considered the model closest to the Graen model (1976) exploring the interaction between the job and the job holder. The model was subsequently used to help understand an individual's perception in a job in three manufacturing companies in different industries (Marshall and Stewart, 1981). In her paper Stewart (1982) laid increasing stress on the importance of the manager learning to differentiate demands from choices. She placed emphasis on choice as the key element on the manager's accommodation of conflicting expectations.

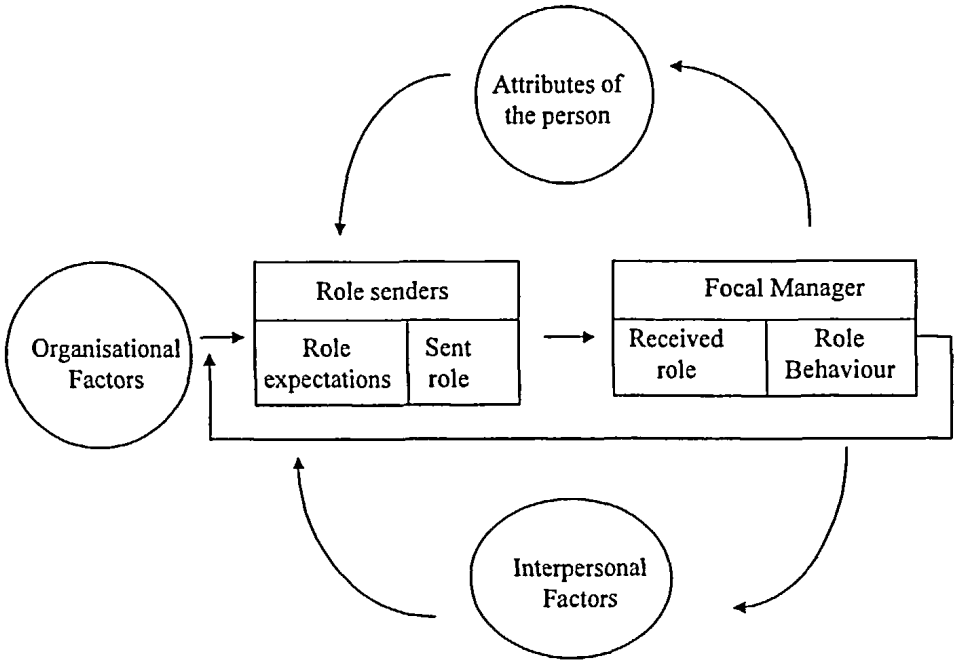
Rodham (2000) in her study of occupational health professionals produced four distinct role options. These emerged as strategies which allowed role incumbents to cope with the dilemma of integrating their medical role within a managerial context. The role of an occupational health physician is to remain an impartial advisor whose advisory responsibility is both for management and employees. The four options are the roles of manager, manager + medical skills, medic + managerial skills and medic. The results of this doctoral study are that the options are not 'fixed' and the occupational health professional is able to move forward and backwards between the options as a function of situation/interpersonal context. Conclusions of this study were that it demonstrated the need to conceptualise role as something which involves a dynamic interaction between the role incumbent under observation and the role sets with whom they interact. It is difficult to see from this study how the aim of understanding the processes underlying and leading to role behaviour have been fulfilled through the methods described and the results. That there is a dynamic interaction between the role incumbent and the role set confirms other research (Tsui, 1984, Willcocks, 1996). Findings from this particular study claim that individuals can move between the identified role options, but does not explore any of the issues

associated with making choices between roles. The clinical director role moves between similar medical and management roles, but has different accountabilities.

The concept of the role set provides a different perspective for looking at an individual's contacts from that of a network, as Kotter (1982) used the term, which is more commonly used in research on managerial jobs and behaviour. A network is described from the manager's perspective with emphasis on the manager's purpose and actions in relating to the network. By contrast, with role set the emphasis is more on the communication episodes and influence attempts of others with whom the manager interacts.

The Graen model (1976) does not draw attention to the complexities which surround and underpin the interaction between role holder and role sender. These are shown in the Katz and Kahn 1978 model (Fig. 2.3). Here the role holder was referred to as the focal manager, but the principles of the interaction were the same as the Graen model. However, surrounding the interaction are the other factors which influence the process of role making. These are the attributes and interpersonal factors of the individuals and the organisational factors such as the culture and climate. These factors have links with those referred to earlier in section 2.3.2, (Biddle and Thomas, 1966).

Fig. 2.3 The Role Model



The Katz & Kahn (1978) model

The complexity and ambiguity of strategic roles almost invites role conflict. Often there are many individuals who have different and conflicting objectives. Role conflict is defined as the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with another more difficult (Katz and Kahn, 1966).

Some role theorists (Graen and Cashman, 1975, and Graen and Scandura 1987) saw the period when individuals interpret and make their role as a phenomenon that exists only in the early weeks of job occupancy and under special circumstances. However, others argued that role making occurs continually as a by-product of the job holder's interaction with members of the role set (Fondas and Stewart, 1994).

This was reinforced earlier by Smith (1973) and Weick (1976) who saw the creation and making of roles as an ongoing, indeterminate process and not one where quick conclusions are reached. Differences and ambiguities in demands from role senders will lead role holders to make social comparisons with relevant others and enact their roles in a manner which reflects what they want as well as what others want.

One reason for paying attention to this interaction between the role set and role holder may be that when a manager fulfils the role set's expectations, he or she is judged effective by them, which leads to better performance appraisals, more frequent promotions, and other indicators of success (Tsui, 1984).

The complexity that surrounds the role set, the focal manager (role holder) and the role set relationship have been considered by examining three previously separate streams of research (Fondas and Stewart, 1994) From the fields of leadership dyads, symbolic interactionism and managerial behaviour hypothesised relationships have been summarised to provide a set of testable propositions. This conceptual framework adds a challenge to those interested in the field of expectation enactment.

A different perspective is cast on looking at the clinical director role to many evidenced in research into this particular role in the previous section. The emphasis here is 'making a role' through understanding and recognising the requirements of the system and the individual members in it.

2.3.4 Role Conflict Defined

Acknowledging the complexity in the interactions between the role holder and the role set it does not take a great leap of imagination to realise that within these interactions there lies conflict. The study of role conflict and ambiguity has its own set of definitions which helps to develop a shared understanding. The following definitions (Kahn et al, 1964) are still accepted. Kahn and his colleagues were interested in understanding conflicting expectations primarily because they create psychological conflict for the person who is the target. The types of role conflict are defined as:

Sent role conflict – the simultaneous occurrence of two (or more) sets of pressures such as the compliance with one would make the more difficult compliance with the other. In the extreme case, compliance with one set of pressures excludes completely the possibility of compliance with another set, the two sets of pressures being mutually contradictory.

Intra-sender conflict – different prescriptions or proscriptions from a single member of the role set may be incompatible.

Inter-sender conflict – pressures from one role sender opposes pressure from one or more other senders.
Inter-role conflict – role pressures associated with membership in one organisation are in conflict with pressures stemming from membership in other groups.
Person role conflict – role violates values, conflict of priorities, difficulty in deciding which pressures to deny, part of role overload with inter-sender conflict.

2.3.5 Role Ambiguity

Much of role conflict can be thought of as a kind of inadequate role sending; lack of agreement or coordination among role senders produces a pattern of sent expectations which contains logical incompatibilities or which takes an inadequate account of the needs and abilities of the focal person. A different pattern of inadequacy in role sending constitutes role ambiguity (Ilgen and Hollenbeck, 1991, Kahn et al, 1964).

Individuals in organisations must have certain kinds of information at their disposal if they are to perform their job adequately. The processes of communication and how the communication networks operate is a concern for individuals and linked to the effectiveness of the organisation. The availability of information related to an individual's role has profound implications for their personal adjustment and emotional well-being (Kahn et al, 1964).

Kahn continues, that certain information is required for adequate role performance, that is, in order for a person to confirm to role expectations held by members of the role set. First of all, there needs to be clarity about the rights, duties and responsibilities of any post. Second, there needs to be an understanding of what activities need to be undertaken to fulfil these responsibilities and how they can be best performed. The person needs to know the potential consequences of role performance and non-performance.

Certain information is required for personal comfort and psychological well-being. In general there is a need to know what kinds of behaviour will be rewarded or punished, the nature of the rewards and punishments, and the likelihood of their occurrence. A person needs to know what kinds of behaviour will be satisfying or frustrating for their own personal needs and values. Certain needs, values and aspirations are held

sufficiently in common among members of a particular population, that regardless of what particular person occupies a position, the requirement for certain types of information is predictable. Needs exist and characterise individuals, but there are certain kinds of common needs, these may related to such things as safety, security, recognition or achievement. Common needs allow different environments to be compared.

Ambiguity may exist because information is simply not available or because existing information is inadequately communicated. The term 'experienced ambiguity' is the state of a person when their perception of the environment and their understanding of the implications of their behaviour does not fit the real world (Kahn et al, 1964). It is expected the greater the experienced ambiguity the more the person experiences tension and anxiety. There are, however, some individuals who have a tendency to respond negatively to ambiguity.

Ambiguity and conflict cause the individual problems in adjustment. The problems and how they are dealt with depends on two sets of factors other than the ones described here. The first of these is personality; a set of predispositions formed throughout life. The second includes all the current relationships with members of the individual's role set. This research does not address personality factors, but considers the part a professional career plays in the life history of the individual and seeks an understanding of how the individual perceives the expectations of his or her role set.

The findings from research by Katz et al was derived from a series of case studies and a national survey to test the findings concerning the organisational determinants of role ambiguity and conflict. While no later research has been found to cast doubt on the findings as they are relevant for this study, it is acknowledged that the research is 40 years old and took place in industrial locations in the United States. The research is reported in the male gender of this male dominated environment.

Ambiguity is acknowledged in management roles as seen later in this review. It is also seen as an issue in research into the clinical director role due to the nature of the role and the lack of preparation for it (Thorne, 1997). Dangers are seen if the clinical

director role remains ambiguous and clinical consultants are not used effectively (Ashburner and Fitzgerald, 1996).

2.3.6 Managing Multiple Roles

Inter-role conflict, where the role pressures associated with membership in one organisation are in conflict with pressures stemming from membership in other groups (Kahn et al, 1964) is often the subject of research into work and family roles. Dominating this area of research are studies concerning women in work and a caregiving role at home (Kossek and Ozeki, 1998, Kossek et al, 1999). This area of research has implications for how individuals make choices in their lives and what factors determine those choices and outcomes. This leads to other research domains from social pressures in society influencing choices, personal values and motivation to how organisations respond to changing their employment policies to reflect a 'family friendly culture'. Arguments concerning role strain and role enhancement predict different outcomes for women occupying multiple roles (Reid and Hardy, 1999). Studies from a role strain perspective suggest that multiple roles can make women feel overburdened, having a detrimental effect on mental and physical well-being (Pearlin, 1989, Young and Kahana, 1989). Other studies from a role enhancement perspective argue multiple role improve mental well-being. Roles outside the home put them in touch with more emotional and economic resources and temper their conflicting responsibilities (Crosby, 1991, Parris Stephens et al, 1995).

This area of research highlights the complexity of understanding individuals and their specific context. Generalisations are difficult in such a complex field of study, but studies into the clinical director role have found time pressure and role overload created difficulties in managing multiple roles. Time spent in the clinical director role was seen to erode time spent on other professional roles and time at home and with the family. (Dawson et al, 1995, Buchanan et al, 1997 and Hearing 1999).

2.3.7 Micro Role Transition

Many studies have been undertaken into inter-role conflict and relatively few have focused on role transition (Ashforth et al, 2000). Here the distinction is made between the transition from one role and another on a regular basis (micro transition) and the transition into a role as in moving from one job to another as career

progression. We consider the transition between one role and another on a regular basis. Here as in inter-role conflict this is often thought of and researched as the daily transition between a work role and a home role or social role. Managing the boundaries between role is loosely described as boundary theory (Michaelson and Johnson, 1997, Nippert Eng, 1997).

Boundaries have been used in numerous disciplines to refer to the physical, temporal, emotional, cognitive, and/or relational limits that define entities as separate from one another (Ashforth et al, 2000). Individuals create and maintain boundaries as a means of simplifying and ordering the environment. Mental fences (Zerubavel, 1991) are erected around geographical areas, people and ideas. This creates a sense of relatedness to social domains, work, home, a sport or hobby. Boundaries are what an individual perceives them to be. It relates to how they make sense of the world around them.

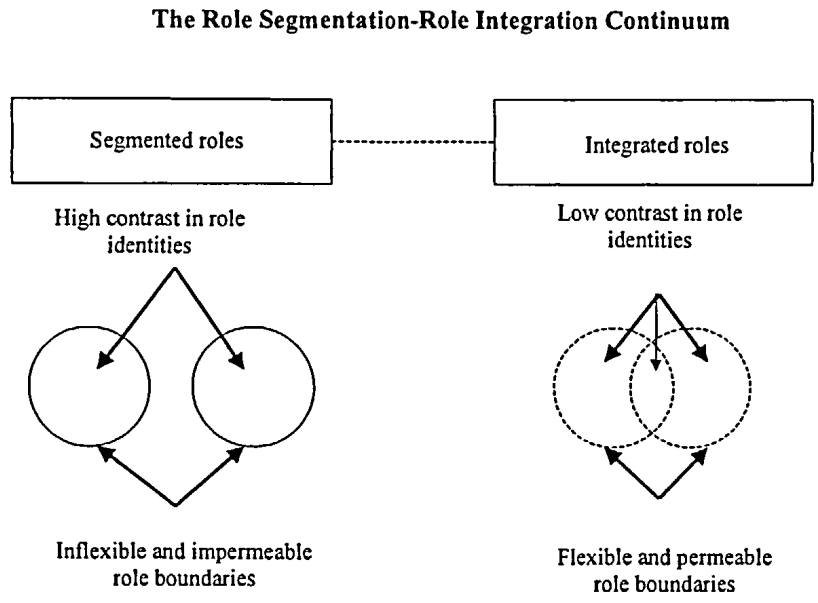
Two key concepts affecting the process of these micro role transitions in individuals daily lives are the flexibility and permeability of a given role boundary (Ashforth et al, 2000). Flexibility is the degree to which special and temporal boundaries are pliable (Hall and Richter, 1988). This flexibility means a role can be enacted in various settings and at various times. Conversely inflexible boundaries severely constrain when and where a role may be enacted. Permeability is the degree to which a role allows one to be physically located in a role's domain, but physiologically and/or behaviourally involved in another role (Pleck, 1977; Hall and Richter, 1998). Conversely, a person who has little access or time to attend to other roles has an impermeable boundary. Issues of permeability and flexibility in role boundaries are likely to influence the inter-role conflict (Ashforth, 2000).

Role identity is associated with role transition in the following ways. Role identities are socially constructed definitions of self-in-role (that is the role occupant or the focal person) consisting of core and peripheral features. Core features tend to be important, necessary or typical characteristics that define the identity. Peripheral ones may be more concerned with style. Greenhaus and Beutell, (1985) found that the stereotypical managerial role identity emphasises the core features of self-reliance, emotional stability, aggressiveness and objectivity, whereas more peripheral features may include intelligence and charisma. Core and peripheral feature may also include

aspects of context that help situate the role identities, such as, geographical location, role set members and status. What makes role identities relevant to role transitions is the 'contrast', that is the number of core and peripheral features that differ between a pair of role identities and the extent of the differences where the core features are weighted more heavily (Louis, 1980). The greater the contrast between the role identities, the greater the magnitude of transition and, therefore the potential difficulty of the transition.

The difficulty in moving between role identities lies in switching cognitive gears (Louis and Sutton, 1991. Ashforth et al (2000) argue that by combining the concepts of role boundary (flexibility and permeability) and role identity (contrast) the comparisons between pairs of role identities can be arrayed on a continuum from high segmentation (i.e. high contrast role identities and flexible and permeable role boundaries) to high integration (i.e. low contrast role identities and flexible and permeable boundaries). The relationship between role boundaries and the contrast in role identities is shown in Fig. 2.4 below.

Fig. 2.4 The Role Continuum



Ashforth et al, 2000

This continuum has been expounded by Nippert-Eng (1996) who found individuals differed in the degree to which they segment or integrate their work roles. Also Hartmann (1997) found that individuals vary in the degree to which they have 'thick' (segmented) and 'thin' (integrated) boundaries around roles. High segmentation in work roles is less evident in earlier research. The rationale for this is work roles usually have the organisational context in common, together with whatever role identities are implied by that context. Through an argument built around propositions and earlier research Ashforth et al (2000) state that high segmentation decreases the blurring of roles, but increases the magnitude of change between roles, fostering the transition challenge of crossing role boundaries. Exit from one role and entry to another are often facilitated by personal and collective rights of passage that signal to the individual and members of the role set(s) the change in roles and attendant identities. Conversely, high integration decreases the magnitude of change, but increases role blurring, fostering the challenge of creating and maintaining role boundaries. More research is urged by Ashforth et al (2000) to assess their argument in other areas of role transition, such as what role attributes are central to roles that integrate or segment and to what extent do people generally prefer and seek segmentation.

The concept of transition and boundary management can be seen in different contexts. This literature review is bounded around a background of understanding of a particular role where there are two prime boundaries the professional role and the clinical role. Research into boundary spanning roles by Adams (1976) identified two boundary roles, representatives and influence agents. Representatives are responsible for obtaining social support and legitimation by managing the organisation's impression in the external environment. Influence agents are responsible for bargaining with external actors over differing preferences. On the one hand, autonomy may be critical to representational roles, because impression management is important for these roles, and autonomy affords the role incumbent the opportunity to 'role make'. On the other hand, resource adequacy and role clarity may be critical for people in an influence role. This is because in this role, meeting the demands of both the customer and the organisation is likely to be a resource-costly venture and understanding one's responsibility to each constituency might provide a better template for action. Friedman and Podolny (1992) extends Adam's argument suggests that role conflict might be mediated through role differentiation. Research by Troyer et al (2000) contends that role conflict will be greater and more problematic for workers engaged in customer work within very large organisations than those engaged in the same work in smaller organisations. This was a survey of 5,811 employees in a national telecommunications firm. Hypotheses were tested and findings support the argument that those interacting with customers require flexibility (autonomy) more than clear behaviour guidelines (role clarity) if they are to avoid role conflict. As organisations continue to grow more role conflict is predicted for those who work with customers unless their roles become well defined and rigid. This argument can be compared to this particular study of a dual role where there is customer (patient) contact and organisational objectives which may cause role conflict.

2.3.8 Transition into Management Roles

Sociologists and psychoanalytic theorists have devoted much attention to explaining the processes and meaning of role acquisition. The two sociological concepts associated with role are first, the concept related to status and second, the meaning of the label associated with the role (Czander, 1993). The first concept refers to status as

the function of the role as it defines and delineates the differences between roles and how the occupant of one role relates to the occupant of another. The second concept of a label attached to a role becomes socially meaningful when it alters the expectations others hold for the behaviour of an individual (e.g. boss, accountant). From this perspective, in organisational life, a role defines an employee's place in the world; it can bring clarity and stability to an ambiguous environment. The function and labelling of the two elements of the dual role in this study are reviewed later in the literature review.

This study is not considering role from a psychoanalytic perspective where such issues as the link between role and personality are explored. An understanding of the complex psychological processes that accompany taking up of a role is not within the boundaries of this research. Evidence, however, of the frustration and stress that is felt is reported later in this study as interest for further research.

Transition into managerial roles and understanding how individuals take up a management role is seen in an ethnographic study of managerial work where it was concluded that the image that was emerging as the meaning of management was one that is was 'essentially . . . a social moral craft . . . a human social craft' (Watson 2001). What the role required of individuals was 'the ability to interpret the thoughts and wants of others, be these customers, competitors or whatever, and the ability to shape meanings, values and human commitments (Watson 2000). This view of management not as a role where technical knowledge and a specialised set of competences are required, but as a social role where life skills such as political, cultural and influencing skills concurs with other social sciences analyses of managerial work (Roberts, 1996, Watson, 1998). Watson's study involved interviewing 40 managers, who were relatively new to management. Two interviews with each individual were conducted a year or so apart with individuals from a wide range of contexts. His findings show that 'management learning' can be seen occurring well before occupational entry, but that the most significant learning occurs, and continues to occur, after entry into the management post (Watson and Harris, 1999). The concept of the 'emergent manager' is developed in his research and recognises there is no obvious point at which one becomes a manager. The managers in Watson's study viewed their past lives as having an influence on their managerial

situation in broadly three ways; personal characteristics and ambitions, management experience and managing in schools and leisure activities. These managers came from a range of backgrounds from schools to bingo halls. The most common responses to the relevance of previous work experience was related to a range of communication skills including listening, networking and building up trusting relationships. In this sample there were few individuals with a professional background.

This concept of the 'emergent manager' and the transition into a management role contrasts with many professions, including the medical profession, where one passes through a number of stages by examination and being granted the status of a particular profession. Learning in a professional role is continued through further study and experience, but usually there is a clear entry point to a profession. For the role in this study there is a frequent transition between the professional role and the management role.

2.3.9 Role Conflict and Role Ambiguity- Linking the Concepts

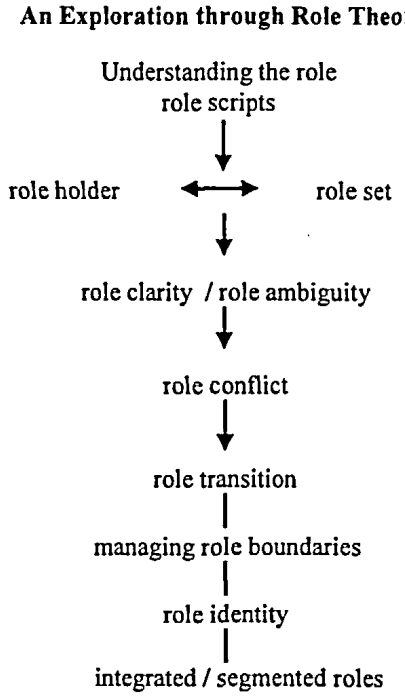
As the complex pattern emerges of the nature of taking up a role from the perspective of this study we consider the links between the concepts discussed. To summarise, a role is defined as a pattern of behaviours; role ambiguity refers to the expectations surrounding a role and role conflict involves the incompatibility of demands facing an individual (Ilgen and Hollenbeck, 1991). Research involving these constructs has been sighted in three meta-analysis reviews (Abramis, 1994, Fisher and Gitelson, 1983, Jackson and Schuler, 1985). The general conclusion of these reviews has been that role ambiguity and role conflict tend to be associated with negatively valued states such as tension and low job satisfaction (Jackson and Schuler, 1985). These reviews also suggest a weak and negative relationship between role ambiguity and job performance (Abramis, 1994) and role conflict and job performance (Jackson and Schuler, 1985). These reviews were seen as limited by small sample sizes and inadequate information on criterion reliability (Tubre and Collis, 2000). Using a much larger and more comprehensive data base that allowed for meaningful tests of moderator variables Tubre and Collins (2000). Their research found a consistency with Jackson and Schuler's (1985) findings that role ambiguity is negatively related to performance. These findings are congruent with other studies, since role ambiguity

represents a lack of information about what behaviours are appropriate. The findings of Tubre and Collins (2000), however, do indicate that the relationship between ambiguity and performance is variable, depending on condition and that these effects are not trivial. Although helpful at a meta level this leaves the small specific study with only broad generalisations. Also this research categorises job type with one category for professional, technical and managerial, so no distinction can be made between professional and managerial can be made. By their own admission the breadth of the job categories is a limitation of the research.

2.3.10 Summary

These extracts from the role literature are designed to bring an understanding to the focus of the role in this research. Although role theory still lacks a propositional structure that pulls it all together, it remains useful to researchers as it lies at the intersection of organisational and individual behaviour. Fig. 2.5 below outlines the approach taken to address the role literature for this research.

Fig. 2.5 An Exploration through Role Theory



Through the origin of the word role we see a role as a social script that is acted out as part of a performance. In the dual role there is a script for the clinical element of the

role which is well rehearsed and understood. Also, there is a script for the strategic leadership role which is comparatively new and less well defined. It is perceived there is a benefit in exploring both these scripts in the same individual. This has not been done in depth in any research studies in this context.

The choices individuals make in taking up a role or roles are seen as important in understanding how the role is taken up. Roles are performed in complex settings where those around the role holder, the role set, have expectations of him or her. Understanding how expectations are perceived by the role holder for both elements of the role would add a further dimension to the existing knowledge of the dual role. It is the role holder's understanding of the role and the dynamic between the role holder and those around him or her that leads to either role clarity or role ambiguity. Role conflict in its different forms has much to offer how the complex dual role in this research can be understood. Managing the repeated transition from one role to another is seen through how individuals manage the boundaries around their roles. A relationship is seen between boundary management and role identity that is relevant to the dual role. How role transition is managed will be different where roles are seen as integrated and boundaries 'thin' and those where roles are seen as segmented and boundaries 'thick'. Understanding how clinical directors see the boundaries of the two elements of the role will come from understanding personal perceptions. It could be some will see it differently as specific studies into the clinical director role show different views of how the role is experienced.

It is interesting to contrast the reasons for developing the role of doctors in management by the Thatcher government in the late 1980s and early 1990s with the processes that align themselves with the actual taking up a role. The former was very much concerned with efficiency and effectiveness and the measurement of resources. Although the reform of the NHS at that time was quite a spontaneous decision, it was later argued as a business decision built on a very rational organisational model. The processes that relate to the taking up of the role are concerned with how a role is negotiated through sociological and psychological processes which, as evidenced in this section, involve complex interactions between people. I would argue that how the role is taken up has to be understood in some depth before the rational model has any chance of success.

The next section of the literature review is concerned with bringing sufficient understanding of the nature of leadership and management roles to provide a context for the 'management' element of the dual role.

2.4 DOCTORS TRANSITION INTO A LEADERSHIP AND MANAGEMENT ROLE

2.4.1 Introduction

The history of doctors' involvement in management the NHS was summarised in chapter 1. Doctors have, in the main, had an ambivalent relationship with the management process in the NHS. This is partly due to the lack of agreement about what management actually is and a range of attempts to either involve doctors in management or keep them at a distance. The dual role at the centre of this research is described nationally and locally as a strategic leadership role. In section 2.2 it was seen from earlier research that there are different understandings of the nature of the dual role which poses questions such as: What type of role is it? Is it a strategic role, leadership role or a management role? This section explores the literature to place those differences in a context, in terms of their meaning, content and how they could be expected be taken up. This understanding can then be related to develop the research questions and research design and ultimately the findings.

First the nature of a strategic role is put in perspective, followed a summary of the key areas of leadership research and concluding with a summary of the nature of a management role.

2.4.2 The Strategic Perspective

What is a strategic role? The first distinction most researchers make is between considering the strategic process or the strategic content. Amongst the first to make this distinction were the renowned works of Chandlers' Strategy and Structure (1962), Ansoff's Corporate Strategy (1965) and Andrew's The Concept of Strategic Management (1971). The distinction is defined here by Huff and Reger (1987) in their review of the research. The content part of a strategic role is concerned with the subject of the strategic decision itself. It has focused on linking specific decisions and broader economic structures to performance outcomes. It has also given considerable attention to defining similarities and differences among strategic units within the firm, among strategic groups within industries, and among firms in similar circumstances. Process research, in contrast, has been research primarily focused on the actions that lead to and support the strategy. Research in this area has included prescriptive and

descriptive work on planning methods and decision-making, with attention directed toward the effectiveness for generating and implementing strategy. Also included in this area are the impacts of individual and group characteristics and organisational structure on the implementation of strategic decisions.

My research links to the process of strategy which can be further divided into Andrew (1971) enduring division between strategy formulation (how decisions are generated) and strategy implementation (how decisions are put into action) or three areas of strategic analysis, strategic choice and strategy implementation (Johnson and Scholes, 1999). Analysis and choice being part of formulation in Andrew's two categories. Understanding these processes and how the strategy is formulated and implemented means understanding the external environmental and internal organisational influences that interact. The obvious inherent complexity in this interaction makes strategy 'an on-going, messy incomplete process' (Huff, 1998).

National and local definitions of the role in this study view strategy as a component of the leadership role which is one influence on the strategy process. Researchers in the leadership field and the strategy field still link the influence of the individual to the delivery of the effective strategies. The influence of individuals in delivering an organisation's strategic intent relies on significant and powerful actors developing a set of shared expectations within the workforce (Bennis, 1994; Gabarro, 1987; Kotter, 1990). How individuals interpret strategic issues, to create a set of shared expectations, is important to the understanding of strategic action, organisational change and learning (Thomas and McDaniel, 1990). In support of understanding the individual in a strategic role, researchers are now arguing that the emphasis in the study of strategic management should shift to give much greater attention to micro level aspects of managing and organisational behaviour (Johnson and Bowman, 1999). Considering strategic change from an individual's perspective in a particular context is recognised by researchers as essential to achieve durable change (Bowman and Ambrosini, 2000; Balogun and Hope Hailey, 1999). It is the processing and interpretation of information by the individual which comes together to form a 'workable version of reality' (Weick, 1979). This is also of interest to role theorists who strive to understand individual role performance. This study provides a role

theory perspective on how the career history and experience of individuals influences the interpretation of strategic leadership roles.

What is strategic leadership? Strategic leadership narrows the leadership definition to address leadership as it relates to the strategic management of the organisation. This research is concerned with the individual in a strategic leadership role who may influence the process and the content of the organisational strategy. The importance of the strategic leadership role in this research is seen as the need for the individual to see and give importance to the 'bigger picture'. This requires individuals to take their thinking beyond the well practised role of relating to the individual patient or procedure to looking at wider corporate considerations.

2.4.3 The Leadership Perspective

From ancient philosophers to current researchers finding out what makes a great leader, has made leadership the most researched area of the social sciences. This review of the literature is confined to a summary of approaches that are relevant for this research.

There are many definitions of ***leadership***, but there appears to be three common components in many definitions, ***influence, people and goals***. ***Influence*** in this research will be focus on style and behaviour. ***People***, in earlier research, were mainly considered as subordinates, but now research is broadening to cover a whole range of networks and relationships. ***Goals***, in organisational terms, may be referred to as aims, objectives, targets or they may be communicated in a mission statement. For this study they will be linked to achievement or effectiveness in the dual role. Effective leaders are able to obtain the co-operation of other people and to harness the resources provided by that co-operation to the attainment of a goal (Chemers, 1993) is a reasonable working definition that captures the essence of this vast subject.

For some researchers and practitioners there is a belief that leadership is innate, something we are born with or just common sense. Early research placed an emphasis on the inheritance of leadership qualities (Galton 1870). The theory that leaders were born and leadership qualities were innate continued into this century with Carlyle's (1907) 'great man' theory emphasising that it is the unique

characteristics of traits of the individual that make the person a great leader. We see this belief stretching across decades and continuing to the present time where the search for universal solutions and neat set of traits appear to provide the answer (Kouzes and Posner, 1995). An approach that has been devoted to many studies divides our understanding of leadership into different styles. Although different language is used to describe these styles, in broad terms they divide into two areas. One associated with task, a style focused on the 'job' to be performed and another focused on relationships where the focus is on people. Examples are, initiating structure and consideration (Stogdill and Coons, Ohio studies, 1951); production oriented and employee oriented (Michigan studies, Katz and Kahn, 1960); autocratic and democratic behaviour; (Tannenbaum and Schmidt, 1958); concern for production and concern for people Blake and Mouton, 1964). Reviews by Filley, House and Kerr, 1976, Hamner and Organ, 1978 found the participative, relationship oriented approach, was associated with greater satisfaction on the part of subordinates than the non-participative, task approach. There are arguments that these two styles operate along a continuum with individuals placing a different emphasis on either a task or relationship approach.

Other studies which are relevant for this research are those relating to contingency theory where the complexity of the context is recognised. Here leadership style and behaviour is linked to the context or situation, the difficulty is first, identifying all the situational variables, second, determining how variables influence behaviour and style and third, how the variables interact.

It is little wonder Fiedler (1996) with his vast experience concluded that "the most important lesson learned over the last forty years is leadership of groups and organisations is a highly complex interaction between an individual and the task environment. How well the leader's particular style, abilities and background contribute to performance is largely contingent on the control and influence the leadership situation provides". This approach has a relationship with role theory in seeing the importance of the dynamic between the leadership role (role occupant) and the individuals in a particular context (role set).

The enormous output of leadership researchers in the field of contingency theory seemed to have yielded very little that could be clung to with any certainty. It is felt that there are more lessons to be learned from the trait approach and that the distinction between task oriented and relationship oriented leadership still has wide currency and has proved to be an important and basic classification of leadership behaviour. It is also clear that leadership styles that work well in one situation will not necessarily be appropriate in another context (Bryman, 1992).

Leadership research over the period of the 1980's and 1990's, when the role being studied was developing, is often referred to as 'new leadership'. However, there is a return to the search for universals and the trait approach. The 'new' is defining the traits that are appropriate for end of the century rather than the beginning. There appears to be some consensus in the view that the leadership role is to impart a sense of vision, purpose, strategic intent and purpose. Effective leaders are said by Bennis (1994) to share the traits shown below. It is these competencies that he believes deliver a 'pull' style of leadership which energises people.

Leadership Traits

- a great deal of self knowledge
- a strongly defined sense of purpose
- a capacity to generate and sustain trust
- a bias towards action

Leadership Competencies

- attention - draw people to him/her, communicate a focus of commitment, share a concern of intention and outcome
- meaning - communication of alignment, turn facts and information into meaning
- trust - essential, determinant is constancy and reliability
- self - knowing one's own skills and developing them effectively

Bennis (1994) argues that with these competencies managers see themes and patterns in the common and shared objectives, values, problems, products, concern about performance of people and groups within the organisation. They communicate them to others in a forceful and impressive manner.

One body of the leadership literature relies on interviews with senior managers and leaders of organisations, from such interviews, interesting generalisations emerge. These usually focus on similarities and pay little attention to differences. Leadership practices and commitments as expressed by Kouzes and Posner (1995) have a transformational flavour and result from wide ranging research. The research is confined to identifying practices when leaders are "doing their best" and postulates that there is little variation from industry to industry, profession to profession, community to community and country to country. The researchers conclude that good leadership is an understandable and universal process. It is appreciated that the practical outcomes of this research are presented in a positive and encouraging manner for aspiring leaders. However, from the focus of this research are we really meant to believe that there are universal solutions? I would hypothesise that some universality could be expected if you ask people to describe what happened when things went well.

A considerable amount of work has been undertaken on comparisons between leadership and management (Kotter, 1990). From this, we are left with notions of leadership being transformational and management being transactional and all the associations that conjures up in our minds. Transformational leadership is concerned with taking an organisation and changing or 'transforming' it. This usually means leading an organisation towards a new vision, having an ability to inspire others and stimulating people to think in new ways. Transactional leadership is more concerned with implementation and those tasks that we associate with managing rather than leading. Kouzes and Posner (1995) agree that from their research the transactional leader closely resembles the traditional definition of a manager. It is about keeping the organisation on the right road, moving it along, but not necessarily changing it. Other researchers (Kakabadse and Kakabadse, 1999) inform us a mixture of transformational and transactional management is required. Possibly it is too much to ask that an individual has the ability to be both, but surely the skill is recognising the need for both contributions to be present in an organisation and that both contributions are valuable and to be valued. This is feasible in most organisations where it is acknowledged that leadership is not just vested in one or two individuals in an organisation.

Large scale studies are referred to earlier in this review. These have continued to add to this enormous body of literature Avolio et al (1999) discuss theirs and others use of the Multifactor Leadership Questionnaire (MLQ). He argues there is value in understanding the different components of the three factor model, transformational, transactional and passive leadership, despite the valid criticism which still exist of large scale surveys. Also, he urges more research with alternative methodologies such as observation and or interviews to get a better handle on discriminating between these factors.

A recent higher profile of the term emotional intelligence has been achieved largely through the work of Goleman (1996, 1998). Emotional Intelligence refers to 'the capacity for recognising our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships' (Goleman, 1998). It was Howard Gardner (1983), a Harvard psychologist, who proposed a widely regarded model of multiple intelligence His list of seven kinds of intelligence included the familiar verbal and mathematical abilities, but also two personal varieties; knowing one's inner world and social adeptness. A comprehensive theory of emotional intelligence was proposed by Salovey and Mayer (1990) with several other theorists proposing variations on the same idea.

This distinction between the purely cognitive capabilities measured by IQ and those now labelled as emotional intelligence (EQ), has become popular vocabulary in some academic and management communities. A summary of the capabilities and *traits* associated with EQ, as explained by Golemam (2000), are as follows:

- Self-Awareness - *emotional self-awareness, accurate self-assessment, self-confidence.*
- Self-Management - *self-control, trustworthiness, conscientiousness, adaptability, achievement orientation, initiative.*
- Social Awareness - *empathy, organisational awareness, service orientation.*
- Social Skill - *visionary leadership, influence, developing others, communication, change catalyst, conflict management, building bonds, teamwork and collaboration.*

It is easy to see a mixture of those capabilities measured by IQ and EQ in leadership research already quoted in this review (Boyatzis, 1982; Bennis, 1994; Kouzes and Posner, 1995).

Research led by a team from Hay/McBer working with Golemam (2000) found six distinct leadership styles, each springing from different components of emotional intelligence. The styles are described as - coercive, authoritative, affiliative, democratic, pacesetting, coaching. In this large worldwide random sample of 3,871 executives the research indicated that leaders with the best results (financial and 'climate' measures) used most leadership styles in one week, seamlessly and in different measures. Four of the styles had a positive impact on the dimensions described as 'climate' and two, authoritative and pacesetting, had a negative impact. This probably underlies the complexity of knowing when and in what measure to use different styles.

In my research, how might the beliefs of what leadership means to individuals influence how they take up the role. Will it be seen as innate? What is needed to perform the role? Can traits and competencies be defined and learned? Is the role seen as managing tasks, processes and or people? Is there an emotional element in the role?

2.4.4 The Management Perspective

This area of the literature review is to provide a perspective which broadens our thinking about the role which is the subject of this research. It is clear from research in section 2.2.2 (Fitzgerald and Sturt, 1992; Burgoyne and Lorbiecki, 1993) that there are different interpretations of the non-clinical element of the role. Following the discussion to understand some of the relevant leadership literature, this section considers research in the field of management.

What is management and what do managers do? Two questions which relate to the understanding of the role in this study. To answer the questions many reviewers understandably begin with reference to Henri Fayol's (1916) description of five basic managerial functions, planning, organising, co-ordination, commanding and controlling. Other studies, over the decades, have expanded on Fayol's five functions

Gulick (1937) and Mahoney et al (1965) to mention two. It was Mintzberg (1973) with his study of chief executives that is remembered and still quoted in this body of literature. Mintzberg's work combined with findings from other research led him to argue that any manager had ten roles. A manager being defined as someone who is formally in charge of an organisational unit. The ten roles are shown below in Fig.2.6. These were divided into three groups – three interpersonal roles, three informational roles and four decisional roles. The formal status gives the person the interpersonal roles, with this formal authority the individual has access to information and responsibility for the decision roles.

Fig. 2.6 Managerial Roles

Formal Authority and Status

↓

Interpersonal Roles

Figurehead

Leader

Liaison

↓

Informational Roles

Monitor

Disseminator

Spokesman

↓

Decisional Roles

Entrepreneur

Disturbance Handler

Resource allocator

Negotiator

Mintzberg (1980)

Generally there was broad agreement with Mintzberg's findings. Kotter (1982), Kurke and Aldrich (1983) and Martinko and Gardner (1990), supported the view that manager's work was characterised by brevity, variety, fragmentation and oral communication with a wide variety of people inside and outside the organisation.

Comments on Mintzberg's research are more about what the research does not address, e.g. the relationship between the roles and their link with organisational effectiveness, but his study does not purport to deal with these issues.

Mintzberg (1973), Kotter (1982) and Stewart (1982) are helpful in clarifying the nature of managerial work. Kotter (1982) in his study of 15 general managers is probably most associated with connecting the managerial responsibilities with the formation and maintenance of a network of relationships. Stewart from her studies into managerial jobs and behaviour developed the 'demands, constraints and choices' model. She sees the choices people make in taking up a role as important. Her review of this research field (Stewart 1989) urged more research in several areas including the study of how individual managers think about their work and jobs. Stewart saw this as the most open-ended and potentially the most difficult and the most exciting of the possibilities she outlined. Hales (1986) review of the evidence for 'what managers do' provides, by his own admission an unremarkable list of the common core findings. These include responsibility for work processes, but primarily consist of spasmodic, day-to-day communication, influencing 'politiking' with planning and decision-making taking place in the course of other activity. He argues there is considerable choice in what is done and how it is done. He sees managerial work is setting the boundaries of and negotiating the work itself.

For studies to be of real value to the academic and practitioner communities we have to understand the specific focus of a study. Hales (1986) referred to the almost exclusive focus on managerial role performance sighting only Kotter (1982) and Stewart (1976) and Stewart et al. (1980) as studying the behaviour of managers in the context of substantive role demands. He identified, at the time of his review, that no study has sought to compare managers with non-managers and, thereby identify the 'differentia specifica of their work'. He also drew attention to the lack of a study to demonstrate if there was a bounded and separable set of activities which may be called 'managerial work' – and not merely activities which managers had been shown to do.

Moving away from the general to the specific in exploring managerial roles, all studies have taken place in a particular context at a particular point or over a period of

time. It is acknowledged that studies have examined variables in and beyond the organisational context (Allan 1981, Child and Kaiser, 1981; Boisot and Laing, 1992; Stewart et al., 1994). Mintzberg's (1994) acknowledgement of context was viewed through the 'frame of the job' as conceived by the manager. In this model there was an acknowledgement of the influence of context, but the individual appears to be the dominant force in shaping the role. Mintzberg's model is derived from a conceptualisation of his knowledge, research and experience, but there was little evidence discussed of how the model is empirically grounded.

Hales (1999) sought to address the question Why do Managers Do What They Do? through reconciling the evidence and theory in the area of managerial work. He concluded that the commonalities in managerial work reflect, how all managers feel compelled, because of the ambiguous and problematic nature of managerial responsibility and the precarious nature of 'managerial' subjectivity, to engage in institutionalised routines to draw upon and reproduce the resources and rules which underpin them.

Hales (1999) proposed that what new forms of research will need to do is show *how* managers make 'managing' what it is: how day-today managerial practices reproduce the distribution of resources and reaffirm the meanings and norms upon which these practices trade. Managing therefore may, entail not merely the 'management of meaning' (Gowler and Legge, 1983), but the management of its *own* meaning. In short, managers act in the way they do because these actions are constituted, defined and legitimised, by the resources and rules of the systems in which they are located, as actions which affirm their identity, responsibility and accountability of managers. Hales (1999) believes that what needs to be explained is not why managers engage in certain common activities, but why and how such activities are negotiated as acceptable descriptors of 'managing'.

Whatever label we give this complex interaction, we know that managers spend a large percentage of their time engaged with others (Mintzberg, 1973). Findings from their own study and research by others led Martinko and Gardner (1990) to support earlier conclusions regarding the brief, varied, fragmented and interpersonal nature of

managerial work. Their results also point to the important relationship between the environment and managerial behaviour.

Tsoukas (1994) pleaded for more research to clarify the link between management roles on the one hand and types of jobs, hierarchical position, organisational effectiveness, industry characteristics, national features etc. on the other.

This section raises similar questions to those in the last section about how the dual role will be viewed in the study. This overview will help relate the research to an understanding of management roles.

2.4.5 Research Implications

From studies into this the role at the centre of this research in section 2.2.2 we know the role is viewed in different ways. If viewed as strategic leadership role we would expect to see contributions being made to the content and process of strategy and importance given to the 'bigger picture'. The leadership role may be seen as one that is innate or can be learned by acquiring a particular set of universal competencies. There may be sensitivity to the particular context of this particular role and the leadership role seen as contingent on the organisational setting and climate. Will the role be seen as transformational or transactional? There could be self-awareness amongst individuals of their own capabilities and skills in the role. Is the role about driving through tasks towards an aim or goal or is the emphasis on delivery through people and relationships?

A management role is described in much more transactional terms, being concerned with everyday problems and tasks delivered in short encounters with others. Confusingly, some of the language is shared with the language of leadership, e.g. being a leader, an influencer. However, there is need for leadership and management in organisations. How individuals manage the meaning of the role and place boundaries around it will determine the nature of the role. In studies of managers' roles the choices people make are seen as important to how they take up a role (Stewart, 1982). It is argued that no research looks at mangers and non-managers. In the role in this research we have a manager and 'non-manager' in one role.

Research into this specific role has shed little light on how the dual role is taken up. Perceptions from individuals of how, collectively, research populations see the management role are described in some studies in section 2.2.2, but these insights do not look at how they actually take up the dual role and how they view their performance it. What it means for the individual, for example, how the positive and negative feelings about the role do or do not come together for an individual.

From this section an understanding of the nature of a strategic role, leadership role and management role has been gained to help identify the contribution this research can make to existing knowledge.

2.5 TRANSITION INTO A MANAGEMENT AND LEADERSHIP ROLE FROM A PROFESSIONAL CAREER

2.5.1 Introduction

This section aims to develop an overview of careers and the nature of the professional career. The career of individuals in this study is perceived to have a particularly strong influence on how they take up their professional and leadership/management role. The culture of the medical profession is believed to be so strong that conflict arising between the management of resources and medical need may only be resolved by removing decisions from the system (Burgoyne and Lorbiecki, 1993). This part of the literature reviews aims to provide an understanding of the career context from which individuals make sense and give meaning to the dual role as they perform both elements almost simultaneously.

The definitions of career vary as the terms cross disciplinary boundaries. Within the disciplines of psychology, sociology, political science, economics, history and geography, Arthur et al (1989) identified 11 separate descriptions of what constitutes career. Common to all these are the characteristics of work experiences occurring over some span of time. In its broadest sense a career is 'the evolving sequence of a person's work experiences over time' (Arthur et al, 1989). However, this definition seems sterile and lacks the dynamic feel that we may expect the concept of career to convey. Career derives from the French 'carriere', meaning course or road which brings the sense of a journey to the word. However, a journey is far more than a series of chronological steps which plot a route.

The changing nature of the environment in the 1980s an 1990s has made the career journey a turbulent one for many individuals. As organisations have responded to external pressures they have cut costs by reducing the number of hierarchical layers in their organisational structures. Well trodden career paths have been destroyed with individuals left floundering and uncertain about the route to a senior position in their organisation. Flatter structures means that competition for senior posts has increased and more lateral moves have to be made to gain career progression. The leap to a general management post in a flat structure can be seen as a challenging and yet daunting leap into an unknown strategic world. With the changing shape of small

number of staff are seen as core and remain permanent employees, others are from the contractual fringe who are often self employed and work on a payment for results basis. The third level of resource is the flexible labour force seen as the hired help of whom little is expected and little is given. These trends have shifted the emphasis of the concept of career from the organisation to the individual. Increasingly individuals are realising that they must take more responsibility for their own careers. Organisations no longer offer jobs for life or clearly visible upward career paths. This trend has been felt in management in the public sector.

In this research it is interesting that, as with many professional roles, there is some independence in having a portable professional qualification. However, unlike lawyers, architects, accountants, etc. there is really only one organisation in England, the NHS, in which the vast majority of practising medical doctors work. While many consultants work in the private sector, generally this is only a small part of their working week. All doctors including consultants have not felt the changes in career patterns that many employees have in the last two decades. They have remained secure and sometimes introspective in professional roles where demand for their services has increased. However, they do exist in a huge political bureaucracy where change is always part of the agenda. Individuals in this study have decided to put their toes in the wider organisational context often after several decades in one function. Understanding their career background is seen as relevant to understanding how they take up the dual role. Taking up the wider dual role poses no risk to their career as they can return to their professional role where the concept of a job for life is still a reality.

2.5.2 Areas of Research

The current wave of interest in careers emanated from the Institute of Massachusetts (MIT) and the work of Lotte Bailyn, Douglas (Tim) Hall, Edgar Schein and John Van Maanen in the 1970's and 80's (Hall, 1976; Van Maanen, 1977; Schein, 1978; Bailyn, 1980). Their contributions included the affirmation from the Chicago School of Sociology and the Columbia School of Educational Psychology that career applies to all workers, and all sequences of work roles (Hughes, 1958; Super, 1957). The MIT group moved on from the narrow confines of job design and job satisfaction to establish career as a focus for interdisciplinary study. Career had been seen more

from the objective rather than the subjective perspective. The objective referring to the institutional, organisational or societal interpretation of the career situation. The subjective referring to the individuals' own interpretation of his or her career.

This groundbreaking work established career studies in the broader organisational studies area. At this time there were assumptions that organisations and their environments were relatively stable and that organisational structures were inherently hierarchical (Arthur, 1994). These assumptions prevailed through much of the literature of the 1980's and into the 90's (Arthur, 1994). Also the subjective was compared to the objective out of concern about existing organisational arrangements. As a result, the objective career constrains how the subjective career is viewed. Despite the emergent and gathering pace of organisational change career research has clung to its orthodox approach. Examples of the science viewpoint of the career concept are shown in the following extract from Arthur et al. (1989)

Table 2.1 Career Concepts (Arthur, Hall and Lawrence, 1989)

Psychology

Career as vocation: a viewpoint accepting the traditional psychological position on stability of personality in adulthood; associated theory is intended to help guide individuals and organisations fill job openings in a mutually satisfactory way (e.g., Holland, 1985).

Career as a vehicle for self-realisation: a humanistic viewpoint focusing on the opportunities a career can provide for further individual growth and how that growth can in turn benefit organisations and society (e.g., Shepard, 1984).

Career as a component of the individual life structure: from this viewpoint eras and transitions throughout the career are predictable and are to be accommodated in the work arrangements made (e.g., Levinson, 1984).

Social psychology

Career as an individually mediated response to outside role messages: a viewpoint that studies particular occupational circumstances, such as those of priests (Schneider and Hall, 1972) or scientist and engineers (Bailyn, 1980), for their psychological effects.

Sociology

Career as the unfolding of social roles: this viewpoint overlaps with social psychology but places greater emphasis on the individual's reciprocal contribution to the social order (e.g., Hughes, 1958; Van Maanen and Barley, 1984).

Career as social mobility: seeing a person's title as an indicator of social position (e.g., Blau and Duncan, 1967; Featherman and Hauser, 1978; Warner and Abegglen, 1955).

Anthropology

Career as status passages: a viewpoint overlapping with functional sociology about how rites and ceremonies serve to maintain a society or culture over time (e.g., Glaser and Strauss, 1971).

Economics

Career as a response to market forces: a viewpoint emphasising the near-term distribution of employment opportunities and the long-term accumulation of human capital (e.g., Becker, 1975; Doeringer and Piore, 1971).

Political science

Career as the enactment of self-interest: this views individual needs such as power, wealth, prestige, or autonomy as prominent objects of self-interested behaviour in the context of institutional political realities (e.g., Kaufman, 1960).

History

Career as a correlate of historical outcomes: looking at the reciprocal influence of prominent people and period events on each other (e.g., Schlesinger, 1965).

Geography

Career as a response to geographic circumstances: focusing on variables such as availability of raw materials, a natural harbour, or a population ready for work or trade as they effect the way working lives unfold (e.g., Van Maanen, 1982).

Now a number of approaches are offered as new lenses through which to view careers. Careers defined as accumulation of information and knowledge embodied in skills, expertise and relationship networks acquired through an evolving sequence of work experiences over time (Bird, 1994). This captures some of the flexibility that is required in today's changing environment where individuals are being urged to take more responsibility for their own careers and rely less on organisations to plan a career route for them. This change requires a psychological adjustment by individuals (Weick and Berlinger, 1989) to decouple their identity from the jobs they perform, preserve discretion over the work they do and the learning it provides. A major challenge for individuals is to adjust their expectations about continuous upward mobility and career success. Many will have to cope with more complex work roles and home roles as social structures change (Mirvis and Hall 1994). The role of the clinical consultant is for the vast majority of doctors the most senior role to which they aspire. For them there is no longer an expectation and pressure for further upward movement. Many will remain in that role for 20+ years often at the same hospital.

Autonomy is key to the acquisition of skills and knowledge. Individuals need to build their own reputation and employability through building networks in a range of organisations (Kanter, 1989). The boundaryless career has evolved to take on a number of interpretations, but a common theme is one of independence from, rather than dependence on, traditional organisational career principles (Arthur, 1994).

Career can be seen through different lens, but the concept belongs to the individual and can, as expressed earlier, be viewed as a journey that evolves overtime as knowledge and experience are acquired. The medical career may be viewed differently by individuals seeing its roots in different scientific fields.

2.5.3 The Professional Career

The study of occupational careers (Slocum, 1966) foundered in the 1970's and 1980's as most attention became re-focused on employing organisations. However, investment in an occupational or professional career provides an attractive alternative to organisational dependency. The importance of occupation to a person's career was consistent with the competency based perspective on individual know-how learning.

According to this perspective, individual learning was likely to be strongly influenced by a person's prior history of skill accumulation and task and relevant experience. Most career workers spent their careers working in a relatively narrow range of occupational settings and workers who transferred to unrelated occupations experience lower status and earnings (Markey and Parkes, 1989). The greatest movement across occupations occurred during the earliest years of a person's career history (Mergenhagen, 1991). It is interesting to note that this is not the case for this research as the strategic leadership role is taken on in the advanced stages of the professional career. One could also hypothesise that retaining the professional career is important to ensure status and self esteem is maintained.

What is a professional career as distinct from another type of career?

"Profession means largely non-manual, full-time occupation whose practice presupposes specialised, systematic and scholarly training ... access depends upon passing certain examinations which entitle to titles and diplomas, thereby sanctions its role in the division of labour. Professions tend to demand a monopoly of services as well as freedom from control by others such as laymen, the state etc. Based upon competence, professional ethics and the special importance of their work for society... the professions claim specific material rewards and higher social prestige" (Kocka, 1988)

Other definitions also place an emphasis on knowledge as a chief aspect of profession. Millerson (1964) "A profession involves a skill based on knowledge . . . the intellectual, practical technique involved depends on a substantial theoretical foundation . . . to provide competent service, knowledge and experience must be obtained". Earlier Carr-Saunders and Wilson (1933) had identified the application of an intellectual technique as the chief distinguishing characteristic of professions. They state that "Profession is a set complex of characteristics. The acknowledged professions (law and medicine) exhibit all or most of these features; they stand at the centre, and all around them on all sides are growing vocations exhibiting some but not all of these features". This view was shared by Parsons (1951) in his study of the medical profession. Twenty-three traits were identified in the research literature survey by Millerson (1964). This work is still valued in more recent research (Burrage et al, 1990). Knowledge as an important component of the definition of

profession was shared by other researchers (Goode, 1969; Moore, 1970; Torstendahl, 1990; Ovretveit, 1992)

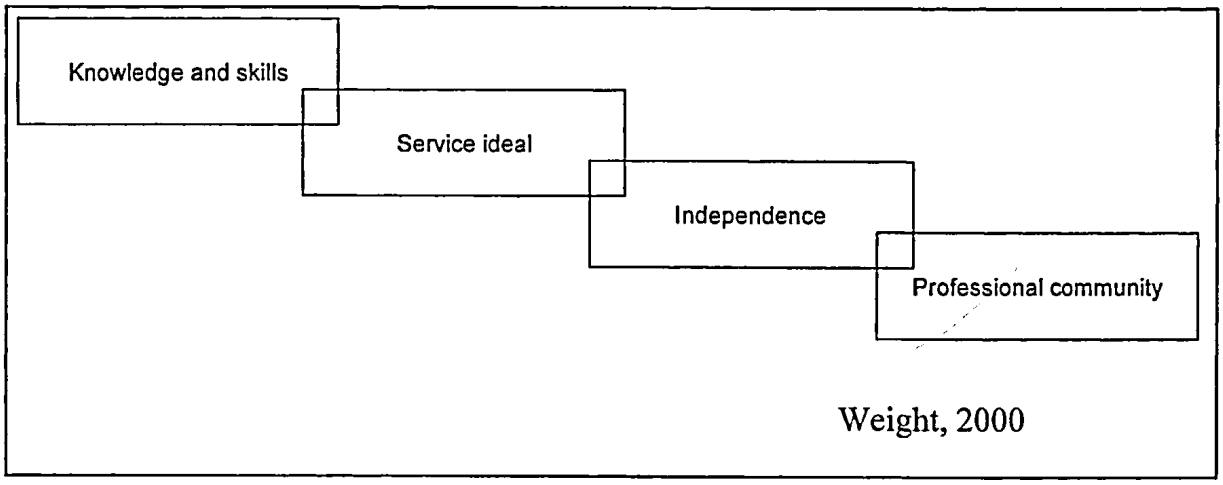
The biggest cluster of professional traits identified by Millerson (1964) was knowledge and skill categories: "skills based on theoretical knowledge; practice modified by general knowledge; and the application of principles to concrete professional practice; foresight based on theory, theory based on understanding and the application of skills to the affairs of others"

The second largest cluster centres loosely around the traits of ethical beliefs and behaviours associated with the "altruistic service ideal". These beliefs and behaviours are: "putting clients' interests before one's own (altruism); adherence to a professional code of conduct; loyalty to colleagues; members prepared to contribute to professional development; best impartial service given; fiduciary client relationship". These are labelled as 'service ideal' in Fig. 2.7.

To the characteristics of a knowledge base and a service ideal was added an autonomy granted on the basis of public trust (Ovretveit, 1992) which introduces the independence and power perspective to this discussion.

A final group of traits are described as "institutional elements of professions" (Torstendahl, 1990). These are: "the provision of training and education supervised by professional organisation; recognised status; definite compensation (i.e. fee or fixed charge); profits not dependent on capital; guaranteed service raises association's prestige thus securing employment and improving income". This cluster is referred to in Fig. 2.7 as professional community.

Fig. 2.7 The Four Clusters of Professional Career Traits



Links can be made to the career competency derivative framework seeing knowledge and skills as 'know-how', service ideal and independence as 'know-why' and professional community as 'know-whom' (Defillippi and Arthur, 1994).

2.5.4 Research Implications

Viewing career as a journey along a road conjures up a picture of the long journey of the clinical consultant. Careers can be researched from several scientific viewpoints. This research is concerned with the subjective perspective on careers, wanting to understand the individual's own interpretation of their career. This research already points towards a psychological and sociological perspective. The changing shape of organisations and career patterns that have affected management roles in all sectors has left the medical profession largely untouched.

The characteristics of the professional careers, particularly the 'acknowledged' professions of law and medicine share a set of career traits as shown in Fig. 2.7. Their knowledge and skills place individuals in a position where membership of the profession gives them an organisational independence. In the role in this study few actually exert that independence by moving NHS trusts, but they have the ability to do if they wish. The strength of the professional community and their recognised status is powerful. These characteristics create a bond between professional colleagues. In earlier research into the dual role it is this bond that causes problems of how to 'manage' professional colleagues.

The professional perspective of the dual role is an extremely important part of the role. It is viewed as the main employment and where the individual stills spends the majority of their time. Therefore, it is seen as important to include an understanding of the career background of this element of the role to the individual as part of this research.

2.6 LITERATURE SUMMARY

Research into the role of clinicians in management attracted quite a lot of attention in the early 1990s as the dual role gained momentum when NHS Trusts were developed. This and more recent research into the role offers some insights into the role, but little real understanding of the individual's own perceptions of the dual role.

Research into the dual role, generally known as the clinical director role, has identified the role as described in several ways: a strategic role, leadership role, management role or a representative role. Research has often been linked to training and development programmes and, as admitted, is therefore not typical sampling as training is limited and patchy. With this focus, however, the knowledge and skills required for the role have been identified in several studies. The unattractive aspects of the role feature prominently in many findings - the pressure of time and work overload, the conflict between different roles, managing colleagues, all contribute to the perceived stressful nature of the role.

In studies into the role reference is made to the medical profession and the medical culture from an understanding of the profession by the researchers or anecdotal evidence. The influence of the profession is recognised as powerful. Consideration of the literature on professional careers exemplifies this powerful profession and identifies the characteristics that set apart those within it.

No research has tried to understand the individual's perception of the total role and explored the two main elements of the role in some depth and in equal measure. Given the importance of the professional clinical role and the fact that it is the individuals' main employment and where, when in the dual role, the individual spends the vast majority of his or her time, it appears an omission that this 'duality' has not been explored. We may know much about doctors' roles and managers' roles, but there is a lack of knowledge about the meaning and sense the individual makes of the combined dual role.

What appears to be agreed upon is the dual role is seen in different ways. The findings, however, show little consensus in the unattractive or attractive features of

the dual role and mixed views of why the role is taken up. There is no perception of how the role is made sense of by an individual. Many of the findings although helpful in bringing some general features of the management role together, do not help us understand how the features come together in an individual. The nature of the role is seen differently and we know from the leadership and management research literature, roles are ambiguous and taken up in a range of styles often supported by a variety of beliefs about the role.

The role theory literature has been considered as an approach to understanding the dual role lying as it does at the intersection of organisational and individual behaviour. The approach taken in this research will be to explore the meaning of the role as perceived by the individual. A gap, as described above, has been identified in the literature which this research will be designed to address. The role literature brings an understanding of how roles are taken up, the importance of choices, the relevance of understanding the expectations of others, the concept of conflict, meanings of transition and boundary management. These are all are relevant to understanding the meaning individuals place on taking up the dual role as explained in section 2.3.10.

Building on my personal and ontological perspective for this study and the findings in the literature review the research questions are framed in the next section.

2.7 RESEARCH QUESTIONS

The literature review has led me a research gap and the following primary research question.

How do clinical consultants take up the dual role of strategic leadership and clinician?

This question requires more explanation and subsequent questions to describe where the contribution to knowledge will be made. What has not been researched before is the meaning individuals place on both elements of the role and the similarities and differences between them.

1 ***How do individual's describe the professional and the strategic leadership elements of the dual role?***

2 ***What similarities and differences are seen between the two elements of the dual role from the analysis of question 1?***

Understanding the expectations of others is a key concept in role theory and worthy of exploration to establish how individuals take up the role. This will be asked of both elements of the dual role.

3 ***How do individual's understand what is expected of them in the professional and strategic leadership elements of the dual role?***

I wanted to understand why my research participants took up the dual role. This is a question that has been addressed in previous studies, but views from this research may provide links with responses to other questions and may or may not confirm previous findings.

4 ***Why do individual's take up the dual role?***

Role conflict is another question that has been addressed before and has revealed some fairly predictable findings. Again this research may or may not confirm these findings and I hope add others as the research design may have promoted some new ways of thinking about the role.

5 ***What are the main challenges of the dual role, where is there conflict and where is there congruence?***

In addressing these specific questions an understanding of the primary research question will be built in a way that adds to existing knowledge.

What this study is not considering became clearer as the literature review progressed. What is not being studied is the following:

- The transition process, that is, how individuals take up and progress in the role over months or years.
- The difference between what the research subjects say and what they actually do.
- The perceptions of others who work with the individual in the dual role.
- Performance in the role in the sense of good or bad performance.

3 RESEARCH STRATEGY AND METHODS

3.1 INTRODUCTION

This chapter discusses the research strategy and methods which are chosen for this research study. Following the introduction to this chapter section 3.2, considers the research strategy from a philosophical perspective, Section 3.3 describes the research design, the methods used and the sites selected. Section 3.4 outlines the process used in the field work across the three sites. The final section, 3.5, describes the approach to data analysis and the development of the discussion and findings.

The strategy for this research is a matching process between the subject and nature of the research and the philosophical perspective of the researcher **and the need to gain the commitment of the research participants.** The interest and passion often required by the researcher to commit to a rigorous study is driven by a personal ontological perspective. It is this particular perspective of the world and how social reality is constructed that shapes the content and form of the research questions.

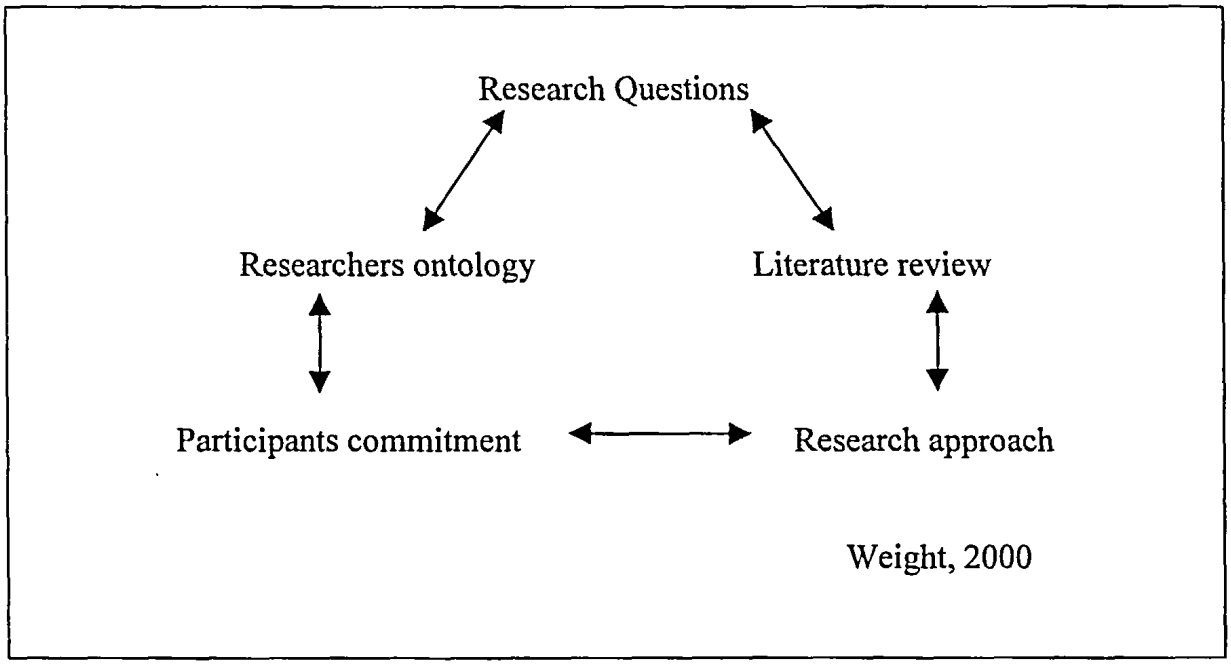
This research aims to understand the role of professionals who move into strategic leadership roles. The unit of research is the individual and the understanding is about how the dual role of professional and strategic leader is taken up. The analysis includes the identification of patterns and themes in clusters and across the population and comments on the unusual which could point to areas for further research.

The strategy for this research is based on a phenomenological approach and the use of qualitative methods as a means of inquiry. The journey which led to this approach was made through acquiring an understanding of the possible approaches, while constantly revisiting and reconfiguring the research questions to find the right 'fit' for me, as the researcher, in this study. A further consideration is the need to undertake a methodology which is seen to be valid, or at least credible, from the research participants' perspective. Consultants are trained in positivistic methodologies and are likely to be suspicious of other approaches. To gain the interest and commitment of consultants is an important consideration. My judgement was that the frameworks would give the interviews credibility as far as the consultants were concerned. There is some compromise here with a phenomenological approach, but I believe the open

ended nature of the questions and subsequent probing for meaning stills allows a understanding of the role from the individual's perspective to emerge. The interviews are not informal conversations. They are interviews grounded in a particular perspective. Also, I believe some structure makes these particular professionals more at ease in the interview than a totally open ended approach.

Underpinning this is the literature review which broadened and deepened my understanding of the subject area and identified where this research could make a contribution to existing knowledge. This iteration is shown below in Fig. 3.1.

Fig. 3.1 The Iterative Process of the Research Strategy



The importance of the philosophical perspective in social science research is reinforced by Trigg. It is therefore natural for this perspective to be discussed first.

"Empirical social science must start from a properly articulated philosophical base if it is to be successful. The philosophy of the social sciences cannot be an optional activity for those reluctant to get on with the 'real' empirical work. It is the indispensable starting point for all social science."

Trigg, Understanding Social Science, In Blaikie 1993

3.2 PHILOSOPHICAL PERSPECTIVE

The philosophical debate concerning the status of social science as a science has spanned many decades. Exploring and articulating the thinking behind the nature of the social sciences provides roots from which individual pieces of research can develop and grow with the vigour and rigour required to make a contribution to knowledge. The researcher, as a social scientist, needs to understand the nature of the reality to be investigated and how an understanding and knowledge of that reality can be obtained. There are matters of ontology and epistemology which structure the route of the journey made by the researcher. These concepts of the 'world view' of the researcher and the individual's belief about how knowledge is acquired will provide a framework and boundaries for the area of research. Since the way we create or acquire new knowledge is influenced by the way we think the world looks, an epistemology implies an ontology, and vice versa. Blaikie (1993) draws out two assumptions that emanate from these concepts. One common assumption is that reality exists independently of the researcher's activities and that it can be reliably observed by use of the senses. Another assumption is that reality is what the concepts and theories of the social scientist say it is; the reality can only be known through the use of these concepts and theories.

An important part of any research study is how the assumptions made about the social reality being explored, described, understood, explained, predicted or evaluated will influence the process and the outcomes of the enquiry. The researcher may often need to search for their own assumptions which lie deep in their personal belief system and may not be easy to articulate as they have become 'taken for granted' by them.

The assumption that reality exists independently of the researcher's activities and can be reliably observed and subjected to a set of rules or laws is a convenient concept. This allows one to consider, to think and perhaps believe that the social world is like the natural world and the same methods can be applied to the natural sciences and the social sciences. The use of language in the last two sentences indicates that this is not my view of the world. This assumption is the classical position of positivism where the belief is that the same method of logic and explanation can be used for the natural

and social sciences. This is based on a position known as naturalism, the doctrine of the 'unity of scientific method'. According to this standpoint, the phenomena of human subjectivity, of volition and will, do not offer any particular barriers to the treatment of social conduct as an "object" on a par with objects in the natural world' (Giddens, 1974).

One can argue through the work of many researchers over decades that this is or is not a valid perspective. However, the relevant argument for this research links to the phenomenon being studied and the research questions. The phenomenon to be studied is the interpretation of a particular role from a particular perspective and the research questions are concerned with how the role is performed. The contribution is to shed understanding on the subjective and personal perceptions of the individual. The driving philosophical perspective is that this phenomenon cannot be likened to an 'object', but is based on phenomenology in the sense that the understanding comes from the actor's own perspective, describing the world as experienced by the individual, with the important reality being what the individual perceives it to be.

To explain this perspective Kvale (1996) defines phenomenology as interested in elucidating both that which appears and the manner in which it appears. It studies the subjects' perspectives on their world; attempts to describe in detail the content and structure of the subjects' consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meanings. Phenomenology attempts to get beyond immediately experienced meanings in order to articulate the prereflective level of lived meanings and to make them visible.

Phenomenological ideas had little influence on the social sciences until the writings of Alfred Schutz, (a major interpreter of Husserl, 1970 and other phenomenologists after the Second World War) came to notice following their translation from the German. The strength of his feelings comes through in this much quoted and forceful passage:

"The world of nature as explored by the natural scientist does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist – social reality – has a specific meaning and relevance structure for the beings, living, acting and thinking within it. By a series of common sense constructs they have pre-selected and pre-

interpreted this world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their behaviour by motivating it. The thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded on the common-sense thinking of men, living their daily lives on the social world."

Schutz, 1962

Two themes in this quotation exemplify the phenomenological approach to the social sciences and recur in the methodological writings of many qualitative researchers (Bryman, 1988). First, the subject matter of social sciences – people and their social reality – is fundamentally different from the subject matter of the natural sciences. This view entails a pointed rejection of the positivist position that the difference between the natural and social orders do not present any problems to the application of the scientific methods to the study of society. Secondly, any attempt to understand the social reality must be grounded in people's experience of that social reality. This reality has already been interpreted by its followers and so the social scientist must grasp individuals' interpretative devices which provide the motivational background to their actions. Failure to recognise and encapsulate the meaningful nature of everyday experience runs the risk of losing touch with social reality and imposing a 'fictional non-existing world constructed by the scientific observer' (Schutz, 1962).

The research design for this study evolves from the link between the researcher's personal passion to contribute to knowledge by understanding the individual in this role in depth; the precise nature of the research questions; the philosophical stance and the need to interest and gain the commitment of the research participants. For an enquiry of this nature, qualitative research in the form of interviews can be the most useful form of investigation. It is the detailed analysis of interviews that brings to life the conceptualisation of how individuals view this particular role and thereby addresses the research questions.

In taking this philosophical stance for this study, the three approaches to qualitative research are considered. These are social anthropology, collaborative research and interpretivism (Miles and Huberman, 1994). In social anthropology the primary methodology is ethnography where there is extended contact with a chosen community over a period of time and data is collected across multiple sources. In this

approach descriptions are often sought of everyday and unusual events. Often social anthropologists are concerned with the genesis or refinement of a theory. Researchers in life history, grounded theory, ecological psychology, narrative studies and a wide range of applied studies often take this general line. The second approach, collaborative research incorporates some of the features of the first approach with the collection of descriptive data in the early stages of the research. However, this approach is concerned with collective action in a social setting. The protagonists seek out a set of researchers comfortable with the action and willing to accompany the process in real time (Schensul and Schensul, 1992). This approach is also known as co-operative enquiry and Reason (1994) views all those involved as co-researchers. Their thinking and decision making contribute to generating ideas, designing and managing the project, and drawing conclusions from the experience. They are also co-subjects, participating in the activity being researched. Associated with this approach the terms action research and collaborative action research are frequently used and applied to interventions involving organisational change.

The collaborative research route is not considered appropriate for this research. It is felt impractical to seek this level of involvement from the research subjects and it is not the right 'fit' for the research questions as they evolved through the design of the study. However, with the findings from this research, a study from this perspective could add further understanding of the role. It may also be of practical benefit in the context of an organisational change.

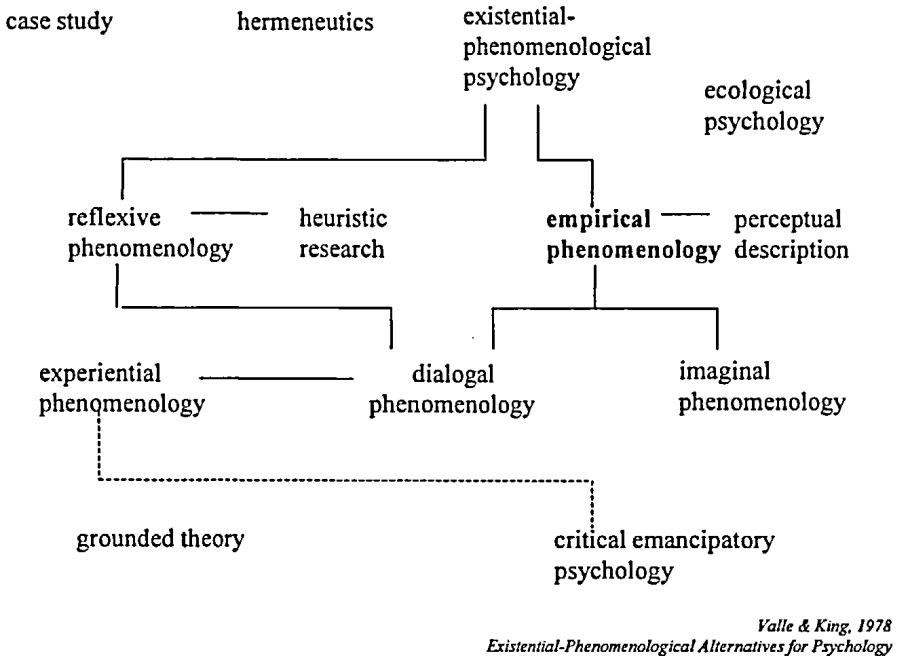
The third approach of interpretivism has a long intellectual history. Dilthey's 1911-77 thesis (Miles and Huberman, 1994) that human discourse and action could not be analysed with the methods of natural and physical science was the defining conceptual perspective. Human activity was seen as 'text' – as a collection of symbols expressing layers of meaning. For Dilthey and the phenomenologists, the way led through deep understanding, an empathy or indwelling with the subject of one's inquiries. Interpretivists argue that researchers have their own understandings, their own convictions, their own conceptual orientations and that they too are members of a particular culture at a point in time. Also, they will be undeniably affected by what they hear and observe in the field, often in unnoticed ways. An interview will be a 'co-elaborated' act on the part of both parties (Miles and

Huberman, 1994). This does pose analytical problems which are addressed in the research design.

Interpretivist lines of inquiry subdivide with special emphases and variations, one such line is the interest of the discovery of regularities, the discerning of patterns and conceptualisation – phenomenology (Tesch, 1990); the route of this research.

Phenomenology, however, has several variations. It is Tesch (1990) who recounts that it was Giorgi, and his colleagues Paul Colaizzi, William and Constance Fischer, and Rolf van Eckartsberg who were the formulators of phenomenological methodology in psychology. They built on van Kaam's work and added variations of their own. It was Van Kaam (1966) who organised a graduate programme in phenomenological psychology at Duquesne University. Valle and King (1978) edited a volume of Duquesne inspired phenomenological studies that serve as methodological examples. This was titled Existential-phenomenological Alternatives for Psychology. Van Kaam used the term 'existential' to describe his work, while Giorgi prefers the term 'phenomenological', the work of these two philosophers is so closely related that the former is implied in the latter, or the two words are linked by a hyphen. Within the approach various schools have evolved – reflexive phenomenology, empirical phenomenology, experiential phenomenology, dialogal phenomenology and imaginal phenomenology. These forms are shown below in Fig. 3.2.

Fig. 3.2 Qualitative Research in Psychology



Tesch 1990

The following descriptions are summarised from Tesch 1990.

Reflexive phenomenology is where researchers use their own experience as data. It 'aims at a descriptive understanding of the phenomena by reflectively disclosing their meaning' . . . 'through the imaginative presence to the investigated phenomenon' (Colaizzi, in Valle and King, 1978). This form of phenomenology is distinguished from those who use descriptive protocols from many subjects which Colaizzi calls an *empirical form of phenomenology.* In this context Fischer (in Valle and King, 1978) defines empirical as 'the researcher is open to all perceivable dimensions and profiles of the phenomenon that is being researched. Hence the experiences of the subjects as well as those of the researcher, are acknowledged as potentially informative . . . to understand the way of being in a situation, from people who have lived through and experience themselves as so involved [called protocols]'.

Some researchers feel uncomfortable with the distinction between 'reflexive' and 'empirical' forms of phenomenological researching, claiming that personal experience is always involved when trying to make sense of someone else's account. *Dialogal*

phenomenology might be viewed as a combination of the two forms where there is a mutual exploration to reach a consensus of the description of the phenomenon. *Experiential phenomenology* starts from the researcher's perspective '. . . the investigators question, explore and arrive at conclusions regarding psychological processes within themselves [so as] to generate testable experiential hypotheses' Price and Barrell, 1980). From a similar perspective Heron (1971) also labelled his research as 'experiential' with the distinction blurring between researcher and research participants to form only co-researchers. The final variation, *imaginal phenomenology* distinguishes itself by the nature of the data rather than the methodological approach. It 'seeks to understand psychological life by going to those sources most regnant with imaginative potency' (Aanstoos, 1987). Data are myths etymology, literature and other art forms.

The form used in this research is empirical phenomenology. The research takes an approach where descriptions of how individuals explain the dual role are gathered to understand the 'way of being in a situation'. My perspective as researcher is shared in the introduction to this research and explains my personal rationale for the study. The research is designed to elicit the individual's meanings relating to the phenomenon with little influence from me as researcher particularly in the first round of interviews. I was much more involved in the second round of interviews when my own experience was helpful in obtaining clarification of the individuals' meanings, and these interviews could be described as co-elaborated acts (Miles and Huberman, 1994).

3.3 RESEARCH DESIGN

The philosophical perspective underpins any research, but alongside this is a pragmatic process which operates as the research takes shape. An iterative process between the philosophical perspective, the research questions and the nature of the research focuses the research design choices. Taking a phenomenological approach infers a paradigm with a basic belief that the world is socially constructed and subjective and that science is driven by human interests. With this paradigm the researcher should focus on meanings, try to understand what is happening and look at the totality of the situation and develop ideas through induction (Easterby-Smith et al, 1991). The methods for this study emanate from this paradigm and pragmatically align with what is feasible and achievable given the background and availability of the research participants.

Linked to the philosophical approach are other design choices. The spectrum of, is the researcher independent or involved is one where the traditional assumption in science has been that the researcher should be independent for the results to be valid. Claims of independence are more difficult to justify in social science. Full independence is certainly not claimed for this research. However, the research design was structured to enable the perceptions of the participants to be collected and analysed with a minimum of 'interference' during the early stages of the process, but with a more phenomenological approach used for the second phase.

The focus on meanings and endeavour to understand the totality of the situation means this is not a study where large samples are used. The concentration is on small numbers of people in similar roles in a few different organisational settings. The sample is stratified with a purpose and logic which is explained later.

Issues of validity and reliability were originally developed for use in quantitative social science. There was some reluctance to apply these ideas to phenomenological research, because they might imply acceptance of one absolute (positivist) reality. However, provided the researcher is committed to providing a faithful description of others' understandings and perceptions, then ideas such as validity and reliability can provide a very useful discipline (Easterby-Smith et al, 1991). This research is carried

out with attention to detail in recording the process and with rigorous adherence to the research design. While a good reliable process demonstrates a discipline it does not of itself make 'good' research. This research design is consistently linked to the philosophical perspective. To address issues of validity I have striven to ensure that full access and understanding of the participants has been gained. Time has been taken to secure the full commitment and interest of the participants. The interview design is guided by the 'Quality Criteria for an Interview' and the 'Qualification Criteria for the Interviewer' as defined by Kvale (1996) The interview framework used in the first taped interview allowed me to remain as detached as possible gaining the individuals perceptions of the dual role by asking only a few open questions. A second interview allowed for participants feedback and further questions to be asked and interpretations verified.

The research questions are exploratory and seek to understand the perceptions of individuals in a particular role. There is a general recognition that research of this nature is best explored through a qualitative approach. For example, Van Maanen, 1977 states that qualitative data with an emphasis on people's "lived experience," are fundamentally suited for locating the meanings people place on the events, processes and structures of their lives: their "perceptions, prejudgements, presuppositions" and for connecting these meanings to the social world around them. On a similar note Marshall and Rossman (1989) indicate that the kind of research questions most amenable to qualitative methods are exploratory ones which examine "what are the salient themes, patterns, categories in participants' meaning structures?" A major feature of qualitative data is that they focus on naturally occurring, ordinary events in natural settings, so that we have a real handle on what "real life" is like (Miles and Huberman, 1994). Some quantitative methods do not allow individuals to express their views freely, but direct their thinking through structured questionnaires. Silvermann 1993 points out that qualitative methods may be particularly useful when participants' views on the research topic could be somewhat unformed. The expectation was, and proved to be, that although the participants were familiar with the research topic it was not always easy for them to articulate their views in the detail required in this research.

From philosophical and practical perspectives addressing the research questions through qualitative and quantitative methods is rejected. Using multiple methods e.g. surveys, interviews, observations, and conducting research over time has problems of securing the commitment of very busy senior people. Also, maintaining a focus on the individual rather than a population is more problematic with multiple methods over time. The aim of this study seeks to understand the totality of the role including the professional clinical role which has and usually continues to be a significant part of the individual's life. It is in the clinical role where observation and other methods would be particularly sensitive. Marshall and Rossman (1989) acknowledge that one cannot understand human behaviour without understanding the framework within which subjects interpret their thoughts, feelings and actions. It is the particular framework of a long professional career and performance of the clinical role that provides a context for this research. Therefore understanding the clinical role from the individual's perspective is seen as an important part of the research design.

3.3.1 Research Methods

With the conviction of the approach to this research and the nature of the questions several choices of methods are available to me to be used individually or in combination. These are summarised by Silvermann (1993) as:

1 Observation
2 Analysing texts and documents
3 Interviews
4 Recording and transcribing

With the questions posed in this research, perceptions and views of individuals in the dual role are required. The decision is made to use semi structured interviews as the prime source of research material. The interviews are recorded and transcribed. Analysing texts and documents concerning each organisation is undertaken as an aide to understanding the context of the CDs and SLCs. This understanding is designed to save interview time and show my commitment to understand the local issues and the context within which the individuals worked.

Semi structured interviews are used for several reasons. From a pragmatic perspective there is a need to make the best use of the time available and focus the CD

on the line of enquiry. It is also my wish to secure the maximum value from the data and therefore the structure is provided by frameworks from the literature. This approach is so often urged by researchers, so we build a body of knowledge and do not become preoccupied in distinguishing our research from others with new and often confusing language. The questions, particularly in the first interview are open-ended and allow individuals the freedom to express their views in their own language. It is acknowledged that structuring the interviews could be viewed as compromising the philosophical perspective to some degree, but this is seen as justified to engage the commitment of the research participants. Although I gave some structure to the format of the first taped interview with each individual the questions were very open.

Interviews are categorised in a number of ways; the structured or focused interview (Merton, Fiske and Kendall, 1956) and the unstructured, elite, specialised or exploratory interview (Dexter, 1970; Richard, Dohrenweld and Klein, 1965). Interviews in this research are not structured in the sense that they are similar to a face to face survey where variations may be handled statistically. They are closer to an elite interview where there is a desire to tap into the experience of senior individuals (Guba, 1981). Braybrooke and Lindblom (1963) make the distinction between action and meaning in the argument for unstructured interviews. They argue that when the norms (rules, standards, principles, social codes and so on) that guide action are clear then the event is defined in terms of action alone. When the norms are not clear then meaning needs to be sought and individuals asked to bring understanding. It will be seen how the design of this research brings into focus this distinction.

The research design is one meeting and two interviews with each individual participant. The first introductory meeting is followed by two semi structured interviews to address the research questions.

3.3.2 The Interview Design and Research Questions

The framework for the first taped interview is a model for understanding managerial jobs and behaviour. This framework has been used in a number of studies dating from the early 1970s. Nothing since improves on the simplicity of this approach which allows individuals to describe a role in their own words. Other approaches are discussed in the literature review, but this is believed the most appropriate way

forward for this specific study. It is seen as useful primarily as a way of thinking about the nature of managerial jobs and how managers do them. The framework can provide a more realistic understanding of both than can be obtained from the traditional ways of describing jobs or thinking about managerial performance, as these tend to be too formal and idealistic (Stewart 1982). Stewart (1989) commented that studying how managers think about their work is the most open-ended, potentially the most difficult and the most exciting of possibilities. My research questions are more than about understanding what individuals do, in terms of how they divide up their work and defining lists of tasks.

The framework for the first interview allows jobs or roles to be explored through open-ended questions in three categories:

Demands - what anyone has to do in a job. It is a narrow term and challenges the individual to consider what *must be done.*
Constraints - the factors, internal or external to the organisation that limit what the role holder can do.
Choices - the activities the job holder can do, but does not have to do. They are opportunities for one job holder to do different work from another and do it in a different way.

The unique feature of this research is the use of this framework to analyse the clinical role and the strategic leadership role of the same individuals. The same questions are asked of both elements of the dual role.

The framework for the second interview take a particular perspective on how roles are made (Graen, 1976). The Role Making framework is another tried and tested model which is still viewed as the preferred model by current researchers in this field (Willcocks, 1996).

In performance of a role there are other people around the individual, known as the role set (Merton, 1957). They consist of different people with whom the manager has contact and who hold expectations about and have a stake in the manager's performance in the job. This research focuses on understanding the dual role and part

of that understanding is about where the role comes from. When we take up a role, what we do and how we do it emanates from somewhere. Here, I see links with concepts about exploring the 'organisation in the mind' (Armstrong, et al, 1994), and the emotional reality which forms the individual's relatedness to the organisation, consciously or unconsciously (Dutton et al, 1997).

The second interview explores where the performance of the dual role comes from using the concept of a role set (role-senders) and views the individual research participant as the role-receiver. What happens between role senders and role receivers is a psychological process consisting of that person's cognition of what was sent (Graen, 1976). Who are the role senders for the dual role and how does the individual understand the messages as the role receiver? The questions for the second interview were framed in a more 'user-friendly' language as:

- Who has an expectation of you in your role?
- What are their expectations?
- How do you know these things/issues are their expectations?

The research questions are confined to understanding the individual's perceptions and not those of the role-set. The emphasis is consistently placed on understanding both elements of the dual role.

Research at the first site (A) is an exciting period for me. Having progressed to this stage I am keen to understand how the CDs respond to the questions and if the research design actually reveals findings which accurately address the research questions. Following the analysis of the interviews at site A minor amendments are made to the interview design with the addition of a questions 6 and 7. By asking the same questions for the professional role and strategic leadership role it is possible to analyse similarities and differences, and patterns and themes, in the responses across the range of questions. The opportunity that is missed is obtaining the individuals' perception of the similarities and differences. However, the research design is not lost on the participants and at site A several individuals talk about their views of the similarities and differences between the two elements of the role.

The interview design is restructured and finalised to address the following research questions.

Primary research question

How do clinical consultants take up the dual role of strategic leadership and clinician?

Questions which focus and put in context the primary research question

1 How do individuals describe the professional and the strategic leadership elements of the dual role? (Framework for the first interview)
2 What similarities and differences are seen between the two elements of the dual role from the analysis of question 1?
3 How do individuals understand what is expected of them in the professional and strategic leadership elements of the dual role? (Framework for the second interview)
4 Why do individuals take up the dual role? (Direct question)
5 What are the main challenges of the dual role, where is there conflict and where is there congruence? (From analysis of the first interview and direct questions in the second interview)
6 Do individuals actually see the two elements of the dual role as separate or is the dual role actually seen as one role? (Direct question, second interview)
7 What similarities and differences do individuals believe exist between the professional and the strategic leadership/management elements of the role? (Direct question, second interview)

3.3.3 The Research Sites

There are approximately 500 NHS Trusts where this research could be undertaken. They vary in size in relation to the population they serve, staffing levels and budget. Trusts are providers of health services and their budgets are primarily made up of contract income from Health Authorities who assess health care needs of the local population and purchase services to meet these needs.

The Trusts also differ in the type of NHS services they provide and their location which is broadly either, rural, urban or metropolitan. My experience as a senior manager in the NHS and also my research masters degree tells me that all these

differences are significant and result in very different types of organisation. For example, a large world renowned teaching hospital in London and a small community mental health facility in a rural community may both have CDs, but the context in which they perform their roles would be so different that comparison would have little real value.

To enable these important elements of size and type of service to be similar, the three sites chosen are NHS Trusts centred on a district general hospital. They are representative of the largest proportion of NHS Trusts and are broadly similar in size serving a local population of 300,000 to 400,000. They provide a range of acute services and are located in or close to a town which forms a substantial part of their catchment area. They can be described as a 'Middle England' type of local hospital service and are representative of most of the acute service provision in England.

They have all involved clinicians in the management and leadership in their trusts. While the titles and responsibilities of the individuals varied, they are all defined as strategic leadership roles in job descriptions.

Research Site A

The first site (A) is chosen as I am aware the Chief Executive (CE) has an interest in the development of clinicians in management and the CD role. Also, I have known the HR Director of the Trust for many years, so I believe that access will not a problem. Particularly for the first site, I want somewhere that will want to be involved in some original research and not make too many demands for feedback.

At site A interviews are conducted with the seven clinical directors, the medical director, who had a different role as an executive member of the board, and the CE.

Research Site B

The second site is a NHS Trust (B) with a similar profile to Trust A in terms of size and population served. This Trust has divided the CDs areas of responsibilities into slightly smaller areas, trying where possible to have CDs responsible for mainly just their own specialty. This Trust has eleven Clinical Directors. The Trust is chosen for its profile and I know the Chief Executive very well and estimate that a) access will

not be a problem and b) the Chief Executive will probably have the respect and support of most of the CDs and, therefore, they will be likely to give their time willingly.

Research Site C

The third site (C) has a similar profile, but has adopted a different structure with consultants as lead clinicians in charge of their own specialty, but with no general management responsibilities. At a senior level there were four consultants in Senior Lead Clinician (SLC) roles who have a strategic leadership role, as defined in the job description, for a number of specialties. This Chief Executive is known to have an interest in academic research and therefore is likely to agree to participate in this research.

The Research Process

Selling the idea to the CEs was relatively easy, and achieved through either a telephone conversation or a letter and a meeting. All three CEs asked their CDs and SLCs to support the research and everyone participated willingly. Other studies of this role have found 100% participation not possible (Willcocks, 1996).

During the process of locating sites one other Chief Executive was approached, but he failed to influence his CDs to participate or at least agree to a first meeting. It is therefore acknowledged that the three sites for this study are in Trusts where relationships between the CE and the CDs and SLCs appeared to be positive. This is not always the case and may in some way affect the view the CDs and SLCs view management and their leadership role.

The Process - Site A

Part of the rationale for the first meeting followed by the semi-structured interviews is to engage the CDs by first seeking their personal permission and raising their interest and curiosity in the research. I believe that I will obtain more thoughtful and considered responses if they are interested and believe the interviews are an effective use of their time. This is paramount as a close rapport with respondents opens doors to more informed research (Fontana and Frey, 1994).

At the first meeting I also inform the participants the interviews will be taped, and remain confidential only being shared with colleagues who are supporting me in the doctoral programme. I explain that I hope to publish the research, but assure them their comments will never be attributed to them personally outside my academic colleagues. All agreed to the interviews which are arranged by secretaries at sites A and B and by myself at site C.

The initial meeting allows me to make the maximum use of the one hour interviews as no introductions are necessary and the CDs know what to expect. At the start of both taped interviews I briefly explain the theoretical perspective behind the questions. This is to reinforce the value of their contribution to my doctoral research programme. It is also aimed at giving the research credibility as most consultants will be used to research with positivistic methodologies and possibly sceptical of my approach. They appear to be genuinely interested! I say they will notice a change in my style from our first meeting, as I am going to ask open-ended questions and talk very little during the interview. I want them to respond to the questions without me leading them. I then repeat my rules of confidentiality.

My careful preparation for these interviews is aimed at making the CDs feel involved and relaxed. For the first meetings I go to their offices, this has all the benefits of being on their territory. However, it is obvious from constant interruptions in some cases, this is not the right place if I want their attention for a one hour taped interview. In these cases a separate room is found for the interviews. Time spent in preparation mean the interviews go very smoothly. One even takes place in the comfort of the consultant's home while he is convalescing from back surgery.

At the first site the process is organised in eight stages shown in Table 3.1 below.

Table 3.1 Conducting the Interviews – The Process

Stage	Process
1	Obtaining the interest and permission of the Chief Executive.
2	Background reading for familiarisation with the Trust.
3	Meeting the CDs collectively at one of their meetings. This acknowledged the fact that I had the Chief Executive's approval.
4	A short meeting (15-30 minutes) with each CD to obtain their permission personally, explain the process, time commitment, rules of confidentiality and to answer any questions. Take basic biographical detail.
5	First interview (1 hour), using the framework for understanding the nature of managerial work and behaviour
6	Interview with the Chief Executive to determine his perspective of the CDs role using the framework from stage 5 and stage 7.
7	Second interview (1 hour), using a framework from role theory to describe the perception of the expectations of the role.
8	Feedback has still to be given. The format of the feedback was left open until the research had been concluded.

Stage 3, my attendance at the CDs meeting, is largely symbolic. This is not an envisaged as part of the original design, but is offered by the Chief Executive who is very enthusiastic for me to meet the CDs collectively. Also, the timing is right with their meeting being close to my appointment with the Chief Executive. My attendance at the meeting endorses the Chief Executive's wish for the Trust to participate in my research.

The Process - Sites B And C

The process for sites B and C follows a similar pattern, but stages 3 and 6 are not included. Stage 3 is not appropriate as following a meeting with both Chief Executives it is clear they wish to encourage their CDs and SLCs to participate by discussing it with them without my presence. Stage 6, the formal interview with the CE is not part of the research design and although interesting it is not actually relevant to the research questions. This study is concerned with the individual's perceptions

and not the views of those working with them. The critical part of the process remains obtaining the permission and interest of the Chief Executive and the individual commitment of all the CDs and SLCs.

3.3.4 The Research Participants

Basic biographical details are given by the participants at the first meeting. Those stated in Table 3.2 below are seen as the variables which are relevant to their career and this study and distinguished one individual from his or her colleagues. There are twenty-three participants who are all seen on three occasions, making sixty-nine contacts. There is only one woman in the sample.

The research participants are shown below by site, with their title. The last three columns in the tables show the numbers of years they have been in the dual role of CD or SLC; how long they have been a consultant and the years they have been at this particular trust/hospital. From these tables it can be seen that the length of time in the dual role ranges from a few months to 6 years. At these three sites the dual role is usually held for three years. At site A this period has been extended for most of the CDs. One participant at site B had his contract extended and one had almost completed his second term of three years having had a break of two years when a colleague held the post.

The tables show the widely recognised career pattern for consultants. They move hospitals or NHS trusts when they secure a consultant post and then remain at the same hospital for a long period, often to the end of their career. The implications of this career pattern are discussed in chapter 5.

Table 3.2 The Research Participants

SITE A	Clinical Director	Years in post		
		CD	Consultant	Site A
1	Informatics	5	20	15
2	EET	6	18	18
3	Medical Director	3	15	15
4	Surgery	4	11	11
5	Medical	4	18	18
6	Children and Women	3	12	12
7	Radiology	5	10	10
8	Pathology	4	11	11
SITE B	Clinical Director	Years in post		
		CD	Consultant	Site B
1	Paediatrics	5½	25	23
2	Anaesthetics	1	2	2
3	Medicine	1½	24	24
4	Accident & Emergency	3	4	4
5	Medical Specialties	4	21	21
6	Obstetrics & Gynaecology	3	16	16
7	Radiology	3½	10	10
8	Trauma and Orthopaedics	3	10	10
9	Head & Neck Services	2	5	5
10	Surgery	3	10	10
11	Pathology	4	9	9

SITE C	Senior Lead Clinician	Years in post		
		SLC	Consultant	Site B
1	Surgery	2	22	22
2	Women & Children's Services	½	5	5
3	Medicine	2	14	14
4	Clinical & Life Support Services	1	13	13

3.4 CODING AND ANALYSIS

It is generally agreed that the basic process of qualitative analysis is one of abstraction, that is moving from raw data by means of coding to more general categories, from which are developed higher level theoretical concepts from which theory is built (e.g. Miles and Huberman, 1994). My journey through the analysis a series of iterations. This process of overlap between different stages of analysis and an interweaving with other aspects of the research process is observed by Bryman and Burgess (1994). There are, however, recognisable stages which occur during analysis. These are interconnected and described by Ritchie and Spencer (1994) as familiarisation, developing themes and charting (or coding), mapping and interpreting.

Data collected at the first meeting was designed not just to gain the commitment of the individuals, but it was also used to collect brief biographical information as shown in Table 3. Two taped interviews with each individual formed the main part of data collection. The aim was for me, as the researcher, to remain as detached as possible in the first interview while encouraging the individuals to speak freely. As described earlier, data were collected relating to the professional role and the management elements of the role in the demands, constraints, choices framework. Clarification of any issues that were unclear was sought. The second interview provided an opportunity for further clarification, followed by questions concerning role expectations, similarities and differences between the elements of the role, where there is conflict or congruence and if the dual role was actually seen as one role or two separate roles.

A similar approach to the analysis was used for both sets of interviews and all three sites. My view was that use of the computer-aided qualitative analysis software package, QSR NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorising) would assist the coding and analysis of the large volume of data. This proved to be true. I wanted, however, to be very familiar with the content of the tapes before using the software package. I had a concern that giving my attention to understanding and using the software might distract me from becoming really familiar

with the data. This was less of an issue for the other two sites when the NUDIST programme was less of a mystery to me.

Familiarisation

Data were analysed initially by individual and by site as this is how the research was conducted finishing all interviews on one site before moving on to the next.

The interviews with the CDs were recorded and transcribed. Notes were also taken during the interviews to record any views about the situation and comments when the tape recorder was not in use. Also, notes were made quickly after the interview to capture any views or impressions about the interview that might add value to the analysis.

The tapes were replayed and checked and the transcriptions amended. Listening to the tapes with my notes about the interview, although time consuming, added a deeper understanding than just reading the transcripts. I made notes about where there were strong feelings expressed, where there was humour or other non-verbal cues that bought a greater understanding of the contextual flavour to the interview. Was the interviewee interested in the interview, giving expansive responses or were they guarded in the replies? Posing these questions in my mind as I listened to the tapes reinforced the views I had gained at the time of the interview.

I read the interview transcripts for each individual again and wrote notes about what was being talked about, for example, when asked to summarise the role the responses fell into three categories with some blurring in between them. These categories were described as leadership/management/representative role. It was clear there were issues that challenged and put pressure on them. Some individuals were relaxed in the role, others were stressed and overwhelmed. Some seemed very much to take charge in the role, while others appeared more laid back and less involved. This process gave me a detailed insight into each individual.

Problems became obvious as I looked at the data in this initial browsing and thought about the coding process. The art or craft of thinking about what was being said and the meaning of what was being said and coding it was going to be a challenge. For

example, looking at the first interviews, as I made notes about where the role was seen as a leadership role I could see the difficulties. I could simply look for variations of the word leadership or a description of leadership which linked to the literature. For example, one individual described the role as that of a supervisor, but when the individual expanded on how he actually took up the role the detailed description aligned to a much broader strategic leadership role. This raised heightened my awareness of the issues of analysing the data and reflecting views across the population.

The level of analysis of the first round of interviews had at least reached the above stage of analysis before the second round of interview was undertaken. It was seen as important to look for issues that required further clarification or appeared on reflection simply not to make sense so those could be clarified in the second interview.

This process of familiarising myself with the data preceded the use of NUDIST and brought me close to the data about each individual. This process was followed for both rounds of interviews. At the second interview with each individual I explored different aspects of the role as outlined earlier and clarified issues from the first interview. By the end of the familiarisation process for the second interview I had built up a picture of the individual. I could see the person, understand some meanings of how they took up the dual role and what it meant to them. Their views about managing the dual role, their feelings and emotions about the role were clear to me. The challenge was now to move to analysing and coding the data and developing findings.

Having understood the issues associated with coding at a rational level from learning in the research methodology programme the task now became a very practical and personal issue of coding my own complex set of data.

Initial Coding Process

The following stages outlined the coding process.

- Coded the base data, individual, site, specialty, time in post at the site as a consultant and time in post as a CD/SLC.
- Coded the data under the questions in the interview framework for the individuals.
- Printed out the data under the headings for all individuals as I found it difficult to review the data on the screen of the PC. At this stage I had, for example, the responses to "what are the demands of the role?" in one place to browse and investigate.
- Browsed the data and made notes in the margins regrouping the responses into topics under the headings in the interview framework. These groupings form part of the coding framework, for example issues about communication, relationship with colleagues.
- Coded the data under these groupings/themes. Within these themes is another layer of meaning which forms the next layer of coding, for example the type of communication, the style of communication.

A similar process of coding was then adopted for the second interview preceded by the familiarisation process.

As I progressed from site 1 to 2 and finally 3, I brought the analysis together by site. I felt there were differences between the sites that could be of interest. Nonetheless, my research questions were related to individuals and site issues were not relevant to this research. In chapter four, therefore, the analysis is shown by individual and not by site. Brief comment is made about the sites. Analysis originally undertaken by site was retained and referred to where it was felt to be of interest for further research. Also as the sites were added I revised the coding structure as different issues emerged. It was now I could see and confirm site differences more clearly than I perceived at the interviews. For example, most individuals at the first site spoke about stress in the role, whilst at the second site, this was mentioned much less frequently and at the third site hardly at all. Comment is made on these differences for future research. I also experienced the difficulty of interpretation and recording the detail, for example, the individual who explains what could be interpreted as mischievous behaviour at

meetings by pretending to be participating. Later explanations reveal he was experiencing a mixture of feelings being bored, complying to gain and enjoy power, feeling his contribution was not valued.

Similarities, differences and areas of conflict between the dual elements of the role were analysed in response to direct questions and from data drawn from the responses across the transcripts. Other significant issues were coded across the population and are reported separately in the chapters 4 and 5. For example, although the research questions do not specifically look for differences between the specialties many individuals believe this is an important influence on how they and their colleagues take up the dual role.

Interpreting

Interpreting may be referred to as a final stage of the analysis but I felt that interpretations were being made at all stages. The coding process is one of interpretation. As explained looking at the same piece of data individuals could produce a different interpretation. The focus for this research is being clear about the research questions, anchoring the analysis back to these and seeing the role in the context of the framework provided by the literature review.

As the research progressed, through the interviews and the stages of analysis I was aware that there were some similarities in the responses found in previous research and confirmation of those that might have been anecdotally understood. There were, however, some new and unexpected responses as summarised in the analysis chapter.

One problem was while understanding that the data had to be analysed across the population, by doing this I felt that I was losing the identity of the individuals. The data appeared dull to me and I lost the sense of the personality of the individual. In the familiarisation process I could see responses which gave individuals an 'identity' formed from many of his or her responses. As the 'identities' emerged conceptually they fell into clusters, but I found these difficult to code or describe using small illustrative pieces of data. The challenge of this study is to describe the individuals' meaning of the role. But eventually I regained the sense of the liveliness of the data as the role constructs grew and took on their own characteristics. However, many

questions filled my mind. Is this 'identity' linked to the time in the CD or SLC role, their time as a consultant, their specialty, their different experiences in the role, their motivations for taking the role, their attitudes or their personality? Answers to these questions are not sought, but the analysis brings a new level of understanding about the role and almost inevitably brings some unexpected outcomes which gave rise to more questions.

Having interviewed, probably many thousands of people for a whole range of reasons, I have never taped and rigorously analysed an interview before. For me personally, the volume of data from 23 meetings and 46 taped interviews and the richness of what is said had to be experienced to be believed. I experienced a mixture of fascination, enthusiasm and panic.

Review of Data and Coding

Patterns in the responses from an individual were clearer when I had disaggregated the data and then brought it back together and reread the transcriptions. This was a time consuming iterative process, which on reflection, I was not sure why it was necessary, but it appeared to be. Ideas of how individuals take up the role were formed by rereading the transcripts and being, by now, so familiar with the data that the individuals were vivid pictures on paper and in my mind. The feelings I had during the interview and on listening to transcripts returned. I could see the enthusiast attacking problems head on contrasting with the more laid back consultant who appeared to be taking most things in his stride. The ideas formed emerging themes and my process of thinking about individual profiles needed to be explicit and justified.

- The data was reviewed and coded into themes.

These themes were linked in some individual profiles and blurred in others. The themes were found to cluster around two dimensions. This final stage of the analysis is shown with coded extracts from interviews across the population.

- Examples of individual profiles were tested.

Individual profiles are shown to illustrate how these themes come alive in the individual. In some the distinction is stark in others it is less clear.

The coding process is summarised in Table 3.3 as follows:

Table 3.3 Summary of the Coding Process

Summary of the Coding Process
Base data - information as shown in table?
↓
Coded by themes e.g. demands of the management role
↓
Coded by clusters e.g. communication
↓
Coded meanings within the clusters e.g. style of communication
↓
Brought the sites together (A+B+C), updating codes
↓
Re-read transcripts
↓
Conceptualised ideas of themes individual profiles
↓
Searched data and coded further themes
↓
Considered patterns between the themes
↓
Checked these against individual profiles

I concluded that the process of using NUDIST software helped me index the documents and coding system and organise the data. The task of investigating and browsing the documents was also helped by using the software which made the task of sorting and resorting easier as I added data from other sites and revisited the

coding. Although not the function of NUDIST, it had not helped me make the creative leap from analysis to interpretation. I still feel that it was listening to, reading and rereading of the original transcripts and coded transcripts that helped me gain the insight that addressed the research question and led to the findings.

The final coding structure used in NUDIST for the analysis can be seen in Appendix A.

4 ANALYSIS

Quotations from interviews with the CDs and SLCs are shown in italics

4.1 INTRODUCTION

The first part of the analysis is reported in sections that reflect the interview questions. The aim of this section is to provide an understanding of how the two elements of the role are understood by individuals. The frameworks drawn from the literature are used as a vehicle to explore the research questions are discussed in chapter 3 and are briefly summarised again under the appropriate section. The second part of the analysis is reported from themes developed outside the interview framework.

The analysis is reported under coded headings examples of responses relating to each code are shown in italics. The coding framework is shown in Appendix A

4.2 THE INTERVIEW FRAMEWORK FOR UNDERSTANDING THE DUAL ROLE

The individual's detailed understanding of the dual role was first examined through the demands, constraints and choices framework outlined in section 3.3.2. The opening question asks interviewees to summarise their role in one or two sentences. This is followed by the three open questions set out below. The questions are first asked about the strategic leadership role and then about the clinical role:

- What are the demands of the role, that is, what must be done in the role?
- What are the constraints of the role, what gets in the way of you performing the role?
- What are the choices you have in the role, that is, in what you do and how you do it?

The analysis is explored under these three headings for each of the three sites. The strategic role is analysed followed by the professional role.

4.3 UNDERSTANDING THE STRATEGIC LEADERSHIP ROLE

4.3.1 Overview of the Role

The literature review showed that from a national government and academic perspective the role of clinical director is potentially of great significance in enhancing the organisation's strategic capability (DOH, 1989; Harrison and Miller, 1999). This is reflected in this study where the job descriptions agreed by the executive at all three sites view the post of CD and SLC as a strategic leadership role.

Not surprisingly some of the interviewees describe the role in ways that suggest there is a strategic perspective to the role. This is closely linked by the literature to the nature of a leadership role. A good proportion, however, see the role as that of a manager delivering rather than shaping the service. A stage removed from this is the role of being a representative. This role being that of an individual who acts as a communication channel primarily between clinicians and 'management'. These quotes scope the breadth of views and reflect how the total population see the role. In a few cases there is a need to treat an overview of the role with some caution. Sometimes a more detailed description of the role later in the interview contradicts the overview. For example one individual described himself as a supervisor and then went on to develop a meaning that related to an much more strategic role.

The following extracts from the interviews provide a broad overview of how the role is perceived which is consistent with their fuller descriptions of the role.

Strategic perspective → Leadership

These quotes give a sense of providing direction and taking people with them.

Giving policy direction with nuts and bolts left to others.

Requires a clear thinking and a broad vision, innovation and direction.

With the input (to planning and direction) of a doctor as well, the horizons can be much broader and not just in the department.

It's seeing the future and working out a direction.

You need to set some strategic goals.

I contribute to the strategic plans and agree them with the manager before they go the executive and the board.

I am making a contribution to the strategic direction of the trust, but the thing I find about this role is frustration, there are so many external influences in how we have to operate.

Giving direction and leadership, tilting the rudder in the right direction.
It's showing leadership, it's bringing it (the directorate) together.
I suppose it means that I have to really act as the lead for the directorate.
I am the consultant in overall leadership of ...
Some of the role is just talking to people cajoling them and making them do things, but you can't lead with a heavy hand you have to have a light touch on the tiller.

Manager → Representative

The quotes span the definitions of the individual who feels he/she is responsible for seeing the service is delivered to the individual who is primarily a communication channel between clinicians and management

I feel I am a sort of figurehead.
It is delivering a service that has been agreed at a corporate level.
My responsibility is to deliver the agreed level of service within budget.
I am responsible for setting up an annual business plan and then we have quarterly reviews on our progress.
I have a managerial responsibility for surgical services.
You have to have a grasp on how the whole department is organised, both in terms of line management responsibility and budgetary responsibility.
It's pulling it all together to make it manageable.
Making sure the money balances, although finance keep a jolly close eye on you.
I feel in many ways it is more of a supervisory role.

I see myself as go between clinicians and management.
I try to represent things as fairly as I can.
I provide a clinical input to the Board and Trust Executive.
I am the conduit for my colleagues (consultants).

We would have expected to see differences in responses as there are some obvious differences in the responsibilities of the role at the three sites, particularly when at two

sites there are budgetary and staff responsibilities, and at one site there is no formal responsibility for staff or budgets associated with the role. But, at this early differences were often within the sites. In each trust there is also recognition by the individuals that there would be a difference in how they and their colleagues manage the role. They believe the main differences would be down to their personalities and the specialties they manage. At one site there is strong consensus amongst CDs about the role being a strategic leadership role, giving direction and looking forward. At the two other sites the CDs and SLCs were fairly evenly divided between a strategic leadership role, an implementer/manager and a representative. Given the big differences in responsibilities at the site where this role is known as a SLC role it is interesting to realise this difference has no link to how the role is perceived in general terms. This overview suggests we would be able to think the roles would be seen as broadly similar within and across the trusts.

The level of analysis in this research is the individual. Attention is drawn to differences between the sites only when it is considered to be an interesting observation for further research related to context.

An overview of the nature of the role provides a broad hierarchy of the perspectives of how the role is taken up. There is some blurring and overlap between the distinctions made here, but they provide an indication of the range of views. These are summarised below in Fig. 4.1 below.

Fig. 4.1 Overview of the CD/SLC Role

4.3.2 What are the Demands in the Role?

The demands or 'what must be done' in the role is dominated by various forms of communication. At the heart of the role for many is the attendance at meetings. Some see a value in meetings keeping them informed and regard them as a routine part of the role, while others are frustrated at having to attend for long periods of time. Being specific about the purpose of the communication is quite difficult for most interviewees.

Communication/meetings

Attendance at meetings is a key feature of the demands of the role.

You are expected to attend and have an input to Board meetings.

Meetings are an opportunity to contribute to the direction of the Trust

We are kept informed of everything at the Board, therefore consultants can come to me if they hear rumours and I can tell them what is really going on.

There are all the obligatory meetings, with the executive, with colleagues. I don't go to all of them.

I represent my colleagues at meetings. I pass information down to them and they pass information up to me. It's the interjunction between me as the figurehead and the

surgical consultants. I have a managerial responsibility to manage surgical services in conjunction with the general manager for surgery.
Attending the various meetings and making sure my colleagues are aware of the developments. I provide a clinical input at the executive level.

Communication/meetings/frustration

Some individuals express great frustration about attendance at meetings. Meetings are, however, seen as an essential part of the role

I am sceptical of the value of me being on the trust executive and the trust board, because it doesn't make any difference. Sorting things out on a one to one with colleagues makes a difference. I have the SLC muscle to do that. I go to meetings so people think I am doing the job in the way they want. I comply to get freedom.
Six hours the meetings last sometimes, it's ridiculous. I say so, but it makes no difference.
I have felt more value sometimes in the board meeting than the executive meeting. You can explain graphically to board members what the reality of the situation is. Executive meetings are quite useful times for doodling and writing things down, not listening to what is happening, when they are discussing the laundry contract and things. If you are writing things down, people sometimes think that you are listening and concentrating.

Communication/being reactive

Some do not actively seek informal communication

I rely on meetings to communicate with colleagues and I meet with the nurses and PAMs (Professions Allied to Medicine).
People can come and see me. I don't have time to walk around much. I don't interfere.

Communication/being proactive

Communicating proactively by walking around, by listening and sensing what is going is seen as essential by some CDs.

I think communication is a very big area, communication between the Trust Board and the directorate.

You need to meet with everyone, therefore you have to have some clue as to where you are going. Sometimes Lord knows where we are going.
To communicate with colleagues, which is particularly consultants in different specialties and the senior nurses, to get feedback from them as to where the problems are, where we need to develop.
I need to make sure things are as I expect them to be.
I need a handle on pretty well everything that is going on in the care group. When I am doing my clinical work I am picking up information about my CD role. This may be spotting potential problems.
You need to listen and be available, you need an openness, but also a strategic privateness.
I need to talk and I need to listen to what people are saying.

Relationship with colleagues

Communication is also part of the role of managing consultant colleagues. Managing the relationship with colleagues is, however, seen as major role for most CDs. This is clearly a professional relationship and the only one to afford the title 'colleague' while everyone else is referred to solely by their job title or similar attribution. It is the relationship with colleagues that is seen as critical to the role. Some express their views simply as a key component of the role, others see the relationship as a constraint to performing the role and further views are reported in 4.3.3.

I am responsible for managing my colleagues and I don't think I am very good at it. I am probably too nice to them. I listen to what they say.
I think consultants are intelligent people and they have got to have their head. Most of them do things with the right interest. A few people think only of themselves, but not many.
It means managing my colleagues, which I think is the most difficult bit of the whole role.
I think we act as a rubber wall and a sounding board, I don't particularly like this part of it, to act as the dog to be kicked, often people just come with gripes about intra colleague relationships.
They like to come and talk to somebody, sometimes it is enough just to talk. You have to try to get a team approach.

I am lucky, we don't have any internal grievances or conflicts between the consultants.

Consultants are leaders in their own right. They have a defined position that involves taking decisions which no-one else is going to question.

One respondent acknowledges the complexity of managing senior individualistic people who are acting within a complex system.

My colleagues are a cohort of people within the top echelons of the organisation who are all acting individually in their own right, perfectly rightly so, but wrapped around them is an organisation which is trying to make the whole thing work.

Another consultant expresses the challenge in a more graphic way.

It's like carrying around a sack load of ferrets or, as my father-in-law says a barrow load of monkeys. They are everywhere, they go behind your back and go off elsewhere. At the end of the day you know what budget you have got and you just have to manage.

Staff Motivation

Part of the meaning behind the communication role for some is that of nurturing staff morale and motivation. This is seen as part of the broader role taken by some individuals. Personal motivation is talked about as a constraint and mentioned in the section.

I have corporate and personal objectives. I see myself as responsible for the recruitment and welfare of the staff. I have an important role in maintaining the morale of the staff, particularly the junior staff (doctors). I rely on the directorate manager for her expertise in managing the nursing staff.

You need to keep everybody enthusiastic about achieving our goals. I am a player/manager I can demonstrate I am working hard in my clinical director role and my clinical role. You try to get, that hackneyed phrase, the culture right, but it can feel like trying to get your football team to play hard in the last half hour of the game when they are five nil down.

Survival

For some their energy is used in communicating to fight for the survival of the service. Survival is an instinct that causes anxiety amongst some individuals.

I can argue for the survival of a service without having the budgetary responsibility, although I do work with the manager to look at ways we can reduce the overspend in the overall budget.
One thing that causes me the most anxiety is the likelihood of my department going up in a puff of smoke, which is a probability.
Survival is critical keeping the service from being taken over by another trust.

Summary

The demands or the essential 'must do' parts of this element of the role are dominated by various forms of communication. Managing relationships, particularly with consultant colleagues is a key component of the role. Responses to this question challenge individuals to think about the essence of the role. From broad descriptions of an overview of the role to asking about the specifics of what must be done reveals little of the content of the communication, but some of the frustration of the role. A reactive or proactive approach is taken to communication which is concerned with maintaining morale and ultimately survival of the service. These demands are summarised in Table 4.1 below.

This description contrasts with the demands of the clinical role which are described later in the analysis.

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Some responses to the question 'What are the constraints in the role?' were predictable such as most individuals mentioned the main constraint as managing time. The strength of feeling about the lack of time is expressed in different ways. Some felt almost overwhelmed and just too busy to perform the role well. Others stressed how the management role encroached on their clinical and personal time. At one site where there was no formal responsibility for staff and budgets and time as a constraint is hardly mentioned. One lone voice at this site felt there was enough time and blamed his inefficiency for not having enough time.

Time/overload

This quote encapsulates the views of those who feel overwhelmed by the workload

There is no thinking time left now. We are too busy shovelling coal into the engine furnace to actually look out of the window and see where the train is going.

Time/little flexibility

These individuals provide a sense of frustration at not being able to fulfil the role due to other commitments. For many there is little flexibility in their clinical role. We see later how individuals in some specialties are able to be more flexible.

You often lose the impetus because you have to put things down and go and do other things. We could argue our case stronger if we had more time to put it together.

If I had the time to knock on a few more doors and lobby more then they might take us more seriously. I often think we are too reasonable.

It's time at the right time. You cannot just be free for meetings.

Time is a constraint, because sometimes you just cannot be available for a meeting.

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Here the encroachment of the management role pushes out other important and valued other roles.

It is a real struggle because I am not prepared to see either my clinical work slip or more time at home being eroded.

The biggest problem I find is separating the clinical side from the director side in terms of allocating time. I enjoy teaching and preparing for teaching, but I am loosing contact and giving up and I am not happy with that.
Well, obviously it's going to be time, your clinical commitments are not easily put aside.

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The unusual individual who thinks there is time to do the role.
I can do it. I have got the time to do it. I am not a very efficient person, a well organised efficient person could do it very easily.

The constraints relating to time were often expressed in with a real feeling and emotion and a sense of not being able to perform the dual role well.

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The constraints on the budget are ridiculous, there is always these ludicrous cost improvement targets.
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The lack of information and the difficulty of knowing what information was viewed as a constraint by a few individuals.
The lack of information holds me back. I never seem to have enough information, but I have a very good computer, sometimes I just don't ask it the right questions or I haven't thought to look at something in a particular way.

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At the site where the individual did not have formal budget responsibility views were expressed that the financial information was poor.

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This definition is about the drain on the individual's motivation.
The biggest constraint is, it's not money, it's not people, we could get more if we needed them, we don't particularly need them. The biggest constraint is my time and my emotional energy.

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This important part of the role is a subject that emerged, almost whatever the question. This code is defined in the context of the relationship with colleagues being a constraint in the role.

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In influencing colleagues you have to be very tactful. With 10 consultants, you have 10 different views about everything. So getting them all pulling together is difficult.

Trying to get them (colleagues) to see it your way is problematic. They are far more of a barrier to doing the job than the hospital administration, which in the main is very helpful.

You're up against personalities, although it's logical to do something in a particular way, because of little interpersonal struggles, they (colleagues) just dig their heels in.

For some (colleagues) they have got themselves into a situation where their job is comfortable, they like their routine, it works well for them and their family life, someone asks them to change and they don't want to do it, but we all have to work together.

It's their (colleagues) bloody mindedness, they don't like being told what to do, even if it is in the best interest of patients.

*I think the SLCs have different problems in bringing colleagues into line. It is difficult when it is outside your specialty. I suppose my difficult lot are the ********** and the ********** that need some sorting out. That's done in my office. It never gets to the executive.*

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We have had several changes of the manager who works with us, that has made it quite stressful.

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Summary

Constraints seem relatively easier for the CDs to define than demands. Table 4.2 below shows the constraints as the tangible ones of time, money and information. Along with these are the more intangible issues of their own personal motivation, of uncertainty over their performance, their ability to influence colleagues and their own personal stress levels. The frustration expressed over the amount and duration of

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The next area also posed challenges for them in thinking what choices they have in their role, for several they have never thought of the role in these terms.

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So much of the budget is already committed and the things we have choices in are relatively very small.

Technically we have a budget that's devolved to us, but there is a very strong hand from the finance department . . . and there isn't much to play with, the amount of costs that's fixed in various ways is virtually 100%.

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I am lucky, we don't have any internal grievances or conflicts between the consultants.

Consultants are leaders in their own right. They have a defined position that involves taking decisions which no-one else is going to question.

One respondent acknowledges the complexity of managing senior individualistic people who are acting within a complex system.

My colleagues are a cohort of people within the top echelons of the organisation who are all acting individually in their own right, perfectly rightly so, but wrapped around them is an organisation which is trying to make the whole thing work.

Another consultant expresses the challenge in a more graphic way.

It's like carrying around a sack load of ferrets or, as my father-in-law says a barrow load of monkeys. They are everywhere, they go behind your back and go off elsewhere. At the end of the day you know what budget you have got and you just have to manage.

Staff Motivation

Part of the meaning behind the communication role for some is that of nurturing staff morale and motivation. This is seen as part of the broader role taken by some individuals. Personal motivation is talked about as a constraint and mentioned in the section.

I have corporate and personal objectives. I see myself as responsible for the recruitment and welfare of the staff. I have an important role in maintaining the morale of the staff, particularly the junior staff (doctors). I rely on the directorate manager for her expertise in managing the nursing staff.

You need to keep everybody enthusiastic about achieving our goals. I am a player/manager I can demonstrate I am working hard in my clinical director role and my clinical role. You try to get, that hackneyed phrase, the culture right, but it can feel like trying to get your football team to play hard in the last half hour of the game when they are five nil down.

Survival

For some their energy is used in communicating to fight for the survival of the service. Survival is an instinct that causes anxiety amongst some individuals.

I can argue for the survival of a service without having the budgetary responsibility, although I do work with the manager to look at ways we can reduce the overspend in the overall budget.

One thing that causes me the most anxiety is the likelihood of my department going up in a puff of smoke, which is a probability.

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conscience for all the other work that is not being done. I don't need to look at that at all, I could go on the same way.
You have choice in how much time you spend doing the role and how you do it.

What is done (content)

There appears to be choice concerning what is actually is done in the role.
This attitude of sifting unwanted mail is not uncommon amongst the CDs. Perhaps this is one reason why the executive provides, and has good links with, the management support for CDs.
Some things I am sent I just bin, for example, the question 'where is my back up team for the millennium?'
There is a job description, but it's very broad. You can do it how you want really. I think we all do it differently, each of our areas have different issues really.
Perhaps reading the post is a demand in the role, but I exercise choice and bin a lot of it.

From status

Choice is viewed by some as emanating from their professional status. There was recognition that their view would not be challenged.
Because I am a clinician I have been able to say 'No' very effectively to my colleagues.
I think we have quite a few choices. It would be a sterile job if there were no choices, what would be the point of doing it. It's quite easy to bring in new clinical practices; generally surgeons are highly motivated and are always trying to change things for the better. Sometimes for their own betterment, sometimes for patients and sometimes for both.

Staff

Having the right to choose staff.
We have a choice with the staff we pick.
Several CDs do see selecting staff is an important choice in their role, although most are only involved in choosing medical staff. They delegated the role of choosing other staff.

Behaviour between colleagues/collegiate (apparent harmony)

We see here again the issue of relationships with colleagues which is quite complex and seen in different ways. It is a demand of the role; it is seen as constraint for several reasons and was also responded to as a choice in the role. The issues of not 'rocking the boat' with colleagues relates to the professional relationship between them and the effect of having a short term appointment and not wishing to upset those who might be a CD when their time expires. This may extend to the relationship between CDs as there to appears to be little fighting for more resources as most realise more for them is less for a colleague. This was particularly evident at one site.

The discussion is very even and fair and people aren't just going for their turf. They can see their bit of extra money is somebody else's loss. We all know each other well and I don't think most people are particularly selfish so they don't think along the lines of entirely I want more for my department and blow everybody else.

Certainly not all consultants have harmonious relationships and evidence of long standing difficult interpersonal relationships that have persisted for many years exist. However, this peaceful coexistence between CDs is attributed by several of them to their personalities and their understanding of each other.

Resignation

Individuals do refer to the ultimate choice of resignation being open to them.

Of course the biggest choice a CD has is to resign, because the clinical director is not their main employment, so you could always take the hump and resign if you get fed up with it and some people do.

Summary

The view is that there is choice in the role, in terms of, what the individuals (volume) and how much they do (content). This raises a paradox concerning why there is stress and frustration felt in the role if they have so much choice. They feel there is little flexibility in the budget, but are pleased to be able to choose their staff. Some feel volunteered for the role with little choice of refusal. There is recognition that their status gives them authority and yet some feel almost forced into the role. This looks like another paradox. In the demands and constraints of the role there are many concerns about relationships with their colleagues. Certainly there is a feeling they

cannot resolve difficult issues and antagonise colleagues particularly as their CD/SLC role is time limited. The example in this section is where there is an acknowledgement of their status and an ability to say 'no' in some circumstances mixed with an apparent collegiate harmony. The ultimate choice of resignation is valued. These features are summarised in Table 4.3 below.

Table 4.3 Choices in the CD/SLC Role

Choices	Description
Volunteered for role	Colleagues volunteer the person
Budget – little choice	The budget is handed down
How much is done	Free to choose the volume of work
What is done	Free to choose what is done
From status	Easy to choose, you can say 'no'
Staff	Important to choose your staff
Behaviour between colleagues	Perception of harmony between colleagues
Resignation	The ultimate choice as this is not their main employment

4.3.5 Summary of the Strategic Leadership (CD/SLC) Role

This research seeks an understanding of how individuals take up the role, the complexity of what lies behind how the role is taken up starts to emerge in this section. From this part of the analysis what findings can we draw from how the interviewees see their CD or SLC role? **An overview of the role reveals that across the population the role can be conceptualised as a broad hierarchy of a strategic perspective, a leadership role, a management role and a representative role.**

The demands of the role (Table 4.1 below) are seen as primarily concerned with communication, managing relationships with colleagues and maintaining staff morale and motivation. For some, there is a guardianship role to ensure the survival of the service.

Table 4.1 Demands in the CD/SLC Role

Demands	Description
Communication	
- meetings	Attendance with different expectations -opportunities and obligations Some sense of frustration
- reactive	Not seeking communication
- proactive	Walking about, listening, sensing what is essential
Relationships with colleagues	Critical (important) and often problematic
Staff Motivation	Maintaining morale and motivation
Survival	Fighting for the survival of the service

Constraints (Table 4.5 below) are the predictable tangible ones of time and money with recognition by some individuals that poor financial information is a constraint. There is a sense of frustration about the tangible constraints, but a more deeply felt frustration and concern over some of the intangible constraints. The role is said to drain the enthusiasm and emotional energy of some individuals, this has links with the most talked about constraint of relationships with consultant colleagues. Uncertainty over performance is a concern which is also expressed as stress and a lack of confidence in the role. Stress is described in a number of ways. Stress could even be behind the view that a constraint is working with other people.

Table 4.2 Constraints in the CD/SLC Role

Constraints	Description
Tangible	
Time	
- overload	Overwhelmed by workload
- little flexibility	Inability to resond
- encroachment	Pushes out other roles
- adequate	Blaming oneself, it is possible
Money	The almost inevitable constraint
Information	Financial information inadequate
Intangible	
Motivation – enthusiasm and emotional energy	Draining of these energies
Relationships with colleagues	Complex and challenging
- influencing	Need for tact, difficult personalities, bloody mindedness
- inability to act	Short term role – unwise to upset colleagues
- inability to sack individuals	Seen as different to the private sector
Uncertainty over performance	Difficult to know how well you are doing
Stress	
- time management	Separating the management role from the clinical role
- aggression	Aggression from others
- confidence	Lacking personal confidence in the role
- frustration	A deep level which induces stress
- key staff changes	Changes in manager who supports the role
Working with others	Lone voice wanting not to work with others

Choices (Table 4.6 below) are seen as limited by those who feel they are volunteered for the role. There is sense that the budget is committed with little flexibility. In other respects the dominant feeling is one of choice in the volume of work they do and what they do. Choosing staff is important to them. Once again the issue of working with colleagues is talked about. The view is that at one site in particular,

colleagues chose to work harmoniously with each other. The ultimate choice is resignation, as this role is not seen as their main employment.

Table 4.3 Choices in the CD/SLC Role

Choices	Description
Volunteered for role	Colleagues volunteer the person
Budget – little choice	The budget is handed down
How much is done	Free to choose the volume of work
What is done	Free to choose what is done
From status	Easy to choose, you can say 'no'
Staff	Important to choose your staff
Behaviour between colleagues	Perception of harmony between colleagues
Resignation	The ultimate choice as this is not their main employment

4.4 UNDERSTANDING THE PROFESSIONAL CLINICAL ROLE

4.4.1 Overview of the role

When asked to describe their clinical role in one or two sentences the CDs and SLCs either physically, dropped their shoulders, looked more relaxed and started to easily describe their role or they held back their shoulders and crisply and succinctly say 'I am the . . .' In both approaches to answering this question there is an ease and confidence about not only what they do, but who they are. The strength of this feeling is seen in the following responses.

Personal identity

The code relates to the centrality of the individual's own identity to the role. These comments are examples, but indicate the strength of feeling across the population.

I am a consultant histopathologist and I am one of a team of five

That's much easier to answer, I am a consultant anaesthetist so I have a specialist training.

I am a consultant urologist, I've been at this hospital for 20 years.

My clinical job is general medicine . . . as soon as the patients comes through the door, they are my responsibility.

My job description reads you will look after all patients with leukaemia and lymphoma that come through the door.

My clinical role as a radiologist is to problem solve first of all and then there are the specific areas I have specialised in.

As a consultant histopathologist my job is to examine samples sent to me by clinicians. I give them a report to give them information to make a diagnosis, help them with a prognosis and further management of the patient.

I am the specialist rheumatologist . . . I am not the big cheese, on a ward round there is me, occasionally an SHO and the nurse who knows the patients.

I am a consultant orthodontist it can be rather like the director role, it's providing a service to the patients and practitioners in the local area.

(laughter at the question) I take Xrays, scans and interpret them. I look at thousands throughout the year and come to a clinical decision about each one of them. It seems pretty obvious to me.

I give anaesthetics as required and cover emergencies. Not much more I can say really.
I am a general surgeon, with a special interest in breast surgery.
The clinical role involves managing all 50,000 patients that come to my department (Accident and Emergency).
Oh (hesitation) delivering a service to the ladies of our district (Obstetrician).
As an ENT consultant I provide a service to patients who are referred to me by GPs.
It's obviously obstetrics and gynaecology with a specific interest in reproductive medicine and fertility.
I am a consultant physician. I run the diabetes service.
I provide a diagnostic service to colleagues and GPs
In a way, well it's more difficult because you have been doing it for much longer. It's become a way of life, I come to work . . . we make people better you know (said with a wry smile).

On reflection these responses may not seem surprising. These are highly trained and experienced professionals. The striking difference, however, is thinking about the similarities and differences of these responses compared to those about the other part of their role. The clinical role is about them as an individual, 'I am trained, I am a specialist'. From the short quotes above in many cases it is clear what the role is about. Little further explanation is required. There is a confidence and perceived credibility which shines through the words as they are spoken. However, for some there is almost embarrassment at having to describe something they thought is so obvious.

The clinical roles actually differ in quite fundamental ways as seen later in the more detailed descriptions of the role. For example their role can be:
A direct service to the patient, referred by a general (medical) practitioner – an obstetrician.
A service to patients and general (dental) practitioners – an orthodontist.
A service to colleagues (internal customers) providing them with clinical information to help manage patients. – a pathologist.
A service to colleagues working with them (assisting them) –an anaesthetist.

Managing (processing) patients who often just turn up, without a referral – Accident and Emergency.

Many CDs see differences in how they and their colleagues manage the dual role. They also believe some of those differences are influenced by their specialty. These are considered separately in a later section of the analysis.

The overriding factor associated with the professional role is one of personal identity and clarity.

4.4.2 What are the Demands in the Role?

While there are differences expressed in the demands of the clinical roles there are meanings which translate across specialties and sites.

The demands are described as tasks, but with little actual mention of communication as a distinct role and relationships are not stated as an important and central part of the role. Why the task is being undertaken appears to be self evident and require little explanation in the clinical role. The demands shown below, are clearly about specific actions and 'doing things'.

What is done/Diagnose/treat/teach

Three areas of the clinical role, diagnose, treat, teach almost tripped off the tongue for many individuals. There is an ease with which the clarity of the role is explained.

I make sure the acute emergency illnesses are treated.

As a consultant you are obviously treating patients and you operate on them, so you diagnose and treat them yourself and you supervise other people doing it and you teach other people to do it.

What is done/specific tasks

This explanation demonstrates the simple and clear way individuals could be specific about what they do.

Histopathology has two major functions, we do post mortems for people who die in the hospital or in the county and we look at microscope sections from bits and pieces removed from people.

The clinicians know how the clinical aspects of the role are performed, through their long training, something others outside their specialist area would not know, but many would take the professional competence for granted. However, even a fairly wide audience would not need to ask 'why do you do that?' in response to the statements about the role. The 'why' things are done and broadly what is done is implicitly understood. The role is planned around a work schedule which can also be described clearly and brings a sense of order to how the role is performed.

Nature of the role/Planned work schedule

The role is explained easily through the schedule of work they perform. It is a planned and usually well mapped out pattern.

There are the obligatory operating sessions and an obligatory on call which requires ward rounds.

I have fixed sessions for clinics, operating sessions.

I do six outpatients clinics a week. I see patients on the wards, do quite a lot of teaching and some private work.

We do a one in four rota and the type of work we do is planned into the rota (this is part of a detailed explanation of the pathology department)

In making other observations about the role, responses could be divided into three broad categories. First, the demands of the role where they relate to direct patient contact and the clinician has the lead responsibility for the patient, second, those where the clinician has an input into the management of the patient, but not lead responsibility and third, those individuals who have both categories in their role. In all these categories their responsibilities are clear.

Direct patient contact/individual in control

The first category of individuals appears to have control over the planning of their role. They view the role and themselves as important.

We have a general sense of what we do during the week, operating lists and clinical sessions in specific areas.

I manage the outpatient and inpatient waiting lists.

I like the fact that it really matters what I do, it does matter, surgeons do matter, what we do is never trivial, it's at the core of being useful

Direct patient contact/not lead responsibility

Others performing part or all of their role in the second category feel less able to control their workload and can feel less valued.
The following comment is from a radiologist who has many groups of internal and external customers to serve in her clinical role.

You have a planned day and any number of things can destroy this as emergencies arise or colleagues want their priorities dealt with.

This clinician describes a role with demands for in-patient paediatrics, where perhaps an immediate response is needed and contrasts this with running a mammography clinic which is planned, but with people who are well or who have been recalled and therefore have different levels of anxiety. The latter example is where the role is under public scrutiny through a national screening programme.

We have a team who come and assess us as doctors we are not used to that, not used to having our work scrutinised and therefore you feel the pressure because it is open to debate.

Another consultant feels under pressure as the clinical role is changing and expectations are heightened.

Communication - focused

The explanations of the clinical role are easily understood descriptions of tasks, however, there must be lots of essential social interaction when the work is carried out. Communication is not described as a 'must do' in the role, possibly it is viewed as just a means to achieve what is actually done and not a function on its own, whereas and targeted.

Communication in the clinical role is often conducted in a language which those outside the profession would not understand. Consultants who have little patient

contact have less need to translate this exclusive language for others. Communication on clinical issues is usually focused and results oriented. Also, mentally processing information is usually fast, targeted and highly specialised. One example of this is what occurred during one my interviews. This illustrates the point and shines through as the dual role in action. A pathologist was interrupted by a telephone call asking him to look at a sample taken from a patient who was on the operating table. He agreed to this and the sample was brought to his office. He and a technician looked at the sample through the microscope and exchanged a few words. He then telephoned the surgeon and gave him his views on the sample. I only understood one or two words in this conversation. A three minute intervention, on a clearly important issue, dealt with in a fast apparently efficient manner in a professional language. The interview continued with the pathologist trying to articulate why communication was so important in his management role. This practical example threw into sharp contrast, some of the differences between the clinical role and the management role. This CD explained his approach to communication in the management role as:

I have an open door policy, well actually the door is always closed, but has a window in it. I am in here a lot and people know they can come and see me. I don't go out and ask people what they want or seek opinions. I don't have time to do that.

During the interview, I observed this style operating in his clinical role. People know where to find this person and they do. It is difficult to assess if this style actually works in the management role. However adopting the same style for both roles is attributed to the lack of time to communicate any other way. It appears to be a method that works for this individual.

Capability

Responses which link to capability and performance demonstrate individualism and competitive spirit. These views show a confidence and self-belief in their capability. However, one CD sees a weakness amongst his colleagues.

I am still the consultant that sees the most patients (and yet this person complains about his workload and inability to delegate). *I am quite efficient clinically, I can see patients quickly and sort them out when I get to them. I actually enjoy it and see the necessity of it.*

I think it (urology) is quite an academic specialty really, a lot of planning and thinking. So I think we are the more organised end of the surgical spectrum.

(Referring to experience outside the NHS) *I learned to listen. I think doctors by and large are very, very, bad listeners, they hear what you say, but that's not listening.*

You develop routines for every sort of eventuality. I rarely see things I have not experienced before.

Long training

They refer to an apprenticeship for the role with long training and long service going up the steps with approval at each stage. This is in stark contrast to their experience in the CD role where little or no training is undertaken.

You are pointed to the next hill based on interviews and people feeling you are ready for the next step, it is a long process.

Clinical changes

Many consultants seek greater specialisation in their clinical field. Therefore there is a tendency to have clearer and narrower definitions of their work. Changes in expectations and technology also put pressure, and possibly frustration, on particular roles.

(In histology) We get all the blame when things go wrong and none of the credit for getting it right. It sounds very bitter doesn't it? We now get a sea of tiny little specimens which really cause a lot of pain and mental anguish in the diagnosis and which you are expected to get right.

Summary

The demands of the clinical role contrast with the demands of the management role. The clinical role is seen as far more focused and clear. Communication is seen as central to the management role, but is rarely described as a demand in the clinical role. In the clinical role there is clarity about what is done and the planned nature of the role. Boundaries and responsibilities are clear and communication is focused and task based. Communication between professionals is in their own professional language. There is a confidence about their capability in the role that is probably linked to the long training period where approval is given at each stage of their development. Some individuals are, however, frustrated by changes in clinical practice. The features are summarised in Table 4.7 below.

Table 4.4 Demands in the Clinical Role

Demands	Description
What is done	Clarity of tasks
Nature of the work	Planned approach
Patient contact	Clear responsibilities
Communication	Focused
Capability	Confidence
Long training	Approval given
Clinical changes	Some frustration

4.4.3 What are the Constraints in the Role?

Constraints are expressed easily and simply by most of the CDs. In the clinical role there are still comments about time being a constraint with some mention of money and personnel. Time is a constraint primarily because of the increasing clinical workload and the number of management meetings. Evidence of these views is:

Time/overload

Work overload is defined here primarily as an issue of the volume of work.

One of the biggest difficulties is just the number of patients that are referred.

There is a lot of clinical creep.

Volume is the problem. It is like the fat lady in the corset. You devote time to pushing one bulge in and another pops out somewhere else.

It's time management. We don't book an efficient through the day timetable to allow us to do emergency work.

The volume per radiologist is becoming a bit unacceptable. It is a quality versus quantity issue. To keep the volume going through we feel the quality must go down, for the difficult cases you don't really have the time to consult the journals and the books as much as you ought, just because there is another heap sitting on the floor looking menacingly at you.

Time/conflict with management role

Here we confirm, feelings expressed earlier, of conflict as the management role encroaches on the clinical role.

One Tuesday morning every month is wiped out with a trust board meeting, there are lots of meetings which gets people up to speed, but often for a clinician does not achieve as much as one might like to see.

Time to do the CD role gets in the way. The thing that has really suffered is the time to do any reading so in terms of professional development that has gone out of the window.

Relationships with colleagues

The difficulty of working with or 'managing' colleagues, which is a big issue in the CD role, surfaces again as one consultant considers possible solutions to a long waiting list in his specialty. The following quote is from an individual who is the only consultant in his area of work at the Trust.

Relationships with colleagues/Desire for autonomy

One of the nice things about working in this unit is it works as a very happy family. I want to be happy, I only have one life and I am going to be here in the Trust for 20 years. I see so many of my colleagues who are not single handed and there seems to be so much fighting and trauma between them. They are not happy to share the pie. I prefer to bring in other people to help me, that leaves me a free reign to do what I want.

This search for harmony on his terms reflects his wish for autonomy and the happy family is clearly one where he wishes to remain as the head. The fact that he will

remain in the organisation for a long period of time makes him cautious and reluctant to relinquish any control.

Relationships with colleagues/Poor relationships

Another consultant admits to problems with a colleague which have been difficult for many years. This means the atmosphere is very stilted when they are together, a number of attempts to resolve this problem have failed.

With several individuals there was a clear sense that conflict was avoided. Individuals worked for many years in the same hospital and community and did not want conflict. This was strongly expressed by some in their management role where the appointment is for a limited period.

Clinical changes/Patterns of care

A further honest view comes from a CD who admits that for him his enthusiasm for the job is tested at times. Changes in general medicine drew him to conclude.

My enthusiasm is there for endoscopy, it is a practical skill that you might think is tedious, but I enjoy doing it. However, the enthusiasm for general medicine is not rock bottom, but pretty low. 90% of it is little old ladies and little old men who come off their feet in their 80s, so if you go the ward there is not much to teach as they have all been in for some time, they are all old and crumbly. Anyone who is younger with some interesting disease can often be dealt with as an outpatient.

This view is a different perspective on the challenge of changing clinical patterns of care expressed by another individual in the last section.

Clinical changes/Clinical governance

The introduction of clinical governance is seen as a constraint on clinical practice. The individual quoted below believes this initiative will stultify innovation. Perhaps there is also an element of control being reduced.

Clinical Governance has been coming in slowly for a long time, it is putting constraints on the way we do things, so there will be no scope for shortcuts, things will have to be done in a certain way. It is probably good for patient safety, but in

terms of innovation for which British medicine is renowned for, I think it is going to have a stultifying effect on that.

Internal Inefficiencies

Constraints are also experienced through a lack of efficiency in the system. This interviewee has views similar to a number of other CDs and blames the system. He refers to the cultural blockages and believes the private sector experience would be different.

There are in-built inefficiencies that will never change in the operating theatres. It is a capacity issue and a cultural thing as well. If you could double everyone's salary you would get more work done, but people have been under pressure to produce more and more and there comes a backlash. I am actually working too hard and I don't wish to do more, because it is quite unlike industry where you work hard and generally you get promotion or you get share options, there is a strong financial incentive in industry, there is no such thing in the health service.

External interference

Clinicians are not exempt from having the way they plan their workload changed by government. The effects of some changes can be felt very quickly as this example demonstrates.

We (pathologists) decide as a team how we organise the workload, working with the laboratory and reporting to meet clinic sessions when patients are to be seen. You can see the workload as a river which is flowing smoothly, then someone (central government) *puts a boulder in it that says all breast reports must be done in two days and that just causes a lot of turbulence because everything else has to be pushed out of the way.*

It is admitted by the CD that these interruptions are quite rare and therefore when left undisturbed they can be highly efficient. Another consultant stated that he believes the government's priorities and management fads come and go all the time.

Few frustrations

Pathologists have some flexibility in planning their workload and they saw few constraints in performing the clinical role. The sentiment that frustrations were less in the clinical role than in the management role were shared by many individuals.

It is helpful to be here when the laboratory staff are in, but in general I can come in and do my work any hour of the day or night. Of course some results are required urgently but these can be dealt with. The only frustrations are when you can't make a diagnosis. It still does not compare to the frustrations of management, that's why I'd rather do this than manage.

Summary

The constraints seen in the clinical role, as summarised in Table 5 are different to those in the management role. There is still some distinction between the tangible and intangible constraints. A confidence in the clinical role reduced the comments about stress and other frustrations strongly expressed in the management role. Time is the obvious constraint, but was mentioned less often than in the management role. Reference to time was usually about the volume of clinical work and the management role getting in the way of the clinical role. Relationships with colleagues is still an issue. The advantages of being the only consultant in your speciality are well recognised. Where relationships break down they can be difficult to repair. Clinical changes in the patterns of care affected the individual's enthusiasm in the role. This was similar to the example of frustration in the previous section. Clinical governance is seen as a constraint on clinical role. Internal inefficiencies arising from cultural differences and external interference by government are seen as constraints in the clinical role. There was the view shared by others that frustrations were much fewer in the clinical role than in the management role.

Table 4.5 Constraints in the Clinical Role

Constraints	Description
Time - overload - conflict with management role	Volume of clinical work, pressure of management role
Relationships with colleagues - desire for autonomy - poor relationships	Conflict avoidance Living with poor relationships
Clinical changes - patterns of care - clinical governance	Waning enthusiasm; reducing innovation Losing control
Internal inefficiencies	Cultural internal blockages
External interference	External influences changing priorities
Frustrations	Exist, but fewer than in the management role

4.4.4 What Choices are Available in the Role?

Choices are expressed in several ways. The choice about how they undertake their clinical practice, the choice about what patients they see and the choice about how they organise their work. Generally the clinicians feel they have choices in many areas of their work, but some feel they have never thought of them as actual choices before.

Choice/autonomy

The following examples of choices show the autonomy clinicians have in their role.

I choose what operations I do in a session

I choose how much time I give to a patient

Over the years I have had a lot of choice, nobody stooped me extending the scope of the department

We make different choices about how we tackle our clinical work . . . healthcare is almost on a one to one basis. I don't know how my colleagues talk to patients or discuss things with them, I only know how I do it.

What I do is based on past experience, clinical knowledge and observing patients . . . making choices about turnover (of in-patients) *is the most important thing. It is always about risk management, but it is always about individual choice as no one can define what is a reasonable risk.*
I have a very wide choice I can treat what I like I am very lucky in that respect and that's a heck of a privilege to have and I am very aware of that and not to abuse it. I make decisions about who goes on the waiting list, but I know if people don't like that they will complain and I haven't had any complaints in five years, so obviously up to now the decision process has been reasonable.

Two CDs enjoy the challenge of the management role to the extent that they would like to give up the clinical role, but this choice is seen as not available to them for financial reasons. One would like to concentrate on his specialist interest in information systems and the other person prefers the management role to his professional role where changes in clinical practice have made it less attractive for him.

This autonomy puts consultants in a very powerful position, some recognise this as a privilege, but use the rather crude measure of complaints as a method of assessing of customer satisfaction.

While acknowledging the constraints mentioned in the previous section the range of choices and autonomy in the clinical role were strongly felt and expressed. The choices in Table 4.6 are clearly expressed.

Table 4.6 Choices in the Clinical Role

Choices	Description
Autonomy	
- how much is done	Free to choose the volume of work
- what is done	Free to choose what is done
- how the work is done	Experience allows this choice

4.4.5 Summary of the Professional Clinical Role

An overview of the professional clinical role shows that it is dominated by **the role as associated with personal identity and clarity.**

The demands in the role (Table 4.10 below) are described with clarity. It is predominantly a planned role where there are clear responsibilities. The communication is focused and when it is between colleagues, is in their own professional language. There is a confidence in their capability in the role. A long training, often referred to as an apprenticeship goes through many stages with approval to move on given at each stage.

Table 4.4 Demands in the Clinical Role

Demands	Description
What is done	Clarity of tasks
Nature of the work	Planned approach
Patient contact	Clear responsibilities
Communication	Focused
Capability	Confidence
Long training	Approval given
Clinical changes	Some frustration

The constraints in the role (Table 4.5 below) include the predictable one of time and conflict with the management role. There is a search for harmonious relationships with colleagues. Understanding the problems that can arise some strive to preserve their "happiness" by working as the only consultant in their specialty. Others live with poor relationships with colleagues over a long period. Clinical changes are also seen as a constraint by some, with a waning of enthusiasm over some aspects of the role. The interesting cases are often only seen as outpatients, with the less interesting ones filling the general medical beds. Clinical governance is seen as possibly having a stultifying effect on innovation. There is some frustration expressed over internal cultural inefficiencies, once again there is a perception that the private sector would be different and provide more inducements to reduce inefficiency. External government interference in the form of changing priorities and management fads are

also seen as constraints. Although frustrations existed they are perceived as less than those in the management role.

Table 4.5 Constraints in the Clinical Role

Constraints	Description
Time - overload - conflict with management role	Volume of clinical work, pressure of management role
Relationships with colleagues - desire for autonomy - poor relationships	Conflict avoidance Living with poor relationships
Clinical changes - patterns of care - clinical governance	Waning enthusiasm; reducing innovation Losing control
Internal inefficiencies	Cultural internal blockages
External interference	External influences changing priorities
Frustrations	Exist, but fewer than in the management role

The overriding choices (Table 4.6) were related to autonomy in the role. Freedom was expressed in how much work they did, what they did, and how they did it. These views are strongly felt and strongly expressed.

Table 4.6 Choices in the Clinical Role

Choices	Description
Autonomy - how much is done - what is done - how the work is done	Free to choose the volume of work Free to choose what is done Experience allows this choice

4.5 COMPARING THE DESCRIPTIONS OF THE TWO ELEMENTS OF THE DUAL ROLE

4.5.1 Demands of the Two Elements of the Dual Role

The demands in the CD/SLC role and clinical role are shown in Table 4.7 below. The CD/SLC role is dominated by communication and maintaining relationships. Communication in a myriad of meetings is sometimes the cause of frustration. Different styles of communication are discussed. There is also a sense of responsibility of fighting for the survival of the service. In contrast, the clinical role is described as one of clarity, where work is primarily planned and scheduled. Whether role demands direct patient contact or not there are clear responsibilities. Communication is focused on tasks directly associated with the role. In response to this question there was a need to talk about their capability and long training in the clinical role, something not mentioned as a demand in the CD/SLC role.

Table 4.7 Demands of the CD/SLC Role and the Clinical Role

Demands of the CD/SLC Role	Demands of the Clinical Role
Communication – dominant theme - meetings - reactive - proactive	What is done – clarity of tasks
Relationships with colleagues – critical, can be problematic	Nature of the work – planned approach
Staff Motivation – maintaining morale and motivation	Patient contact – clear responsibilities
Survival – of the service	Communication – focused
	Capability – confidence
	Long training approval given
	Clinical changes – some frustration

4.5.2 Constraints of the Two Elements of the Dual Role

The constraints in the CD/SLC role and clinical role are shown in Table 4.14 below. The CD/SLC role and the clinical role share time as a constraint each role getting in the way of the other. There is a reluctance to let go of direct clinical work and therefore the CD/SLC role is seen to encroach on other roles like teaching and home

and family. The clinical role has its frustrations and relationships with colleagues are still an issue for some individuals, but the issues with colleagues in clinical role did not compare to the concerns in the CD/SLC role. Stress is mentioned frequently in the relation to the management role and very rarely mentioned in the clinical role.

Table 4.8 Constraints of the CD/SLC Role and the Clinical Role

Constraints of the CD/SLC Role	**Constraints of the Clinical Role**
Time - overload - little flexibility - encroachment, pushes out other roles - adequate	Time - overload - conflict with management role
Money	Relationships with colleagues - desire for autonomy - poor relationships
Information – poor financial in formation	Clinical changes - changes in patterns of care - clinical governance – losing control
Motivation – enthusiasm and emotional energy is drained	Internal inefficiencies – cultural blockages
Relationships with colleagues - influencing, need for tact, difficult personalities - inability to act, short term role - inability to sack individuals	External interference from government and management fads
Uncertainty over performance	Frustrations, but fewer than management role
Stress - time management - aggression – from others - confidence - lacking - frustration – deep sense - key staff changes	
Working with others	

4.5.3 Choices in the Two Elements of the Dual Role

The choices in the CD/SLC and clinical role and shown in Table 4.15 below. In the CD/SLC role and in the clinical role it is seen there is choice in what is done and how much is done. In the CD/SLC role this appeared to be driven primarily by time constraints and the attractiveness of parts of the role. In contrast, the choices in the clinical role are shown as linked to autonomy in the role. These choices appear to relate to professional decisions about the service they provide. Other choices are all related to the CD/SLC role and have been discussed earlier.

Table 4.9 Choices of the CD/SLC Role and the Clinical Role

Choices in the CD/SLC Role	Choice in the Clinical Role
Volunteered for role	Autonomy - how much is done - what is done - how the work is done
Budget – little choice	
How much is done	
What is done	
From status	
Staff – choosing staff	
Behaviour between colleagues, choosing harmony	
Resignation	

Summary of the Dual Role

The use of the 'demands, constraints, choices' framework for the first interview with each individual achieved the desired outcome of gaining an understanding of how the clinical and CD/SLC elements of the dual role are perceived and understood.

Extracting this section of the analysis to a high level, the detail is lost, but it is possible to discern in broad terms, as shown in Table 4.10, what the clinical and CD/SLC elements of the dual role mean to individuals. The clinical role with its clear boundaries, taken up as a life long career with confidence from long training, contrasts with the other element of the role which is not well defined, where

communication and managing relationships dominate within the context of a short term contract.

Table 4.10 Summary of the Dual Role

CD/SLC Role	Clinical Role
The role is not well defined	Part of individual's personal identity
Vague understanding of the content of the role	Clarity of role content
Concerned with communication and maintaining relationships	Clear responsibilities
Few clear boundaries	Highly specialist and communication is focused
Confidence levels differ	Confident in their capabilities in the role
Little or no training	Approved to perform the role through long training
Short term	Long term

Further detail from this set of interviews is drawn on in later analysis. This approach to understanding how the role is taken up is built on in the next section.

4.5 THE INTERVIEW FRAMEWORK FOR UNDERSTANDING EXPECTATIONS IN THE DUAL ROLE

As explained in the chapter 3, the meaning of how the dual role is taken up is explored through gaining an understanding of how the individual perceives what is expected of them in the strategic leadership and the professional role. Again the questions asked are open questions, with the same questions being asked about both parts of the elements of the dual role.

The questions are:

- Who has an expectation of you in the role?
- What is that expectation?
- How do you know that is the expectation?

The analysis is shown first as it relates to the strategic leadership role and then to the professional role.

4.6 EXPECTATIONS IN THE STRATEGIC LEADERSHIP ROLE

The breadth of the network that individuals considered when asked these questions varied across the sites. Most individuals think of expectations associated with individuals or groups, e.g. the Chief Executive or consultant colleagues. One CD immediately jumped to an army analogy and said:

Expectations/reading the message

This code refers to how the individual understand what is communicated to him.

There are two sides to this one, it is what the troops expect their officer to do and what the generals expect people on the ground to do. The advantage for me is I have been in the department a long time and I understand the personalities. I know what people are saying to me and what they are really saying to me, the two are often not the same.

Expectations/networking

This ability to 'read' people appears to be seen as a real skill when understanding expectations. In general terms the CDs are not in the habit of trying to understand the expectations of others in a direct way. They rely on a 'no news is good news' philosophy or just made assumptions about others expectations.

A CD sought out and valued personal contact with others *I find it is important to keep going to talk to management. I chat to a variety of people you can always say "Look I am going to do this, what do you think?" I suppose if I am being immodest I am quite good at networking.*

Expectations/general/passive approach

The reactive wait and see approach.

I would hope that if there was something I should be doing as CD someone would tell me.

I think I am doing the role well. I have heard nothing to the contrary.

Expectations/not considered

Actually seeking feedback does not appear to be an idea that had occurred to nearly all interviewees until it is mentioned. The examples below are representative of many responses.

What people expect of me. That's a good question, I have never thought of asking that. As I have now been in post a year that would be a good question to ask.

I am not sure what the expectations are from the management side, I really haven't thought about that and I can't give you an answer on it.

4.6.1 The Chief Executive

The Chief Executive was an obvious choice of someone who has an expectation of the CDs and SLCs. Everyone mentions him (all three were men), but the nature of the expectation often seemed quite difficult to explain. The Chief Executive is sometimes not mentioned as an individual but subsumed with the executives and referred to as 'management'. When used this label appeared to indicate that the CD does not see himself as part of 'management'.

Expectations/Chief Executive

Expectations/Chief Executive/Muddling through

Uncertain about the expectations of the Chief Executive.

He (CE) *gave me a job description when he asked me to do the job, but it is so vague and woolly that it doesn't really mean much. I think he expects me to keep the directorate on the straight and narrow and to keep within budget, which is quite impossible.*

The Chief Executive interviewed me for the job, it was more of a social chit chat really. I suppose he has an image of what the job is. If I get a pat on the back I know I am doing OK and if I don't get told off I know I am not doing anything wrong.

There is a job description somewhere, but it doesn't help much.

Expectations/Chief Executive/pragmatism

Yet another CD pragmatically sums up management's expectations as:

They would want us to essentially deliver health care and to give them an easy life.

The 'easy life', although not expressed in such explicit terms, is shown by other comments concerning their role in maintaining good relationships with the consultants.

The Chief Executive and General Manager will expect me to provide a medical opinion and the keep the lads (consultant colleagues) *in line.*

At one site an appraisal system called Joint Review and Development, is in the process of being developed and the SLCs are having some difficulty in thinking how this could be objective. Deciding what is actually expected of them in this role and how it can be measured is proving very difficult.

Expectations/Chief Executive/Feedback/Passive

While another was less sure what is required and reverts to the 'no news is good news' approach.

*I don't get the impression *** (CE) wants to get rid of me . . . so I assume he feels I am doing a reasonable job.*

Expectations/Chief Executive/Clarity

One verbal response recalled by the CD from the CE was clear, this was to act as a communication channel and be efficient by staying within budget.

To run the care group efficiently, stay within budget, act as a liaison between the trust and the care group and to feed ideas and policies between the two.

Expectations/Chief Executive/Clarity/felt challenged

One response from the only woman in the sample is expressed in more emotional terms and focused on behaviour rather than tasks.

. . . I suspect I'll never live up to his standards (the CE), *he has got such high expectations of himself (the CE) and everyone else. When he took me aside and said would I be the CD, what he wanted was someone who was honest, who knew the way the hospital was going, who would plan honestly, wouldn't be self centred in their particular field and push that to the detriment of other areas of the hospital, and I hope, I truly hope that's what I've done because that's what I would have wanted to do anyway.*

Expectations/Chief Executive/Feedback/review mechanism /continuous process

At another site CDs talked about objective setting and six monthly reviews. These are described as one way of understanding expectations.

At the beginning of each year you agree objectives which are continuously looked at and you sit down with management again at six monthly intervals and review what you have done and what you will do.

Expectations/Chief Executive/Feedback/review mechanism /continuous process/positive

At the same site the review process is credited by several CDs as being well managed.

The Chief executive and his colleagues have an expectation that the clinical director and the directorate general manager will between them do their best to ensure that the directorate meets certain objectives. The review also gives you an opportunity of setting personal objectives. Activity levels are set with us at the time of contract and budget setting.

Expectations/Chief Executive/Feedback/review mechanism /continuous process/negative

The above views were not expressed in a positive manner by all as can be seen from the quote below.

*Well, I think the most important thing is that they (management) expect you to take responsibility for the department without providing you with the wherewithal to provide a safe service. You are expected to take more and more responsibility for more and more shoddy practice, not on behalf of clinicians, but shoddy provisions for providing a safe service, we are cutting corners in **********.*

Expectations/Chief Executive/Feedback/review mechanism Continuous process/cynical

At one site quarterly reviews are held by the CE with the CDs. These are to monitor performance, one CD mentions these as a way of understanding expectations, but he refers to the process with some cynicism.

After the review we were sent a list of things we had agreed to do. One was to cut the workload to meet our cloth. We cannot do that, if blood is taken from a patient you

cannot refuse to analyse it. So I tipexed (white fluid used to paint over words) *that one out, signed it and sent it back. I thought that was quite good* (said with a feeling of triumph). *I don't know if anyone will notice until the next review.*

Expectations/Chief Executive/Feedback/only negative

At one site there is a feeling that the only feedback CDs receives is if things are not going well.

The only feedback you have is being called to a meeting if you are overspent. You don't really get told if you are doing well or badly. Although we did get rid of one CD who was doing badly. Still it is not the most desired job!

Expectations/Chief Executive/fear

A view is expressed that one CE is seen by a number of his managers as fairly brutal with some individuals being frightened of him. This individual said the CDs are privileged and protected because, as evidenced in the first set of interviews, they could leave the CD role and return to being a full time consultant.

Expectations/Chief Executive/token involvement

There is another view which cast doubt on the real value management places on the role.

I am not sure what I do sometimes. I do feel as if we are being wheeled out there, to be in meetings, to make sure that you are seen to be having shared responsibility for the decisions across the Trust, then to be moved back into the cupboard again afterwards to get on with it. They can then say "you were there when the decision was made" "Was I, oh right". I probably have a reputation for being cynical, but I really do think there is an element of that.

4.6.2 CD and SLC Colleagues

CD and SLC colleagues were not seen as having many expectations of each other.

Expectations/CDs and SLCs/survival

They (CDs) *expect me to be loyal to the Trust, not to give anything away in negotiations with other Trusts. I wouldn't sell off something or trade off one thing against another whereby someone might lose their job or security as a result.*

Expectations/CD and SLCs/mutual support

Although not articulated amongst themselves, there is an expectation at one site only that the SLCs are there to support each other. The four of them met regularly and one SLC feel this support helped him cope with the isolation he sometimes feels in the role.

4.6.3 Consultants

Consultants wherever they work in the Trust were always referred to as colleagues. As said before, this term, with a rare exception, is reserved for them alone, everyone else was referred to by their job title or role in the trust.

This group is quickly recognised as having expectations of them. These are generally expressed as wanting the CDs to solve their problems, to obtain things for them, protect their domain. Comments are mainly about the consultants in their own directorate. The views ranged from:

Expectations/colleagues/no problems

I haven't had any problems with my colleagues

To:

Expectations/colleagues/troublesome

The most troublesome people who have expectations of me are my consultant colleagues.

Expectations/colleagues/mismatch

One CD enters into the role believing his colleagues want him to protect their interests, but he wants to do more than that.

I didn't go into the role with the intention of creating dissent and problems, but I wanted to change things for the better and they felt what I did was not always in their best interests.

Expectations/colleagues/communication

Clearly the relationship with colleagues is an important relationship for the CDs and SLCs. Communicating with consultants is a challenge which is taken up and seen in different ways.

A recognition of the importance of communication.

Understanding their expectations is quite difficult as they probably all want something different, but being communicated with is probably central to what they want.

A direct comment on how one individual invites feedback

I think it is important to ask your colleagues " Well, what do you think I should do here?" Or "Do you think I was over the top when I did that?"

Expectations/colleagues/communication/conduit to management

Providing the link between consultants and management is one clear expectation seen by many CDs and SLCs.

Many of my colleagues see me as their route to management. They expect me to ensure their voice is heard.

They expect me to be the link between them and management, just to see what is going on and what is actually happening.

They would expect me to give them information from the executive and make their views known to them.

Expectations/colleagues/communication/individual's views

Being a communication channel is not all that was behind everyone's views, it is often about getting their views listened to.

They want me to know that their view is important and I can safely ignore everyone else's.

Expectations/colleagues/communication/non-listeners

A hint of frustration below as an individual recognises the difficulties in managing colleagues.

Some colleagues are not good communicators, they play things very close to their chest and although you have been saying something for ages when you actually do something they say "Well, that's all wrong, why did you do it that way?"

Expectations/colleagues/mediator

A role for a few CDs is seen as that of a mediator.

They expect me to make sure they are all talking to each other. They tend to fall out with each other easily as you would imagine (laughs). *They are very explicit in what they want. They say 'you could stop those two bickering' or 'perhaps you could go and talk to so and so about so and so'. Sometimes I ignore them, sometimes I go and do as I am asked, sometimes I tell them to go and get on with it themselves.*

Expectations/colleagues/using caution

Cautious approaches to understanding expectations can reveal underlying tensions.

Asking colleagues what they expect from me would be pretty risky, wouldn't it. Of course we meet fairly regularly and we can discuss problems, we do talk and discuss perhaps a bit superficially because of personality clashes.

Expectations/colleagues/not asking

This quotation takes 'no news is good news' approach a little further than earlier comments and perhaps hints of an autonomous approach.

I haven't detected any groundswell of grumblings, they are presumably happy with what I am doing, so I haven't felt inclined to either justify what I do or ask their views. That's really a rather negative way of putting it but that's how it works.

Expectations/Consultants/using past experience

One CD develops her own expectations by reflecting on what she wanted from the previous CD, she uses this as an indicator of what others might want from her.

4.6.4 The General Manager Working with CDs and SLCs

At two of the three sites this individual is accountable to the CD, but there is a close relationship between this individual and other senior managers including the executive. This is particularly evident at one of these sites where the executive has close contact with the general managers. At one site the SLC works closely with a manager, but he or she is not accountable to the SLC. Usually these managers have a clinical background, most are nurses. This is a critical relationship as much of the operational work is undertaken by the general manager.

Expectation/General Manager/support/pride

One CD speaks with pride about his general manager.

His business plans are held up as the gold standard for the Trust. They are the benchmark for others.

Expectation/General Manager/support/protection

One CD at site A expresses a motherly feel for her nurse manger, wanting to protect her. This is a very important relationship for the one woman CD.

The relationship between CDs and the general managers is often seen as one of problem sharing and problem solving. Expectations are said to be understood through the CD and general managers meeting each other regularly. However, this understanding is mostly based on assumptions.

Expectations/General Manager/freedom

General managers are usually seen as having a lot of scope.

I think I am there to support her, but I don't actually know. We chatter over what is going on, but I leave the detail up to her. I support her when there are problems with colleagues.

I'm the Chairman, she is the Chief Exec. She runs things past me. She has a fairly long lead which is good. We have worked together for some time and are pretty comfortable with each other. We don't shake the world we evolve it.

With delegation there has to be trust between me and the general manager.

Expectation/General Manager/regular contact

For the SLCs there is little clarity or overt discussion about expectations, but several things seemed important to the SLCs.

We are in constant touch a few times a day on voice mail.

I am in regular contact with the manager for our services. We sort out problems together. However, I feel a responsibility for the decisions we make, but I have no real authority for budgetary decisions.

4.6.5 Nurses

At all sites the relationships with nurses is not strong. Some CDs have little contact with the nurses in their directorate, problems are handled through the general manager, others mention seeing them and keeping in contact through their clinical role. Some say the contact is only present if there is a dispute. It is all very reactive and they have no real idea what nurse's want from the CD or SLC role.

`Expectations/Nurses/Being proactive`

One CD stands out as unusual. He says I ask the junior nurses for their views.
What do you think about your clinical director, what do you think I should be doing. They are all briefed on the role, they need to know why I am not on the shop floor all of the time. I have got other things to do. Managing the department and managing the money. This CD was proud of his relationship with the nurses. *I know all their names and call them by their first name. We crack jokes and that doesn't normally happen between a consultant and a nurse.*

`Relationship/Nurses/Power distance`

The distance that usually exists between nurses and the CDs is acknowledged by several CDs as this comment demonstrates.
Nurses don't come to me with their problems, even the senior ones. Well one does, but she is pretty high powered really.

4.6.6 Clerical and Other Professional Staff

Other groups of staff are rarely mentioned. Clerical staff are referred to as 'other' or lay staff. There is little direct communication with these staff and no understanding what they expected even through other managers.

Some speak in general terms of providing leadership to all staff, but there is no indication that this is ever tested as being what the staff want or that their expectations are met. Others speak of staff not really knowing what the CD role is about, they believe staff would just think it is *some vague administrative role.*

One SLC speaks of his responsibility for all the PAMs (Professions Allied to Medicine), but again at this site there is little clarity what the role or responsibility actually meant.

Expectations/other staff/reactive approach

I don't seek them out to understand their expectations, but they know they can always come and see me.

4.6.7 Chairman and Trust Board

At site one the main expectation of the Chairman and the Trust Board is seen as keeping within the budget. A non-executive director is linked with each directorate at this site, but only one CD mentions this and he feels the non-executive director only wants to be warned of problems that might come up at the board meeting. This is not seen as a particularly helpful relationship.

At another site the Chairman and Board do not feature as having an expectation of the CDs.

One SLC at the third site mentions the Board as having some expectation of him as the Board and the Chief Executive have appointed him. He muses about watching them when he presents something to the Board and imagines they are thinking the following: *Is that person performing appropriately, are they doing things appropriately?*

4.6.8 The Health Authority

The Health Authority is not held in high regard by the CDs or the CE at one site. There is a shared perception that their function of purchasing health care is performed very badly. The Health Authority might use some CDs as a sounding board for testing out ideas, but usually the CDs have little positive contact with them. At the other sites the Health Authority is not mentioned as having an expectation of the CDs or SLCs.

4.6.9 Patients

Most participants did not mention the patient as having an expectation of them in the CD role. They believed they are probably not aware such a person existed unless they meet them through the patient making a complaint.

4.6.10 External Relationships

There is little concept of expectations from external sources. Regional Office (part of central government) meetings and conferences are occasions for sharing information, but some CDs do recognise that in the dual role they are representing the trust. One CD struggles to think of an external relationship and mentioned giving lectures in the local community as part of fulfilling expectations.

One SLC talks about the expectations of GPs (General Medical Practitioners). He believed what they expected and valued *was being able to talk clinician to clinician at a senior level. To talk to a clinician who can make decisions is very important to them.*

4.6.11 Themselves

One CD stated that she has an expectation of herself. It is the first thing she thought of when asked 'who has an expectation of you in the CD role'. Her response is given with a strength and conviction that this is the obvious and almost only answer to the question.

`Expectations/oneself/standards`

Well primarily I have an expectation and wouldn't have taken it on unless I could do it properly, so as ever you try and do it to the best of your ability, so I have to fulfil what I think are my criteria for doing it.

All other CDs even when repeatedly asked if there is anyone else who has an expectation of them never mentioned themselves. This is the only woman in the study, not that any conclusion can be drawn from this.

4.6.12 Summary

Developing an understanding of the CD and SLC roles through this area of questioning, reveals views of how individuals take up the role and the meaning they place on understanding expectations. This adds further meanings to perceptions already obtained at the first round of interviews. References to sites are made where the views cluster around a site and raises questions which might be useful for further research.

The perception of expectations are summarised in Table 4.11 below. These could be expected to relate to the breadth of the general management responsibilities, being broader at two sites than the third. The views are varied and some relationship can be seen with the earlier analysis. The most dominant groups who are perceived as having an expectation of the CD or SLC are the Chief Executive, management in general and consultant colleagues.

In most cases expectations are based on assumptions and intuition. There is little knowledge that has been obtained overtly about expectations others had of them in the role.

Given that the role is described as being concerned with managing relationships and that communication is central to the role it is interesting that some individuals have never even wondered what others expectations might be. Others are quite astute in responding to different personalities and place a value on networking to find out other peoples views on specific issues.

Expectations are often managed on a 'no news is good news basis'. The quotations show there are formal review systems which look at the financial situation and other activity targets with the CDs. However, the CDs have a range of views about the effectiveness of these reviews. When the data was initially reviewed by site it could be seen that the style of the CE at one site has mixed reviews, whereas the CE and management at another site is generally held in high regard particularly for a well managed process. But still there is one voice who saw the process as highly managed and constraining, but by his own admission he is a cynical person. There is little

appraisal on a one to one basis which is meaningful and helps to clarify what the expectations are in the role.

Job descriptions exist, but offer little in help in really defining what has to be done and the actual expectations of the CDs and SLCs.

Expectations of CD and SLC colleagues featured little as the CDs has limited contact with their colleagues in this role. There seems little bond between them which might set up an explicit expectation. They usually only meet as a group with other managers and one to one meetings are usually to discuss particular problems or issues. The SLCs meet on their own as a group, this is felt to be a supportive forum for discussion.

The relationship with consultant colleagues is clearly an important one which required sensitivity and an understanding of the impact their behaviour in the CD or SLC role would have on their colleagues. CDs believe their colleagues have expectations that they would help solve problems amongst the consultants and be a link to management. This is made quite clear by the actions of some who bring interpersonal problems with colleagues to the CD.

The expectations of the manager who worked closest with them is very important to them. They rely heavily on their support and regular communication is clearly an expectation on the part of the CDs and SLCs. The assumption that the managers expect this too is one of the clearest felt expectations. The CDs at one site feel a responsibility for their manager and to a lesser extent this is also true at another site. The SLCs at the third site appeared to have a problem solving approach with the manager, but it is not felt the shared ownership of the problem is so strong at this site.

Expectations of other staff and external relationships are little understood as the contact with these groups is minimal and the CD and SLCs are less able to make a judgement.

Table 4.11 Summary of the Approaches to Managing Expectations in the Strategic Leadership (CD/SLC) Role

Expectation of:	Approaches/Expectations	Comments
Overview	Intuitively reading the message A passive approach No thought given to others expectations	Ranges from the politically astute, to wait and see, to an unawareness of this as an issue
Chief Executive	Muddling through Being pragmatic No news is good news Linking to role clarity Using the review process Experiences - Positive - Negative - Cynical - Fear - Token involvement	Generally reactive approaches. Mixed perceptions.
CDs and SLCs	Protect their survival Mutual support	Support group operates
Consultants	Problem solver	Some cannot match colleagues expectations
	Communicating Being a communication channel Listening to the individual's view Being a mediator Using caution and not asking Using your own experience	Some consultants will not communicate Some want the CD/SLC to get them what they want Some have problems some do not
General Manager	Having regular contact Giving support Giving freedom	Expressions of pride and support
Nurses	Little contact Close contact, proactive approach Appreciation of power distance	Managed through general manager

Clerical and other professional staff	Little or no understanding	
Chairman an Trust Board	Little understanding	Keeping in budget is an expectation. Feeling of being observed at meetings
Health Authority	Not held in high regard Not mentioned	
Patients	Probably unaware of the role	May meet about a complaint
External relationships	Little contact	
Themselves	Fulfilling her own criteria	One CD spoke of having expectations of themselves

4.7 EXPECTATIONS IN THE PROFESSIONAL ROLE

The following general comment concerning expectations in the professional role represents many of the views expressed in this area of questioning.

Understanding expectations/self evident

Immediately there is a clarity and self evident understanding of the clinical role.

I think the clinical role is more clear cut, it's much less nebulous, I think because there is no argument about the expectations that people have. There's not really any considerable debate. We couldn't debate whether you were or whether you were not going to give the best clinical care to the patient.

4.7.1 The Chief Executive

The view expressed by most CDs is that the CE expected them in their clinical role to deal competently with patients. They feel the main measurement is through the complaints made either by patients or GPs. This view is expressed very clearly by one CD.

Expectations/ Chief Executive/competent/work hard

The management haven't got a clue what our job is about. They expect us to do lots of work, to get through lots of patients, not to cancel anyone, to do any extra they ask us to, not to whinge, but they don't understand our job at all!

*They expect you to be competent, but they wouldn't know a competent ************ from an incompetent ************.*

4.7.2 Other Consultants

There is a distinction here between consultants who were in the same area of work and those who provide a service to each other. In providing a service to other consultants the views expect a clinical competence and that patients are treated well:

Expectations/consultants/clinically competent

What they want is their patients looked after to the highest standard possible, and they want to know what's going on.

They expect you to be good at your job, they expect you to be polite and courteous to their patients.

Surgeons want you to be quick and not cancel patients (view of an anaesthetist).

They expect the report on their patient to be correct. However, we all make a mistake occasionally and therefore what they also expect is that they can pick up the phone and query a result.

Another consultant assumes he meets his colleagues expectations as they will have made judgements about his work. These are still concerned with clinical competence. He believes clinical expectations are different to those in the management role.

Presumably they have made value judgements of me over the years of "This chap's results seem to make sense, they are sensible reports on the examinations that he does and he seems to be OK at his job" They probably wouldn't care how the results landed on their desks as long as they get them. So the expectations clinically are quite different.

There is an expectation that your colleagues will not get called to your patients post operatively. If they do them you are probably not looking after them properly.

Expectations/consultants/results oriented

This consultant makes the point that in his CD role *he has to lead his department, maintain motivation and morale and get the work done without reducing people to tears.* In his clinical role *the consultants to whom he provides a service are not worried about tears amongst the staff they just want the results.* The link between staff who are not distressed and the quality of the results are not explored.

Expectations/consultants/building positive relationships

Location of the department and the climate in the trust are seen as important for one CD in promoting an understanding of expectations.

There is a good working relationship and friendship amongst the clinicians. People have to walk past us to get everywhere, so we get rather more interaction than if we were stuck down a corridor somewhere. We get positive and negative feedback from clinicians as they walk through the department. We get on sufficiently well for them to say "you got that one wrong" This happens occasionally, it is not done in meetings where you are seen to be scoring points. It doesn't have the scoring points off colleagues mentality that you have in teaching hospitals.

In this example the relationship is seen to thrive on creating open positive relationships

As part of a team in a laboratory your colleagues expect you will do your bit and get on with the work and finish at a reasonable time. We all get on well and participate in the quality of the work we put out. We are open with each other and discuss cases and ask each others advice. We are not a particularly macho bunch so there is no problem doing that. We must get back to the system we used when we were less busy where we randomly chose forms from each others work and took the slides away to look at. We need to give each other that type of feedback. It is where teams break down that mistakes are made and not picked up.

Expectations/consultants/improved relationships

The history of meeting expectations has not always been so well managed. This pathologist talks about poor relationships in the past.

"Damn pathologists never give you what you need." We were always accused of sitting on the fence, because surgeons don't want maybe, they always want yes or no. To say whether that's mist or rain is not good enough. I think a lot of it is education and working as a team, being based in the same place is helpful we know them all face to face . You know their personalities and how to talk to them. Doing work for people you don't know would be much more difficult. The surgeons now understand our problems. We all work hard at understanding what we need and what is going to happen to the patient at every stage of the treatment.

Expectations/consultants/learn together

Consultants come together to learn across specialties and have expectations of each other in trying find solutions.

I've actually just come from a meeting where we have been chewing over some interesting or problem patients with both the Xray doctor, the pathologist, the surgeon and myself (CD for medicine).

4.7.3 Junior Doctors

Junior doctors featured rarely in response to understanding who had expectations of consultants. These responses acknowledge the training role they have in relation to junior doctors.

Expectations/Junior doctors/Training and support

Juniors expect you to be pleasant to them, to help them out when they have problems and to make an effort to teach them and to be understanding that they need some time to study.

My basic duty is to train them and make them good doctors.

4.7.4 Nurse Managers and Nurses

There are no comments about nurse managers and few about nurses.

Expectations/Nurses/unsure

You don't get much feedback from nurses, so I am not sure what they expect.

I don't know what nurses expect from consultants. I'm not sure I've even thought about it.

I think they want to work in a unit that is providing a high quality of care.

Expectations/Nurses/Availability/Advice

They expect you to be available for patients when they need medical input. They need advice on how they are going to look after that patient.

You chit chat after a ward round or something similar. The nurse will tell the number one chap (the interviewee) *if there is a problem. There isn't much conflict.*

Expectations/Nurses/Leadership

This lone voice actually articulated that he felt the nursing staff looked to him for leadership when acting in a clinical role

I think the nursing staff will look to me for leadership and patient management.

Expectations/Nurses/valued

One individual has a great sense of working with his team and he felt they expected him to set a good example for his colleagues. He is very interested in the idea of expectations as he, like many others, has never asked people what their expectations of him are. He has views of what he felt he ought to do and needs to do. This is to make his team pleased to work with him

The most positive feedback I got from my role was from the nurses in the evening. "Oh, thank God it's you on this week". I always felt relaxed when I was with them and I was trusted, I thought it very important that I never let them down.

4.7.5 Patients

All the CDs and SLCs mention patients as having an expectation of them even if they rarely saw a patient. These are typical responses which express a close one to one relationship.

Expectations/Patients/cared for competently

Well, I will always start with the patient. The patient really does have an expectation and justly so, that you will look after them to the best of your ability, that you will be competently trained and keep your skills up to date and you will guide them safely through whatever medical care they need.

Patients, they are the ones I do it all for. Half I see only once and the other half I see until they die, and hopefully that's 10 years, but all too often it's not.

I think patients expect me to do the best for them and the staff expect me to as well. I think they expect me to be flexible in my working arrangements so I can sort out problems. I think patients are almost part of the family once we take them on.

Expectations/Patients/information and advice

Views are expressed about the level of information individual's want

We have to make sure we give patients a clear and full understanding of their condition, the options for treatment and the risks involved. Many still don't want to know all the detail and look to me for advice.

In my clinical role the first and foremost expectation comes from the patient. They look to me for a diagnosis, an explanation of the problem and ultimately a solution if there is one.

In the quotation below a consultant explains the whole range of choices his patients can make in his specialty of obstetrics and gynaecology. He feels his role is very much to give the information and recommend, if asked, but that it is for the patient to make the decision.

I actually do sometimes ask "What exactly are you wanting to get out of this discussion? What is it you are wanting me to do?" This happens in such a direct way if the consultation is going around in circles.

4.7.6 Themselves

Once again, the one woman in the sample gives the same immediate response concerning the expectation she has of herself.

`Expectation/Oneself`

Well again my own professional expectation of my standards, and keeping up to date in the areas of my specialisation.

No other person mentions having an expectation of themselves in the clinical role.

4.7.7 Summary

Most consultants say that expectations are easier to articulate in their clinical role. For most the expectations, which are summarised in Table 4.12, are still based on assumptions, but there is a confidence that they are right. This view probably comes from having a history and past experience where after performing the role for many years they would have expected feedback if they are not doing the role well and meeting expectations. However, it is acknowledged that consultants who perform a direct service to the patient probably still get very little feedback on their performance in meeting expectations. One consultant said he does ask patients what their expectations are, but this was said in the context of him getting rather frustrated in a consultation than a genuine attempt to get feedback. Those who provide a service to their colleagues do get some feedback, but the content of this depends on the relationship between the individuals.

The clinical role is described as 'consulting' giving an expert opinion. The clear and focused nature of this role usually brings clarity to the expectation of each task, if not of the entire role. Because of this focus, there is little debate about what has to be done. There is a 'what to do' professional aspect related to the task and a 'how to do it' relationship part which has to be managed but is less tangible.

In the clinical role one expectation of the CE and the executive is a professional competence, but consultants accept this is difficult for managers to assess. Consultants believe the reality is they are expected to deliver on targets and increasingly do more work.

Consultant colleagues have different expectations of each other depending on their working relationship. Where they rely on each other's expertise to manage a patient they appeared to collaborate well. There is a sense of learning together which was explained with some pride. Only one problem with relationships is described which mean communication is superficial.

There is quite an uncertainty concerning the expectation of nursing staff although the sense of hierarchy comes through in the responses with consultants being in the dominant role.

Not surprisingly patients are at the centre of who had an expectation of the consultants. Mainly this expectation was understood through years of experience. Several speak of relationships with individual patients whom they have treated for years. A distinction could be drawn in how expectations are understood between those who perhaps never see a patient, those who see patients for a very short time and those who see patients with a chronic or terminal illness over a long period. There is the expert role in all these situations, some provided an answer which sometimes means a cure, others provide *"the sticking plaster"* which alleviates the symptoms. Some consultants offer a whole range of options for patients who have a real choice to make. In this situation it can still be quite difficult for consultants to understand what the patient expects and occasionally a direct question about expectations is asked.

The one woman in the sample remained unique and gave her first response as meeting her own expectations in relation to standards.

Table 4.12 Summary of the Approaches to Managing Expectations in the Professional Clinical Role

Expectation of:	Approaches/Expectations	Comments
Overview	Clear cut, no debate	Probably linked to clarity and confidence in the role
Chief Executive	Measured through complaints	Little real clue about clinicians competence
Other consultants	To be clinically competent To achieve results Building positive relationships and improving relationships Learning together	 Little concern for staff Uncommon in the management role
Junior doctors	To help them and teach them	
Nurse Managers and Nurses	Unsure what they expect Leadership and patient advice and management	Said to be little conflict Pleased to feel valued by nurses
Patients	Cared for competently Information and advice	Expectations are mainly, but not exclusively based on assumptions
Themselves	Own professional standards.	The same person as in the previous section viewed expectations as those of herself.

4.8 COMPARING EXPECTATIONS OF THE TWO ELEMENTS OF THE DUAL ROLE

Posing the questions around the area of what expectations do others have of you, reinforced some of the comparisons from the descriptions of the dual role. Summaries earlier report details the two elements of the role. In Table 4.13 the comparison shows the virtual consensus that expectations are understood for the clinical role, but often based on assumptions. The range of individuals or groups that spring to mind are quite limited for the clinical role compared to the CD/SLC role, although several individuals had little understanding what the expectation would be. The relationship with the Chief Executive is quite distant in the clinical role. In contrast, a range of responses are seen for the CD/SLC role. Expectations from consultants look similar in that they are perceived as wanting a supportive and positive relationship. However, we already know from descriptions of the role this can be a difficult relationship in the CD/SLC role. Meeting expectations when there is a conflict between personal and organisational objectives is seen later to cause some of the problems. The General Manager who is so important in the CD/SLC role is not mentioned in the clinical role.

Table 4.13 Summary of Approaches to Managing Expectations in Both Elements of the Dual Role

Expectation of:	Approaches/Expectations in the CD/SLC Role	Approaches/Expectations in the Clinical Role
Overview	Intuitively reading the message A passive approach No thought given to others expectations	Clear cut, no debate
Chief Executive	Muddling through Being pragmatic No news is good news Linking to role clarity Using the review process Experiences - Positive - Negative - Cynical - Fear - Token involvement	Little clue Measured through complaints
CDs and SLCs	Protect their survival Mutual support	Not mentioned
Consultants	Problem solver Communicator Being a communication channel Listening to the individual's view Being a mediator Using caution and not asking about expectations Using your own experience	To be clinically competent To achieve results Building positive relationships and improving relationships Learning together
Junior doctors	Not mentioned	To help them and teach them
General Manager	Having regular contact Giving support Giving freedom	Not mentioned

Nurse Managers and Nurses	Little contact Close contact, proactive approach Appreciation of power distance	Unsure what they expect Leadership and patient management and advice Own professional standards.
Clerical and other professional staff	Little or no understanding	Not mentioned
Chairman an Trust Board	Little understanding	Not mentioned
Health Authority	Not held in high regard Not mentioned	Not mentioned
Patients	Probably unaware of the role	Cared for competently Information and advice
External relationships	Little contact	Not mentioned
Themselves	Fulfilling her own criteria	Own professional standards

4.9 DIFFERENCES BETWEEN THE STRATEGIC LEADERSHIP (CD/SLC) AND THE PROFESSIONAL CLINICAL ROLE

Differences in the strategic leadership role, which is often quoted as the management role, and the professional clinical role are seen in earlier parts of the analysis using the two frameworks which offered some structure to the interviews. These earlier differences are drawn from the data when individuals are asked to describe each element of the role separately. Many of the differences in this are responses from asking this question directly to the interviewees. Most of these reinforce the findings from earlier in the analysis. It is noted where a new finding has come from asking a direct question about differences. Thinking about differences and similarities between the two elements of the role has not been considered before by many of the CDs and SLCs. Many find considering these questions an interesting challenge.

The differences are summarised as follows:

`Type of role` - Primary/secondary role

Some just thought the two elements of the role were completely different. Being held responsible for your directorate was seen to differ from the individual responsibility in the clinical role.

Just a completely different role!

It is a completely different job and secondary to my role as an orthopaedic surgeon. My clinical role will always come first.

`Area of responsibility` - broad/narrow

In earlier analysis it became clear that many viewed the breadth of the management role as bringing uncertainty to the role. The boundaries of their professional role is narrow by comparison.

You have to take responsibility for what goes on in your directorate, that's more difficult, in that I cannot be held responsible for a wrong diagnosis a colleague makes, that is down to the individual.

`Primary function` - Managing relationships/undertaking tasks

This difference is seen as fundamental and shines through in many of the examples evidenced in the differences between the demands of the management role and the professional role see section 4.3.2, and section 4.4.2. The emphasis placed on managing relationships placed through various forms of communication contrasts with the description of what is done and the nature of the role in the professional role.

Expectations - clear/unclear

The expectations are clear in the clinical role and not in the management role. This is shown in earlier evidence and a further example shown here.

In the diagnostic work the expectation is clear, the SLC role is far less well defined Power relationships are different in the two parts of the role.

In the clinical role I am the expert, patients come to me for advice, so it's a relationship where by and large I am the dominant factor. I don't think that is ideal, it's too much out of balance. Whereas the managerial role, is much more worked on a basis of equals. We are broadly on the same intellectual level and their views (other managers) *about a particular subject are as valid as mine.*

Mindset - Management/medical

This CD clearly demonstrates his view that different mindsets are required for the two elements of the dual role. He relates his recent experience in studying for a law degree. He believes he became able to think in management mode by learning the principles of management, through lectures and talking to people and working on examples.

*After a few days you begin to think like that (*in the management role*), but within 24 hours of getting back into clinical mode it would fade away. It was a different way of thinking about things. It was a different perspective. I think as a manager your bottom line is one of efficiency, effectiveness and meeting the budget. Your bottom line as a doctor is actually helping the patient. The Chief Executive would approach it differently, that is not to say I do not have respect for his position, I do, but my primary direction is the patient.*

I think you need two different mindsets, people with these different mindsets, need to recognise them and work together to develop trust. I mean trust with a big T. I think by and large we come pretty close to that here.

This CD shows that respect by referring to senior managers as colleagues, a term reserved by most CDs for their consultant colleagues only.

Switching between roles is thought to be difficult and has links to having different mindset.

I think there is a great discrepancy between the problems that you are asked to deal with in the CD and clinical role. They range from the huge strategic picture, such as the hospital being under threat to very minor clinical event which is never the less important to the individual. Seeing both these as equally important and switching between the roles is difficult. You have to change the way you think and the way you behave.

Focus - Groups/individuals

The clinical role is seen as with the individual and the focus of the strategic leadership role more with groups.

I see my patients, no one else really knows how I do much of my clinical role. It is often a one to one situation.

Much of the management time is spent in meetings discussing finance.

I see myself as an advocate for the patient which is where I have to bring discussions at the board back to.

This links to the corporate role of the CD. Often there is a lack of interest in areas outside their own individual interest.

Yes, the CD role is a corporate one, but I am not really interested in other peoples areas, especially the non-clinical things.

Capability - Long training/on the job learning

There is a capability and confidence in the clinical role which does not exist in the managerial role. This may, in part, be due to the different nature of the roles, but this is often attributed to the long training in the clinical role with comparatively little formal training in the management role.

In the clinical situation I have the knowledge and ability to answer direct questions. In the management situation everything is not so firm, you don't necessarily feel on solid ground.

You are pointed to the next hill based on interviews and people feeling you are ready for the next step, it is a long process.

This individual recognises the difference in the levels of training, but does appears to believe management ability is innate.

The big difference is in my clinical role I have had a long training and to be a manager I have had none! I certainly do not feel as confident in the management role, but you are not always confident in the microscope work because sometimes you do see something you have not seen before. But I have a simplistic view that management is about two things, common sense and being able to get along with people. Some people are born managers and don't have training and can just do it, others have MBAs and can't do it for toffee.

Delegation - Essential/not available

The issue of delegation is also a difference between the roles. This individual acknowledges there are other people he can delegate work to in his management role, but has the strong conviction this is not available to him in the clinical role.

I am a good delegator in the clinical director role simply because I am one of other good people that do things better than me. But I am medically hubristic enough to know perfectly that there is nobody who does the medical things better than me. I am not good at handing things over.

Communication role - Peer/manager – Group/Expert - Individual

The different nature of communication is recognised by individuals.

As a consultant most of my communication is with a colleague or nurse or patient. Communication is usually being 'consulted' for my opinion. In my CD role I am talking to individuals, but more often in meetings or talking with several people

Influence - Cajoling, persuading/the expert view

Related to problem solving and understanding how to implement issues. This is an example of the different approach that has to be taken

Problem solving in relation to a diagnosis is organising investigations and considering possibilities and taking it from there. You have the knowledge. With the SLC role there is a lot of cajoling people along, persuading people, that sort of thing. It is very different from that point of view.

Some of the management role is just talking to people, cajoling them and making them do things.

Problem solving - Rational, logical/disordered

The management problems are seen as more complex by some. Problem solving is recognised as a different process in the two elements of the dual role. This relates to the clinical role being seen as one which is more of a logical and rational process than the management role. In the management role it is often others who will deliver the solution rather than the clinician as an individual. The problem might well be outside their particular area of expertise and interest.

The problems are trickier. Take the colposcopy service. You gets lots of blurb sent down that lands on your desk and you have to try and address the standards and make sure you deliver a service to those standards. That's much more difficult than doing 10 terminations.

A different perspective is expressed by one individual. He believes that the way he works in his specialty makes the contrast with his managerial role different to that of many of his colleagues

As a manger I may look at a situation and say "Well, actually I want to get there at the end of the day". Whereas in the doctor patient relationship situation it's a question of giving information, answering questions and discussing options with the patient and giving them your advice. You may feel they should be doing one thing, but they have a choice in the matter and may decide to go a slightly different route. In a management situation I think you can be a lot more directional than in the patient situation.

This individual's specialty is obstetrics and gynaecology where he believes there are a number of different approaches to the same problem. He also believes the old paternalistic approach of *"there, there my dear, that's what I think is best for you"* is changing, quite rightly in his opinion, and people don't accept that approach anymore. He is a 'young' SLC. This SLC, although relatively 'young', had the advantage of being welcomed by colleagues as they are pleased to have ousted the previous person in the post.

Decision making - Autonomy/consensus

Power is linked to autonomy in the clinical role and this results in different decision making processes.

The big difference, without any doubt, is as a clinician you are the boss you are the ultimate arbiter and decide what goes on. Whereas, the managerial activities are very much about discussion, consensus and decisions. In this respect the two roles are markedly different, which I think is why some of my colleagues find it difficult to do management. They find it difficult to be in a situation where they can't just say "we couldn't do this and that's the end if it!"

I have to get all my colleagues to agree before I can implement a change in the management arrangements.

Results/outputs - easy to see/not always clear

Results are easy to see in the clinical role, but not in the management role. There is also a frustration in how the time is utilised.

In the clinical role, you make a diagnosis, then there's action and bang it's sorted. Whereas in management you sit there at a meeting for 6 hours and look back think what did I do today? And the answer is sometimes precious little!

Corporacy - Expected/little requirement

Intellectually many CDs see the role as a corporate one, but recognise the temptation not to be corporate.

The more you see the whole picture the better you can do any job. You can't come to being a clinical director thinking the only thing that matters is your little specialism.

A comment below from a CD who is positive about his insight into corporate issues.

Being a clinical director has given me far more insight into the corporate realities and I think, dare I say this, some of my clinical colleagues are not being objective, they are not living in the real world. I think we work together in great empathy here. I have great respect for my colleagues in management.

Clinicians are not used to challenging their professional colleagues. Where relationships are good they might question an Xray result or a pathology report on a one to one basis as evidenced in this study. Challenging or questioning each other

about their area of responsibility in the CD role is less likely. This could be seen as avoiding a corporate approach.

We do make decisions about priorities and agree to these at meetings, but they are based on evidence, or perhaps government priorities. It is relatively easy to go along with those decisions. We never really challenge each other about our area of work when looking for efficiencies.

Learning and review - Unique situations/ability to replicate

This is a new insight from asking a direct question about differences between the roles. The following quotations are insights into how different it is to consider performance in both elements of the role. The individuals describe the opportunity that exists in some clinical situations to revisit and reconsider decisions with little or no change to the factors affecting the decision. However, there is seen to be a transient uniqueness to the management role where managing relationships are critical to performance.

In the CD role you will go to a meeting and present something. If you want to discuss whether you handled the situation well all you can do is try and describe it. With a piece of glass (a slide in pathology) *you could say "Take that away and look at it". You can go back a month later and do the same thing. Whereas to say to somebody "How would you have behaved under those circumstances?"*(in the management role) *is a bit tricky because all the various factors relating to that moment in time are never going to happen again. You don't know how heated the discussion was or what the other stresses were, so you can't really do it.*

Another individual makes a similar point.

When you are dealing with a patient the parameters are largely fixed i.e. you look down a throat, see a bad tonsil or something suspicious, you can look at this a week later and probably little has changed. Whereas, management is something that is interdependent on lots of other people and it's a fluid situation. There's lots more discussion and evaluation of the problems that take place, because there are more variables involved. Things change from week to week. You are in a human interaction situation all the time, I think it is quite different. One situation is never quite the same as the other.

4.9.1 Summary

Like many responses in this study there is a divergence of views. The view is expressed that the management role and the professional role are totally different roles, but the opposite view is also expressed as indicated in the next section.

Asking the direct question concerning differences between the roles confirms and adds to the understanding obtained by using the demands, constraints and choices framework and the understanding of expectations. Also, it is seen as a benefit of the research design that the direct question is asked in a separate interview. This enables me to obtain one set of differences from my own analysis and confirm and add differences in the perceptions of the interviewees.

There is a uniqueness in the management situation with all the variables that go with human interaction, that makes the role difficult to explain and evaluate. Views are expressed that the clinical role is somehow more discrete, you could evaluate or reconsider your work, e.g. samples could be looked at again and nothing would have changed, sometimes clinical conditions change little over the short term and can be revisited. You can recreate a situation in the clinical role in the way you cannot in the management role. This is not an isolated observation and seemed a subtle and yet important point that has not been picked up in any previous area of questioning. It points to the struggle CDs and SLCs have in understanding their performance in the management role. This is not helped as there is little formal appraisal and consultants are not practised in asking for feedback on their performance.

The role of being the expert in the clinical role impacts on there being different power relationships in the clinical and management roles. This links to autonomy in decision making in the clinical role with the clinician being the boss and final arbiter, whereas this is not the case in the management role where there is much more discussion and need for consensus. The type of problems and problem solving are also viewed as a different process with clinical problems being solved through a task focus, with investigations and professional expertise. To solve problems in the management role there is an emphasis on managing the relationships, this is seen as a clear difference when the 'demands/constraints/choices' framework of questioning is used.

Arriving at the position of the expert has emanated from a long period of training which contrasts with little or no training for these individuals in the management role. What training would be appropriate for the management role is a difficult issue for them especially when some CDs feel the role is just common sense and getting on with people.

The view of the management role does vary depending on the specialty. One view is that there is more opportunity in the management role to be proactive and achieve what you think is right than in the clinical role where the patient has many choices.

The nature of the clinical role, being action oriented with outputs and results is less frustrating than the seemingly endless discussions in management meetings.

Some individuals do see both roles as similar and meshed together as seen in the next section. Others view switching between the roles as a real challenge. This appears to be adjusting to the different nature of the work and responding with appropriate behaviours for each role. There is also something more fundamental expressed with the view that you needed a different way of seeing each role, a different mindset is needed for each role. This is about behaving differently and thinking differently. There appears to be a different logic behind the behaviour in each role.

The differences are summarised below in Table 4.14.

Table 4.14 Differences Between the Strategic Leadership (CD/SLC) Role and the Professional Clinical Role

No.	Focus	CD/SLC Role	Clinical Role
1	Type of role	Secondary	Primary
2	Area of responsibility	Broad	Narrow
3	Primary function	Managing Relationships	Undertaking tasks
4	Expectations	Unclear	Clear
5	Mindset	Management	Medical
6	Focus	Groups	Individuals
7	Capability	On the job learning	Training/experience
8	Delegation	Essential	Not available
9	Communication role	Peer/manager - Group	Expert - Individual
10	Influence	Cajoling, persuading	Respect – expert view
11	Problem solving	Disordered	Rational, logical
12	Decision making	Consensus	Autonomous
13	Results/Outputs	Not always clear	Easy to see
14	Corporacy	Expected	Little requirement
15	Learning and review	Unique situations	Able to replicate

4.10 SIMILARITIES BETWEEN THE STRATEGIC LEADERSHIP (CD/SLC) AND THE PROFESSIONAL CLINICAL ROLE

The following description summarises the individual's views of the similarities in the two elements of the role.

One role

Here is a diametrically opposed view to a colleague in the previous section who saw the roles as totally separate.

I really think they merge into one. I don't really separate them out. People remind me I am the clinical director when we are talking about an expensive drug.

One role/contrasting view

This is in contrast to views of a SLC, in the same specialty obstetrics and gynaecology, who sees the management role as a leadership role, but does not think of the clinical role in the same way. His reasons for this are concerned with recent changes.

In the past there was a pyramid structure, you had your team of people working with you. Now, with the reduction in hours and numbers of junior doctors, the new shift system etc. I don't see the same people everyday, you lose the feeling of being in a leadership role. A lot of the time you are working almost in isolation. It's a lot more fragmented than it used to be.

Leadership/presence

One CD in the study mentions leadership as being a similarity in both roles. This is seen as working hard and making his presence felt.

Similarities. Well, yes certainly leadership. I simply need to walk the part, be seen. Keeping up morale, I see that as quite a large part of my role. I respect people, I need to be around, not skive off too much. Turn up and do your bit, get stuck in – I work hard.

Listening/acting

Listening and knowing when to act on what you hear is seen to be a skill in both roles.

Listening to your colleagues moans or your patients moans, not writing them down, but knowing, that is all you need to do. The role where you appear to have the time to listen to people and you don't. This is a skill you develop which is useful in both roles. You manage patients as a physician and manage people in the CD role. You make judgements about when you need to act quickly, with experience you know this instinctively. You triage in both roles.

Consulting/Directing

'Consulting' and 'directing' are two styles which are seen as similar in both roles.

In the CD role I am consulted and asked for views on issues and in my professional role I am consulted. I am the consultant. I can see similarities in that respect.

The roles are similar in that I am providing advice and I am being consulted in both roles.

In the clinical director role I will tell people what the problem is and which is the right way to do it. In the medical role I am better at following things up and doing and managing things myself, but I am not a good manager I am not interested in the business management things. I am quite good at directing and telling somebody what needs to be done. I am not good at doing it. I am the sort of consulting type.

Delegation

Delegation is seen as a similarity by some and a difference by others. The following view demonstrates delegation exists in both roles, but how and why there is delegation differs.

Delegation happens in both roles, there are things I cannot delegate in both roles. I try and delegate as much as possible, but with patients it's safety. You can't delegate because of safety. With the clinical director role you have to do things because you hold that role, you might not do something as well as someone else, but you have to be there because you are the CD.

Intuition

Being good in both parts of the a role is not about reading a book.

I think there is quite a lot of similarity between the two in that all of medicine is written down in a textbook. But reading a textbook doesn't make you a good doctor or a good manager, there is lots of intuition that is used.

Accountability/loyalty

One CD stood out from others in the sample and saw accountability and loyalty as important similarities in both parts of the role.

I think we should be accountable both in terms of the way we spend the National Health Service money and the professionalism we bring to the service. I think we should see that we are getting the best possible value we can for patients.

We have a loyalty to the patient first, a loyalty to the Trust and a loyalty the NHS as a whole. I think those loyalties should be there for all clinicians and clinical directors.

Targets

The process of meeting targets seems similar to a CD in one specialty.

In orthodontics you have plan with a desired outcome what you have to achieve within a treatment time. With the clinical director role it's very target oriented with timescales to achieve objectives. So I see similarities in that sense, it fits very well with orthodontics which is very much a target oriented planned series of events.

Emotion

Emotion is a similarity which is seen to exist in both roles, but different things give rise to the emotion.

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Both roles are capable of causing emotion. There are some things in both that cause highs in me and some things that cause lows. A high in the clinical role would be the diagnosis made that leads to an intervention, particularly if no one else had made the diagnosis, particularly if someone eminent had missed it, than that's an extremely good day. A high in the management role is when something you have been angling for happens, you get agreement to do something.

4.10.1 Summary

Similarities between the strategic leadership and the professional elements of the dual role are far less common than the differences (see Table 4.15 below). Again there is a divergence of views from those expressed earlier where the roles are seen as totally separate. In this section an example shows that some see the elements of the dual role as similar and merging into one. Leadership and being present as a role model

working hard are seen in both roles. The skill of listening and the judgement of knowing when to act is seen as something that you learn from experience and use in both roles.

Consulting and directing are seen as styles which are applicable in both roles. Delegation is a way of working which exists to a much greater extent in the management role. The reasons for delegating are different in the two roles. In the last section we learned of the use of intuitive skills to understand expectations. This is seen as a requirement in both roles.

Loyalty and accountability are qualities which just one individual felt were similar and important in both roles. Targets are present in both roles and one of the hard measurements set locally and nationally. Finally we learned earlier of individuals seeing the level of their emotional energy as an issue in the management role. Here examples of emotion are given for experiences in both roles.

Table 4.15 Similarities Between the Strategic Leadership Role (CD/SLC) and the Professional Clinical Role

Similarities Between the Two Elements of the Dual Role

- The dual role is merged into one.
- Leadership and a presence is required. You have to be there for both roles.
- Listening and knowing when to act are skills for both roles.
- Consulting and directing are styles used in both.
- Delegation can occur in both roles, but for different reasons.
- Intuition is required for both roles.
- Accountability and loyalty.
- There are targets to be met.
- Emotion is stimulated by successes in both roles.

4.11 CONFLICT BETWEEN THE ROLES

Time is the obvious and predictable conflict which practically everyone mentions. There are several ways in which the performance of one element of the role interferes with the performance of the other. This is seen in many of the responses quoted earlier to the question concerning constraints in the management role.

Person role conflict/Work overload → Conflict

There is not enough time to do the management role and therefore all the time it is interfering with the clinical role.

Work overload → Conflict/Consequences of overload /Behavioural change

The lack of time and role overload has implications for performance. Individuals become stressed and their behaviour is affected. Similar issues were seen as a constraint in the role.

Maybe I am not doing as well as I ought to, because of the lack of time I know I get tetchy and am not as friendly as I could be. Patients expect you to be always smiling and delivering the goods. They sometimes seem like birds in the nest with their mouths open waiting to be fed.

The next example is an individual who has tried to tried to solve some long term problems and describes in some detail in his interview the conflict he feels between work and his family.

I am under stress the whole time, my wife says I have changed since I started this role, not for the better at home. I think there are two ways of approaching the role, either you do things as they crop up and do the minimum and stamp your feet, or you can look forward a little bit and try to foresee things and plan a little.

Work overload →Conflict/Consequences of overload /Professional development

Professional development takes a back seat.

It is now so difficult to find reading time, so professional development has more of less gone out of the window.

Person role conflict/Strategic versus operational

There is the conflict which is similar to one often identified by managers who move from an operational role to a strategic role. That is, of leaving the routine to concentrate on the broader issues.

It is very difficult to sit and read a journal or work out something about a strategy when you have a pile of urgent biopsies. There is a tendency to get rid of the routine work to make some clear space. The problem is it is the routine work, which I like doing and it is like a river and won't stop flowing.

Person role conflict/Inability to respond

Clinical commitments are planned on a long lead time and yet the management role can require you to be available at short notice. Different lead times cause a conflict.

There's all the business about the reprovision of clinical services across the County. Well my clinics are booked up months in advance and then they say there is going to be a meeting tomorrow - forget it. That sort of thing is a real conflict. You are disenfranchised from being involved in looking at the bigger picture. You are the person on the ground floor that really knows where the problems lie and has a voice which is important to be heard. Yet many of us cannot go to these sort of meetings.

Inter-role conflict/Pressure to be fair

Belonging to one group for the management element of the role and another for the professional role causes a conflict.

As you are a consultant in the CD role, it could be viewed that you would naturally always side with the consultants, so there may be a perception of bias. So I think you bend over backwards to be seen to be fair.

Patient care versus business needs are often seen as being in conflict.

You are naturally the advocate for the patient and that doesn't always fit smoothly with the business needs. Caring for people and pounds, shillings and pence don't fit together.

In the following example it can be seen that issues which apply to different responsibilities in the clinical role which could have been passed up the management line, cause a conflict in the CD role.

In my role as clinical tutor I work for the Dean, so I have got a conflict because the Dean says you need phlebotomy services on Sunday. As the Dean's agent I say to the Trust you have to provide phlebotomy services on Sunday and the Trust says to me as CD how are going to do it? I say I need some money and it goes around in a circle really. It's a bit like being PooBah, I think that is the right character, in my job as Lord High Executioner I need to chop my own head off sometimes.

Sent role conflict/managing the tension

The conflict of the different roles. This is almost a textbook definition of conflict, but it is seen as positive rather then the more usual negative reaction.

There is so much tension in bringing the two roles together that it means doing either one of them well, is at the expense of the other. However, I think the tension is important. I think it should be there. I think that probably generates the creative bit in individuals.

4.11.1 Summary

What actually causes a conflict between the roles is often seen as time, but this conflict manifests itself in a number of ways. Explanations of how performing in one role actually prevents performance in another is expressed in a number of ways. Table 4.16 shows where conflicts are perceived around the work and the nature of the work and those where the emotional issues of wanting to be fair to a range of individuals. Differences between the roles were shown earlier in the analysis, but many of these were not expressed as conflicts. Role conflict was less evident at the site where there was no budgetary or staff responsibility included in the role.

Table 4.16 Summary of the Perceptions of Role Conflict

Area of Conflict	Outcome
Work overload	Results in behavioural change and stress
Strategic versus operational	The operational tends to take priority
Inability to respond	The planned nature of the clinical role can make it difficult to respond to the management role
	To clinical and management colleagues
	To the patient and the management needs
Pressure to be fair	To the Dean and management colleagues
Managing the tension	Meeting the pressures of the two elements of the role simultaneously

4.12 THE CHALLENGE OF MANAGING DIFFERENT SPECIALTIES

The CDs and SLCs recognise the differences between their role and that of their colleagues. This appears to be an important area for them in understanding how they take up the role. They acknowledge that leading and managing more than their own specialty presents particular challenges. Experiences in some specialties are perceived to lend themselves to taking on the management role. The opposite view is expressed where some individuals see they have particular problems in their directorate.

Like a business

Some specialties are viewed as being quite easy to understand as this CD explains. It is seen that the pathology and some other departments have several advantages when it comes to managing their services.

Pathology is a bit like a shop, you are expected to grow as demand grows. You have premises and equipment, take on staff, you are given samples, you analyse them. It's quite straight forward

Flexibility and location

It has been seen in earlier analysis that the planned nature of some roles prevents individuals from taking part in management meetings and the decision making process. Some specialties do realise their ability to be flexible in the clinical role is an advantage.

Histopathology is reasonably flexible. I can change when I report on biopsies to accommodate meetings, with some other specialties that would not be possible. The lab. is slightly different form other directorates because we are physically together and we have a unique identity. I am sure that applies to Pharmacy and Xray. The Surgical Directorate doesn't probably feel as discrete a unit as we do, because they are all on different wards. I don't know how much they would inter-relate.

Teamwork

In one department there is a particular closeness, not only associated with location. Here the CD places a great emphasis on choosing individuals who would work well together as a team.

Here we plan, share and review our work together as a team. We recruit people who want to work as part of a team. If we make a mistake in our recruitment, which we have, on one occasion, it makes a tremendous difference to our directorate.

Some specialties have been located together and worked as a team for many years. For them the introduction of CDs had made little change.

*We haven't really changed very much. Previously our head of department made the decisions with other consultants and, as it was then, with the Superintendent Radiographer and he did the day to day donkey work of running the department. ***** now fulfils that role. He is here in the department and we see each other all the time and can interact. Unlike some directorates, we don't have to arrange an appointment every time we want to discuss something.*

Some CDs recognise the importance of team work and the skills of sensitivity and judgement in motivating colleagues. Frustrated at not being able to achieve change with colleagues, when it appears to them logic and common sense are on their side. As seen earlier in the analysis, some just act and change things and seem unable to understand the impact of their behaviour and actions on others.

The frustration of a CD for anaesthetics was shown in how he was unable to create a team spirit and effect change.

Our directorate (anaesthetics) is very different we are one step removed from the patient, we have to respond to the surgeon's requirements and they have to respond to things like waiting list targets. But, they have to rely on us to help them out. Another major difference is that we work as a team organising the rota between us.

It's a very frustrating role, you have responsibility with no power. We talk about a CD being someone to be a representative, to lead, but without the power you have to obtain consensus. It is quite an impossible situation at times. We realised that we needed to do more sessions to fulfil our training requirements for the colleges. We could either do more work ourselves or employ more consultants. We could do this ourselves by being more flexible and I worked out an annual hours approach. This meant some more work with a small increase in pay, but you might not always have the same half day off. Although we always pussy foot around not mentioning private practice it is inextricably linked to the health service. Probably this and the excuse 'I

always have Wednesday afternoon off and I always go and get my hair cut and I need to know in advance' resulted in nothing happening. Three colleagues did not agree and eight agreed to change, therefore nothing happened.

Individualism

The individualistic nature of the surgical model clinically encourages a focus which brings with it an isolation from all activities outside their immediate concern. This does not equip individuals for a broader management role. Hence, the interesting quotes from individuals concerning a corporate approach – *Yes, of course I take a corporate approach, but I am not interested in it* (laughter). This is someone who knows what the answer to the question should be, but acknowledges it does not mean anything to him. This may be one illustration why many CDs find executive meetings so tedious. e.g. *Why should I be interested in who gets the laundry contract. I know nothing about it.* This individual had no perception of whether the CE wanted him to question decisions outside his own expertise, to bring a new perspective to the debate or just to be there to own the decision (one cynical view expressed by another CD). The CD is acting as he would in his clinical role, only contributing when he is the expert, not being interested in anything else, and not questioning issues where he is not the expert. There are other CDs who have an interest in management and did question the length of some meetings and said so. They are open to understanding and contributing *to the bigger picture.*

The lack of a team approach in surgery is seen as a barrier to efficiency, by a CD outside surgery.

The main thing to improve efficiency on the surgical side would be to move patients between surgeons a lot easier. Clinical directors need more power with management's backing.

If a patient is referred to a surgeon the patient remains with that surgeon unless they need the expertise of another specialist. No account is taken of different workloads and no person has authority to move patients between surgeons.

As pointed out by the CD quoted above this system does not operate in all countries. However, this CD tries to effect change in his own directorate and is surprised at the resistance he came across.

Multiple specialties

Managing your own clinical specialty brings a confidence in the role. Managing a range of specialties is a much greater challenge.

Oh yes, head and neck, three major surgical specialties, you are bound to be dealing with a lot more inter-specialty conflicts. There seems to be more balls in the air to juggle, it's high volume with lots of patients moving around. If you were to take another directorate, anaesthetics, it's a very different role, they just have their own rota to organise and they know everyone much better. My directorate is quite diffused, I don't get to know everyone and rely on my directorate manager. I will deal with mainly the strategic issues and do not get so involved in the nitty gritty as perhaps I would if it was one specialty.

If you are managing and leading your own team, then you can talk about leadership in the clinical role and the clinical directorate, but once you move out of your own team, them leadership is a bit more uncomfortable for want of a better word.

The challenge is seen as more complex than just managing different specialties. There is a recognition of the different skills that are required in different directorates and specialties and brings us back to the running a shop analogy.

Some of them have to be much better people managers than others if you are close to people in a small directorate you are involved in all the personality issues. If the role is mainly to do with changing services you have to be a good planner and proactive. Some need much more careful financial planning for instance I would imagine if there are small profit margins to deal with. Pharmacy deals with money and drugs, what drugs should we use or stop using, where can we buy them, what can we farm off on GPs. It's a bit like running a shop, well not exactly.

Size

It is recognised that the size of the directorate make a difference to the managerial role.

I think there are some aspects of the job that are exactly the same and others that are entirely different because the directorates are so different. Our's is a vast directorate. We are the biggest directorate in the hospital with over 300 people. Whereas, casualty is one department, it's minute by comparison. You can't get

everybody's views here easily. Size makes it much more difficult. Size and the fact that general medicine is mainly all urgent medicine. Therefore it's very difficult to plan. A totally demoralising job.

Evidence in this study demonstrates there are quite different approaches and ways of working in the different specialties. These are often perceived as driven by the nature of the clinical work. Some are forced into teamwork, which may or may not work well. Others have been similar to a business unit for many years having their own budgets and staffing resources. This history may well have helped their transition into the general management role.

Stereotypes

It would appear consultants do agree that stereotypes exist and contribute to the differences in the specialties.

As a Senior Registrar I went on a management course and amongst the 20 it was so noticeable that the surgeons were very different kind of animals to the physicians. The physicians were cerebral thinking about things, looking at different options, taking time to make decisions. The surgeons were wanting 'quick fixes', immediate action and they didn't think talking about something for half an hour was a good use of time. The stereotypes do exist and I am sure our behaviour in the clinical role influences how we perform the CD role.

Influencing

An SLC, like many other individuals, feel a major challenge in the role is influencing others, particularly colleagues. This quotation illustrates an individual's thinking about the approach to influencing different groups of patients and its possible links with influencing in the management role.

In his specialist clinical area of diabetes, his influencing role of having to persuade patients to have insulin could be just as problematic. This type of challenge is seen as one some that his colleagues did not experience.

Sometimes diabetic patients are adamant they are never going to have insulin. "There's no way that is going to happen, so you can just forget it Doctor". When he does accept the need to take it and then becomes happy using it, that's a real success.

This SLC then discusses the differences in his cardiologist colleague's approach to his patients. The SLC then acknowledges his behaviour changed with cardiac patients. This is a lengthy quotation, but it is a good illustration of the richness of the information obtained from this research design.

On Tuesday afternoon the cardiologist does the clinic and he turns the desk around. He does it every time. He sits on the other side of it and has it as a barrier. I turn it back again as I find it totally unacceptable to do that in my diabetic practice. It may not actually be differences between us as doctors, but differences between specialties. In cardiology you are in charge. The patient can't have a do it yourself coronary bypass. The patient has to have confidence to put their life in this bloke's hands. Whereas I am asking patients, to do quite ridiculous things, like stab their fingers, stab themselves, stop eating things they love. It's a completely different ball game. But, I find also, in my general medical field, that I behave quite differently when I see a diabetic patient, I sit on the bed with them, at their level and talk to them as I am talking now. When I see a cardiac patient, you know I am standing up at the bedside and I tell them what is going to happen. If the patient is also diabetic, I then sit down to talk about diets and insulin and their treatment. This all came about because of this absurd business of changing the desk around. I realised that I changed my behaviour, it was quite a revelation to me. In my management role I'm much more in my seat than standing up.

This seems a subtle and important distinction where a consultant feels the need to change his behaviour towards different groups of patients. I am not pretending here to understand these fascinating issues which have emerged, but I believe there is a value in not ignoring them. Many of the issues raise questions for further research or may reinforce some findings already in the literature which has not been the subject of this study.

4.12.1 Summary

Differences in the specialties and how they are and can be managed are recognised by almost everyone. Managing specialties other than your own is seen as particularly challenging. Many acknowledge differences in their specialty and directorate and the differences faced by their colleagues. There are views that those specialties who have managed their own department for many years, e.g. pathology and radiology find the few differences to the past in the directorate model. It is believed a proactive team working in pathology brought efficiency whereas the lack of team work in surgery is seen to bring inefficiencies. Where work is done by an individual, e.g. reading Xrays or slides there is a flexibility that allowed CDs to play a fuller management role and, for example, attend management meetings at short notice. The larger the directorate, the more difficult it is to manage and most felt managing services outside their own specialty are particularly difficult. Behaviour can be different when managing their own specialty to when they are managing other specialties.

The individualistic nature of specialties like surgery make corporate behaviour quite difficult to either do or be interested in. Being invited to give views on areas where clinicians have no expertise is just not in their frame of thinking. A frustration expressed by some CDs is the resistance of their colleagues particularly in some specialties to change. A rational well founded and argued case did not necessarily win them over. This resistance reflects a point made earlier, that the bloody mindedness of colleagues is a barrier to progress. Awareness of the impact of their own behaviour on others comes through these responses as it has earlier in the analysis. However, an interesting example of a self-observed change in behaviour in a clinical role led an individual to consider his behaviour in his management role.

Certainly there are things to learn from approaches in different specialties some of these appear to be driven by the nature of the service, others seem to reinforce the view that stereotypes do exist.

Table 4.17 Challenges of Managing Different Specialties

Summary of the challenge of managing different specialties

- Some specialties are described as follows:
- Run like a business
- Flexible and undertake most of their work at anytime.
- Located together and form an identity
- Plan, share and review their work as a team
- See each other all the time and can interact
- Find it difficult to act a team
- Act as individuals
- Managing multiple specialties is a challenge
- Large directorates are difficult to manage
- An individual can behave different in different specialties

4.13 TAKING A CORPORATE PERSPECTIVE

Corporate role/committed

Intellectually many CDs see the role as a corporate one.

The more you see the whole picture the better you can do any job. You can't come to being a clinical director thinking he only thing that matters is your little specialism.

However, displaying corporate behaviour is difficult for several reasons. There is a history of making decisions in the clinical role based on the individual's judgement about their own area of expertise. This is well practised over many years.

You decide whether a patient gets an operation or not or whatever, decisions are almost second nature.

Corporate role/Little interest

Often there is a lack of interest in areas outside their own interest.

Yes, the CD role is a corporate one, but I am not really interested in other peoples areas, especially the non-clinical things.

Corporate behaviour exists where there is an openness and ability to question other's areas of expertise formal and informal discussions. This requires a maturity that is often lacking in organisations. Corporate behaviour is often driven by a common purpose and the example set by leaders in the organisation. The comment below is typical of many at sites A and B where there is a respect for management and being involved in decisions at a corporate level appeared to be seen as a positive experience.

Corporate role/Insight

Being a clinical director has given me far more insight into the corporate realities and I think, dare I say this, some of my clinical colleagues are not being objective, they are not living in the real world. I think we work together in great empathy here. I have great respect for my colleagues in management.

Corporate role/Difficulties/Challenging colleagues

Clinicians are not used to challenging their professional colleagues. Where relationships are good they might question an Xray result or a pathology report on a

one to one basis as evidenced in this study. Challenging or questioning each other about their area of responsibility in the CD role is less likely.

We do make decisions about priorities and agree to these at meetings, but they are based on evidence, or perhaps government priorities. It is relatively easy to go along with those decisions. We never really challenge each other about our area of work when looking for efficiencies.

Corporate role/Difficulties/Implementing change

Behaving corporately and implementing organisational change was not easy for the individuals. Their responses were often linked to trying to understand their attitude to change.

Corporate role/Difficulties/Implementing change/Cynicism

There is a feeling that reluctance to organisational change is based on a frustration in the system.

It is difficult to take a lot of things that come from government too seriously. I can see clearly they are politically driven and not necessarily in the long term interests of patients. I still have to go along and pay lip service to them. One year something is really important the year it is dropped. There is a certain level of frustration in the system. You have to do things otherwise it will reflect badly on the hospital, but it doesn't stop the frustration or you pointing out the futility of what's going on.

Corporate role/Difficulties/Implementing change /Influence of clinical training

Some see their reluctance to implement organisational change as linked to their medical training and their clinical role.

It is very difficult to change things. Fundamentally we are trained not to bring in new things until they are tried and tested and tried and tested. If you start not doing that then you run into major problems. Any new drug, new treatment or therapy has got to be proven to work before you can use it. I really think that carries through into the management role. There is a reluctance to change until you know it will work.

Corporate role/Difficulties/Implementing change /Use of power

Sometimes there is a naivety mixed with reality about implementing organisational change.

With more power I could make it a lot more efficient, more like business. But this may not be good in the long run as you would antagonise your colleagues if you change the way they work. This could be counterproductive. If consultants worked to rule you would get far less out of them. You can only carry the business model so far.

These views have links with the views expressed about the differences in the two elements of the dual role

4.13.1 Summary

Some individuals are committed to the corporate nature of the role while others have little corporate interest. There are views about the insight the management role has given them and how their colleagues are not in living the real world. It is accepted that challenging professional colleagues about their area of responsibility is difficult. There is frustration with the whims of government and their short-term approach, and yet a loyalty to the trust concerning the need to respond. One CD linked the reluctance to implement organisational change to clinical training and the need to thoroughly test new things before introducing them. Once again there was a comparison with business and the idea that with more power a CD could be more efficient.

Views are summarised in Table 4.18 below.

Table 4.18 Taking a Corporate Perspective

Summary of taking a corporate perspective

- It is essential
- Not interested in other peoples areas
- You have an insight into corporate realities
- Some colleagues are not in the real world
- Little challenging behaviour between colleagues
- Frustration with government short-term approach
- Implementing untested changes is alien to clinicians
- The power available in business would bring more efficiency

4.14 WHY DO INDIVIDUALS TAKE UP THE DUAL ROLE?

4.14.1 Implications of the CDs and SLCs Career Profile

Before exploring the question 'Why do individuals take up the dual role?' the implications of CDs and SLCs career profiles are considered. The profile of the interviewees as seen in Table 3, section, 3.3.4, pages 96 and 97 is representative of the career pattern of NHS consultants. Generally consultants move to a new hospital/trust on being appointed as a consultant. As in this sample many then remain in the same trust probably until retirement. The pattern of their professional career is very different to many managers, including those in the health service. Managers often change organisations a number of times as they climb the management ladder and during the time they are senior managers. Therefore consultants work with many different managers and chief executives and often view their transition through the trust as a fact of life and something to be accepted and tolerated. The following view expresses the reality of the situation.

Managers come and go, some have more impact on the trust than others. The consultants are the stable workforce.

This stability of consultants occurs for several reasons. Consultant status is the most senior post in the NHS to which most doctors aspire, therefore they are unlikely to move for promotion. Many have private practices in the local area. It would be time consuming and possibly be difficult to develop these elsewhere. Remaining in one trust also provides a stable environment for their children's education and for their own social life. These reasons are expressed in this research, with the added comment by several CDs that they don't like change and don't see any point in moving, this leaves each trust with the strengths and weaknesses of having stability in such a key group of staff. However, the expansion of the number of consultant posts in the NHS provides more new blood (no pun intended) in a trust than relying on retirements as the main source of turnover.

When it is known you will work with colleagues for many years it is seen as important that good working relationships are maintained. However, when rifts do occur they can last for many years. As can be seen in the analysis several CDs

believed an important aspect of their role was to keep their colleagues all talking to each other. Consultant posts have contract tenure and a job for life is still a reality in this profession. This contrasts with the CD and SLC roles which are normally for a period of three years. Some have had their contract extended and a few have had a break of a few years and returned to the role, but these posts are relatively new and the period spent in them is short compared to the time they are a consultant in the trust. The temporary nature of this role is sighted by some as a reason for being wary of undertaking changes especially if it is something that is likely to upset please colleagues. Upsetting individuals who may later be in the position of clinical director or senior lead clinician and managing you is seen as *'foolhardy'*. However, as the analysis shows, not all followed such a cautious approach and some are more successful at implementing change then others. The temporary nature of the dual role has advantages for the clinician, it allows them to see if they gain any benefits from undertaking the role with out committing themselves permanently. The most discussed benefit is the safety net of having a secure full time job to return to and no sanction if they want to resign during the contract.

Against this backdrop we now consider the motivations for taking up the dual role.

4.14.2 Understanding the Motivations for Taking up the Dual Role

The CDs and the SLCs generally view how they are selected for the dual role as a matching process between the Chief Executive choosing someone and the consultant being interested in performing the role.

The structure and size of the areas of the service to be within the directorate or area of responsibility determined the amount of choice open to the Chief Executive, in some cases there is only one consultant to choose. Some individuals felt strongly they have to be acceptable to management and were chosen for particular qualities. Others placed a greater emphasis on their acceptability to their colleagues. The reasons for individuals taking up the role are varied. The reasons include:

Reluctant acceptance

It was my turn.

I was the only one who was acceptable to my colleagues.

The Chief Executive asked me. I felt obligated to accept. It is not the most popular of jobs.
It is important that your colleagues agree with the appointment.

Positive acceptance

I see it as something I should be doing at this stage of my career (nearing retirement). *Also, surgery is getting more complex and stressful. I don't do the real major stuff anymore.*
It is a new challenge for me, after doing clinical work for 25 years.
It was an opportunity to learn more about how the hospital ran.

The above quotations are representative of the majority in the dual role who are seen as a senior colleague by the consultants and therefore someone who could represent them and possibly solve their problems. In earlier analysis we saw that solving problems is the expectation CDs and SLCs thought their colleagues had of them.

One SLC who had less experience than most in the sample as a consultant had very positive views of why he is chosen for the role. He was pleased to reveal that:

The Chief Executive chose me I believe he sees me as having an open style of communication. I am able to take a broad view of the issues and I am someone who would not shirk the difficult issues.

This individual believes he was accepted by his senior colleagues because they didn't want the role and the *previous senior lead clinician was a disaster and they were pleased to get her out of the role.*

The more 'junior' CDs appear to be more direct in trying to deal with difficult issues. One has tried to deal with some disciplinary issues with a colleague and found it extremely stressful. He felt there is more to be done in the role, including further disciplinary issues but he has chosen to resign from his CD role. Although a consultant himself, he is surprised by the power of his colleagues to successfully resist and avoid, what he feel are valid serious issues. His family believe the stress in the role had changed him and he feels he could not and does not want to continue.

Another relatively 'junior' clinical director takes on the role because he *wanted to change things in the orthopaedic department.* He wants to standardise the use of prosthesis in his department and change the behaviour of his colleagues. One of whom purchased a very expensive type of prosthesis. His approach is to divide the budget for prosthesis between his colleagues. If this colleague continues to buy the more expensive prosthesis, he would run out of money and not be able to operate. Predictably the colleague overspends his budget. However, the executive does not support the approach of the CD and put more money in the budget to allow the surgeon to continue to operate. This clinical director is demoralised on two counts. First, the lack of support from management and second the recent discovery that the prosthesis he recommends for standard use proves not to be the best model. He is relieved to have just completed his three years as a clinical director. A hint of revenge is revealed as he explains that if he returns to the role *he would probably give management a harder time, now that he had three years experience.*

These are examples of where clinical directors have acted and tried to do what they felt is right, but they have lacked the sensitivity to understand the impact of their actions. Especially, the second example where the surgeon naively thought he would change behaviour by using a hard budgetary measure. He has not discussed his approach with the executive and does not appear to have thought through the consequences of his action. Certainly he is not used to seeking other peoples permission before he makes decisions in his clinical role. Also, he has made a management decision which affected his colleagues, something he is quite unused to doing. What is also unusual for him was that it is quite a long time before it is known that it is not the right decision. He is also exposed to some embarrassment in front of all his colleagues, something that is unlikely to happen in his clinical role.

Those in the dual role have views about why some of their colleagues do not want to do it. Their reasons are:

Perception of others

Management is not a particularly structured situation. I think it puts a lot of clinicians off, they see it as rather woolly. Whereas doing an operation on someone, that's real work.

Some know they are not good at dealing with people and that is what management is about.

Some wouldn't want the responsibility, they are happy to remain undisturbed in their own little area.

Certainly money is not seen as a motivator to take the role. The monetary reward for being a CD or SLC is two clinical sessions at site A and one clinical session at sites B and C. One session is one eleventh of their salary. Some individuals have reduced their clinical work to take on the new role, others have not. Those who have not given up any or very little of their clinical work give several reasons for this; they do not want to; there is no one to do it; no one is willing to do more. However, one senior lead clinician divides the extra money between him and his colleagues and they do some of his clinical work. Although no one actually feels the money was an incentive for doing the job, it is seen as a recognition of the additional work.

There is a shared view amongst many of the individuals that they have learned a lot about the management of the Trust by taking the dual role. The complexity of the issues and level of central government interference have surprised even the long serving consultants. Generally the executives and senior managers are in held in high regard at sites A and B. This is less evident at site C. The experience gained in the role appears to break down the barriers between clinicians and management. This is probably another area for further research.

4.14.3 Summary

Consultants remain in one hospital trust for many years and the CD and SLC roles are for relatively short periods of three to six years. These two facts have implications for the reasons why individuals take up the dual role and how they perform in it. Some see it as duty to take their turn, while others view it as timely at a certain stage of their career and a few accept the role with enthusiasm. Money is not a motivator for undertaking the dual role, but is seen as recognition of the extra work.

Positive acceptance	Reluctant acceptance
Chosen by the Chief Executive	*Asked by the Chief Executive*
My colleagues chose me	*My colleagues volunteered me*
It was a new challenge	*It was my turn*
It was the right time	*The only one who would do it*
There is only me, it is an opportunity	*I was the only one my colleagues would accept*

4.15 HOW CAN CDS AND SLCS DEVELOP IN THE ROLE?

With much of the previous research into the clinical director role linked to training programmes, this analysis could not be concluded without adding a representative sample of the unsolicited views of CDs and SLCs about their development in the role.

Some individuals thought the skills for the role are almost innate, others look for some training. Training is something they certainly expect to do for their clinical role, but most of this would be scientific training with a positivistic methodology. This may have left some of them sceptical of any other sort of developmental training.

Innate

The following comments suggest to different degrees that management is an innate skill.

I think you can either be a manager or not. I think you can learn the skills to make you a better manager. One is not better than the other because of their skills, but because of their approach and that is something you learn from when you are a baby.

*I think people can do it (*the CD role*) well naturally, but I think some management training is important, throughout your clinical role you are training, you are being trained all the time, so I think that is a major difference.*

You can be given all the skills to sack someone, but if you cannot do it, all the book learning is no good.

Perplexed

Many are unclear about what would help to develop them in the role. Some feel one to one support and guidance would be helpful.

Here we have little or no development for or in the CD role, but that does not stop you asking for some development, but it is difficult to know what would help.

I don't think it is the sort of thing you can get out of a book or somebody telling you what to do. I think having a sort of mentor is a benefit. Someone you can discuss things with, someone who is more experienced. Part of it is finding you feet, seeing how things tend to work, seeing what the pecking order is, that sort of thing.

I did learn from my predecessor. I learned how not to do it. She had an autocratic style with little communication or consultation. We had a vote of no-confidence in her and she was ousted.
I think more feedback on how we are doing would be helpful.

Learning from the clinical role

Some see the clinical role having links with the management role where they transfer the skills. This was evident earlier in the analysis in looking at the similarities between the two elements of the role.

I haven't received any training at all since I have been here apart from cardiac arrest. I don't feel as if I have been trained at all. I have had an apprenticeship. I've read books and learnt. There's been a minor bit of teaching about this and that, but I've learnt it on the job. I have certainly had no training in management. The thing I take from my clinical role into my SLC role is people management and understanding how people who are frightened or feel insecure act in a certain way, but I picked that up for myself.

4.15.1 Summary

These comments demonstrate the different views and uncertainty that exists concerning how best to develop clinical consultants in a strategic leadership role. From earlier responses we have learned about the pressures of the role. The data has also shown that the role is taken up in a number of different ways and is different in many respects to the clinical role. Perhaps these responses indicate support and development should be tailored to individual needs.

5 APPROACHES TO TAKING UP THE DUAL ROLE

5.1 INTRODUCTION

The analysis so far has taken the form of understanding the dual role through open questions linked to frameworks from the role literature. Other direct questions have provided data on areas such as the perceived differences and similarities between the two elements of the role. Questions were designed to address the main research question of 'How do clinical consultants take up the dual role of strategic leadership and clinician?' One thing that is clear is that the dual role is taken up in a number of ways. The nature of the clinical role varies and is seen by some individuals as influencing their ability to participate in the decision making process, for example, having flexibility to attend meetings at short notice. From the data it also appears that similar behaviours in the clinical role influence behaviour in the management role. An example of this is where an individual uses a similar communication style in both elements of the role. Data has shown that individuals have different reasons and motivations for taking up the role, they act differently and take varying degrees of satisfaction from undertaking the role.

This final section of the analysis builds on the understanding of how the role is taken up from the earlier analysis. Contrasting themes on the approaches to the role and the individual's perceptions of the management role are developed. This is followed by themes based on the individual's perception of their own part in the management role.

As described in chapter 3 this process took me back to a review of the original transcripts and the analysis as it unfolds so far in this chapter. This section has been a particular challenge for several reasons. Extracting small pieces of text can be misleading and not really convey the meaning which comes from taking large pieces of the text or the view of the individual's perspective from across the interviews. It was explained earlier, that often individuals say one thing which could be given a particular meaning and later they give examples that do not support the previous comment. The example given earlier was an individual who said he was a supervisor in the role and then went onto to describe behaviour more aligned to a strategic leadership role.

From the data we also know the role is seen and taken up in different ways and the outcome is different. This makes general abstractions difficult and not helpful where a meaning of the complexity of the subject is desired. One example of different perceptions is the challenges of managing consultant colleagues viewed in earlier research as a major issue. It appears, however, this is not a problem for all those in this sample. The examples below illustrate this point.

`Consultants/troublesome`

It means managing my colleagues, which I think is the most difficult bit of the whole role.

The most troublesome people who have expectations of me are my consultant colleagues.

Contrasted with :-

Consultants/no problems

I am lucky, we don't have any internal grievances or conflicts between the consultants.

I haven't had any problems with my colleagues

Why there is this difference is not the subject of this research. In further research we could hypothesise that those who appear to have no difficulties with colleagues are, better at managing them, ignore or don't face up to the problems, are fortunate and have a very amenable group of colleagues, or characteristics of the organisational context are an influence. Conversely, the reverse may apply e.g. the individual has poor management skills, colleagues may be particularly difficult to manage, there may not be mutual respect between individuals and many other reasons. As there are no universal perceptions of the role there are not universal answers or solutions.

What can be seen from this research, however, are some patterns in the different views and approaches to the management role. The patterns are often, as in the example above, made up of contrasting views. These are explored and illustrated in this section. The quotations are made in the context of the meaning from across the interviews i.e. statements are not quoted where there is ambiguity or contradiction with other statements made in the interviews.

5.2 DEVELOPING CONTRASTING THEMES - APPROACHES TO THE ROLE

Extracts from the data support the development of themes that are seen as patterns as the data is explored and revisited. The first five themes concern approaches to the role. They are ways in which the role is taken up.

Providing strategic leadership

It is seen that across the population some individuals believe the role is to provide leadership. They describe the role in strategic terms. They state they are providing a sense of direction leading and shaping their area of responsibility and sometimes are clear they have a corporate responsibility. These characteristics are clearly seen in the leadership literature.

The following quotations illustrate this view.

Giving policy direction with nuts and bolts left to others.

Requires a clear thinking and a broad vision, innovation and direction.

With the input (to planning and direction) of a doctor as well, the horizons can be much broader and not just in the department.

It's seeing the future and working out a direction.

Giving direction and leadership, tilting the rudder in the right direction.

It's showing leadership, it's bringing it (the directorate) together.

The more you see the whole picture the better you can do any job. You can't come to being a clinical director thinking the only thing is your little specialism.

Manager or representative

In contrast to this, other individuals see the role as one where they have a role in managing the delivery of something that is handed to them. These individuals see the role either as one which could be recognised as a management role in the management literature or they see themselves primarily as representative of their colleagues.

It is delivering a service that has been agreed at a corporate level.

My responsibility is to deliver the agreed level of service within budget.

I am responsible for setting up an annual business plan and then we have quarterly reviews on our progress.

I see myself as go between clinicians and management.
I try to represent things as fairly as I can.
I am the conduit for my colleagues (consultants).

➢ Theme one
Strategic Leadership - Manager or Representative

Communication

From earlier analysis we have seen that communication dominates the management role. Styles vary across this sample of individuals. Generally the style for the management role is felt to be more discursive than the clinical role. There are lots of interaction at many management meetings as evidenced when describing the demands of the role. Clearly there are different ways individuals communicate in the management role.

Communication/Proactive

Some individuals seek out views and communicate openly and frequently. They acknowledge that listening is a key part of the communication role. This is style is described as proactive.

This individual expresses his view that communication about the management role creeps into time when he is in his clinical role. He is an individual who sees the two elements of the dual role as integrated. He, like a number of his colleagues, actively seeks views from those around him.

I need to know everything that is happening and will go and talk to staff and see if there are any problems, any issues they want to discuss. One of my assets is that I think I am able to talk to everyone on the patch and I hope they feel able to discuss things with me on an open basis. I certainly do find when I am doing an operating list and I am responsible for patients who are anaesthetised, other people often try and dip in to my time and talk to me, either on the telephone or in person, it is very difficult. I worry about this and shouldn't be allowing it to happen as much. I should be saying when I anaesthetising I will not talk to anyone about business issues.

Managers protect themselves with secretaries, you cannot get them. I need to be stricter with people.

Others speak of listening and being proactive not waiting for problems to arise.
When I am doing my clinical work I am picking up information about my CD role. This may be spotting potential problems.
You need to listen and be available, you need an openness, but also a strategic privateness.
I need to talk and I need to listen to what people are saying.

Referring to his experience outside the NHS this individual believes he has learned to listen. He also shares his own insight into why his colleagues may not have this skill. He links this not to any particular personality trait, but to the influence of learning from the clinical role.

I learned to listen. I think doctors by and large are very, very, bad listeners, they hear what you say, but that's not listening. You develop routines for every sort of eventuality. I rarely see things I have not experienced before.

There is a sense in this group of individuals of listening to preempt isues, to be active themselves on what they are hearing.

Communication/Reactive

In contrast there are those individuals who have a quite different communication style. This is one where individuals have to come to the CD or SLC and seek out some form of communication. This rather long example is repeated with some background scene setting. This extract from the data illustrates the point that for some individuals we could see the link between the style adopted in both elements of the dual role.

Communication in the clinical role is often conducted in a language which 'non-professionals' would not understand. Consultants who have little patient contact have less need to translate this exclusive language for others. Communication on clinical issues is usually focused and results oriented. Also, mentally processing information

is usually fast, targeted and highly specialised. One example of what occurred during one of my interviews illustrates this point. A pathologist was interrupted by a telephone call asking him to look at a sample taken from a patient who was on the operating table. He agreed to this and the sample was brought to his office. He and a technician looked at the sample through the microscope and exchanged a few words. He then telephoned the surgeon and gave him his views on the sample. I only understood one or two words in this conversation. A three minute intervention, on a clearly important issue, dealt with in a fast apparently efficient manner in a professional language. This practical example threw into sharp contrast, the different worlds of the clinical role and the management role. The interview continued with the pathologist trying to articulate why communication was important in his management role.

I have an open door policy, well actually the door is always closed, but has a window in it. I am in here a lot and people know they can come and see me. I don't go out and ask people what they want or seek opinions. I don't have time to do that.

This reactive style appears to be common to both elements of the role for this individual. It may be that time is the reason for him using this style or it may be a natural or learned behaviour. At times he uses the word leadership to describe the role, but his explanation of the role is one of passive more defensive behaviour than proactive leadership. Symbolically he does not personally accept the additional money for the role and shares it with his consultant colleagues.

The views below of other individuals illustrate this reactive style where they act as a communication channel. They do not actively seek out views.

We are kept informed of everything at the Board, therefore consultants can come to me if they hear rumours and I can tell them what is really going on.
I represent my colleagues at meetings. I pass information down to them and they pass information up to me. It's the interjunction between me as the figurehead and the surgical consultants.
Attending the various meetings and making sure my colleagues are aware of the developments.

People can come and see me. I don't have time to walk around much. I don't interfere.

The context of listening would appear to be about listening to pass on information, rather listening to act on information as with the proactive communicators.

- Theme two
  Communication Proactive - Reactive

Involvement and seeking control

Earlier analysis showed most individuals felt they had a lot of choice in how they performed the role. Some felt controlled by external factors, but generally the activities they undertook in the role was up to them. It was seen as the analysis progressed one aspect of that choice and how they exercised it was in the amount of involvement and control they appeared to take.

Views from some individuals such as *I want to make sure things are as I expect them to be* show this person to be in the group who likes to be in control. In the interviews this individual is similar to some others in that they have a feeling of responsibility and accountability for their directorate.

Others express similar comments in the context of being in control.
I need a handle on pretty well everything that goes on in the care group.
You have to know as much as you can about what is happening.
It is important I stay in touch with the manager. We speak several times every day.
I am responsible for the budget and the well being of the staff.

Losing control

Some individuals do not take charge of the role and appear to fall victim to being buffeted around by colleagues.
I think we act as a rubber wall and a sounding board, I don't particularly like this part of it, to act as the dog to be kicked, often people just come with gripes about intra colleague relationships.

As with many quotations it is seeing the relevance of statements in the context of the entire interview. This individual, in common with several others, was very conscious of the fact that he would return to his consultant role and have to relate to another CD. He therefore he expressed the view that he did not want to take on difficult issues and adopted a fairly passive role. His realism shows through in the following quotation.
*If you can't top them, then you'd better be ****** allies with them.*

We have seen examples where stress had been as a direct result of introducing change. In the following example this individual has a rather reactive and cautious approach and is also very mindful of not upsetting colleagues. He believed he experienced stress by just being in the CD role. In common with some colleagues it is the pressure of confrontation that leads to stress. Also, for this individual there is a sense that he feels like a victim in the role.

It is very stressful. We are taking money out of the budget, you get aggressive letters and representations. It involves sleepless nights sometimes, which I find irritating. The stress is the aggression that goes with being the person who is seen to be introducing change.

Calm/laid-back

In contrast to the above view there are a group who display a calm, rather relaxed and laid -back approach.
There is a job description, but it's very broad. You can do it how you want really. I think we all do it differently, each of our areas have different issues really.
The discussion is very even and fair and people aren't just going for their turf. They can see their bit of extra money is somebody else's loss. We all know each other well and I don't think most people are particularly selfish so they don't think along the lines of entirely I want more for my department and blow everybody else.
He (CE) *gave me a job description when he asked me to do the job, but it is so vague and woolly that it doesn't really mean much. I think he expects me to keep the directorate on the straight and narrow and to keep within budget, which is quite impossible.*

The Chief Executive interviewed me for the job, it was more of a social chit chat really. I suppose he has an image of what the job is. If I get a pat on the back I know I am doing OK and if I don't get told off I know I am not doing anything wrong.
There is a job description somewhere, but it doesn't help much.
This does not mean there is an unrealistic approach in this style, some are calm, but still show a hint of frustration. They appear to deal with this by accepting problems are more associated with the system than anything else as the example below shows. The frustration expressed here was still said in a resigned manner. There is a lack of energy in this group who have a 'laissez faire' style.
It is difficult to take a lot of things that come from government too seriously. I can see clearly they are politically driven and not necessarily in the long term interests of patients. I still have to go along and pay lip service to them. One year something is really important the year it is dropped. There is a certain level of frustration in the system. You have to do things otherwise it will reflect badly on the hospital, but it doesn't stop the frustration or you pointing out the futility of what's going on.

An unquestioning approach is adopted by some where individuals seek no feedback. This links with a laid back approach in that there was a calmness in the responses. These individuals remain rather detached and are those who are, in most cases, those who are just 'doing their turn' in the role.

I would hope that if there was something I should be doing as CD someone would tell me.
I think I am doing the role well. I have heard nothing to the contrary.
What people expect of me. That's a good question, I have never thought of asking that. As I have now been in post a year that would be a good question to ask.
I am not sure what the expectations are from the management side, I really haven't thought about that and I can't give you an answer on it.

- Theme three

  Involvement and seeking control and losing control - calm/laid back

Having Confidence

A positive stance

Shining through in some individuals there is a confidence in their own performance in the role. Having confidence is described in several ways. The following examples are of individuals who all display confidence with a sense of progress and achievement.

There is an emphasis here on an ability to influence others.

Generally when there are things that I want to do and they involve other staff I discuss it with them and if there is a general belief it is something we should do then I will find a way of moving it forward. There are few people in the care group I think would be so obstructive as to say 'we are not going to do it because I don't want to'. I think I am able to get people to accept there needs to be some forward movement in the way things are run.

The following extract from the interview with an individual who leads with confidence, takes pleasure in pushing the boundaries and achieving. He is a person who appears, from other extracts of the interview, to proactively manage the expectations of his staff as well as manage the budget.

I have the money to manage. I appoint staff, purchase materials and many other things. I like playing with money. I am good at it. I have been a clinical director for three years and we have always broken even. I don't think there is anything I feel is not possible, it may be delayed, it may not be tomorrow, but it will happen, if you bang something it will move, if you keep banging it will definitely move.

The quotation below is from a confident person who accepts the reality of targets and manages systematically.

There is a performance management system which is top down. I like to try and anticipate cost improvements and plan to avoid a crisis, but finding time to think is difficult. Still we have increased efficiency several hundred percent, because we have had to do the same work for less money.

There appeared a divide between those in the dual role who had the confidence of colleagues and those who believed they did not. The following quotation is from an individual who throughout the interviews demonstrated a mature approach and a grasp of the reality of the role.

They expect me to make sure they are all talking to each other. They tend to fall out with each other easily as you would imagine (laughs). *They are very explicit in what they want. They say 'you could stop those two bickering' or 'perhaps you could go and talk to so and so about so and so'. Sometimes I ignore them, sometimes I go and do as I am asked, sometimes I tell them to go and get on with it themselves.*

A rebellious stance

Signs of a rebellious or independent streak lurk in several individuals. This is a confident approach and often shows a frustration with the system. The first quotation is a good example of trying to cheat the system. It was related with a feeling of playfulness.

After the review we were sent a list of things we had agreed to do. One was to cut the workload to meet our cloth. We cannot do that, if blood is taken from a patient you cannot refuse to analyse it. So I tipp-exed (white fluid used to paint over words) *that one out, signed it and sent it back. I thought that was quite good* (said with a feeling of triumph). *I don't know if anyone will notice until the next review.*

There are all the obligatory meetings, with the executive, with colleagues. I don't go to all of them.

I am sceptical of the value of me being on the trust executive and the trust board, because it doesn't make any difference. Sorting things out on a one to one with colleagues makes a difference. I have the SLC muscle to do that. I go to meetings so people think I am doing the job in the way they want. I comply to get freedom.

Six hours the meetings last sometimes, it's ridiculous. I say so, but it makes no difference.

I have felt more value sometimes in the board meeting than the executive meeting. You can explain graphically to board members what the reality of the situation is. Executive meetings are quite useful times for doodling and writing things down, not listening to what is happening, when they are discussing the laundry contract and things. If you are writing things down, people sometimes think that you are listening and concentrating

Yes, of course I take a corporate approach, but I am not interested in it (laughter).

Lacking confidence

It was not clear how some individuals had acquired confidence in the role, but this was not a characteristic shared by all in the sample. Some struggled to understand the role which lead to personal stress.

How well I do is very difficult to judge, there is no role model for my position.

I though I'd got better and gone through the learning curve and then I would get more efficient, but I seem to have gone back again.

Everyone says the first six months are very stressful. Some of the stress is a personal wish to do things to a very high level and worrying you are going to let someone down. So there is a kind of lack of confidence which I feel is a personal thing and I think women are much more likely to feel like that than men.

The last comment was by the only woman in the sample who perceived differences between her approach and the approach taken by her colleagues.

Self-effacing

A lack of confidence is also shown through comments which reveal a self-effacing characteristic amongst the sample.

I am responsible for managing my colleagues and I don't think I am very good at it. I am probably too nice to them. I listen to what they say.

When he (CE) took me aside and said would I be the CD, what he wanted was someone who was honest, who knew the way the hospital was going, who would plan honestly, wouldn't be self centred in their particular field and push that to the detriment of other areas of the hospital, and I hope, I truly hope that's what I've done because that's what I would have wanted to do anyway.

- **Theme four**
  Having confidence, positive and rebellious stances - Lacking confidence, self effacing

Providing team leadership/with sensitivity

There is a link between having confidence and the confidence of others and the recognition that this is a team leadership role and a broader role than just providing a sense of direction. There is the understanding for some that the role was an inclusive one where harnessing the commitment of those around is important.

I have corporate and personal objectives. I see myself as responsible for the recruitment and welfare of the staff. I have an important role in maintaining the morale of the staff, particularly the junior staff (doctors). I rely on the directorate manager for her expertise in managing the nursing staff.
You need to keep everybody enthusiastic about achieving our goals. I am a player/manager I can demonstrate I am working hard in my clinical director role and my clinical role. You try to get, that hackneyed phrase, the culture right, but it can feel like trying to get your football team to play hard in the last half hour of the game when they are five nil down.

There are individuals who operate as a team leader with a light touch, recognising the needs of colleagues. These were individuals who described taking an active role, but acting with sensitivity and some political astuteness.
I think consultants are intelligent people and they have got to have their head. Most of them do things with the right interest. A few people think only of themselves, but not many.
They like to come and talk to somebody, sometimes it is enough just to talk. You have to try to get a team approach.
Consultants are leaders in their own right. They have a defined position that involves taking decisions which no-one else is going to question. You have to act with some caution and vary your approach.
There are two sides to this one, it is what the troops expect their officer to do and what the generals expect people on the ground to do. The advantage for me is I have been in the department a long time and I understand the personalities. I know what people are saying to me and what they are really saying to me, the two are often not the same.
A CD sought out and valued personal contact with others *I find it is important to keep going to management. I chat to a variety of people you can always say "Look I am*

going to do this, what do you think?" I suppose if I am being immodest I am quite good at networking

Providing leadership/little sensitivity

In contrast to some explanation of sensitivity in the role there were those who still pursued an active role in leading their area of responsibility, but appeared to be less astute in sensing the possible impact of their actions. These were the more 'junior' CDs who appeared to be more direct in trying to deal with difficult issues. One has tried to deal with a change in rotas which would have made savings, slightly increased the salaries of colleagues and provided a better service to patients. He met resistance from colleagues who refused to change their pattern of work. He also tried to address some disciplinary issues with a colleague and found it extremely stressful. He felt there is more to be done in the role, including further disciplinary issues but he has chosen to resign from his CD role. Although a consultant himself, he is surprised by the power of his colleagues to successfully resist and avoid, what he feels are serious issues. As the quotation below shows his family believe the stress in the role had changed him and he feels he could not and does not want to continue.

I am under stress the whole time, my wife says I have changed since I started this role, not for the better at home. I think there are two ways of approaching the role, either you do things as they crop up and do the minimum and stamp your feet, or you can look forward a little bit and try to foresee things and plan a little. The second approach takes more time than we have for the role.

Another relatively 'junior' clinical director takes on the role because he *wanted to change things in the orthopaedic department.* He wants to standardise the use of prosthesis in his department and change the behaviour of his colleagues. One consultant purchased a very expensive type of prosthesis. His approach is to divide the budget for prosthesis between his colleagues. If this colleague continues to buy the more expensive prosthesis, he would run out of money and not be able to operate. Predictably the colleague overspends his budget. However, the executive does not support the approach of the CD and put more money in the budget to allow the surgeon to continue to operate. This clinical director is demoralised on two counts. First, the lack of support from management and second the recent discovery that the prosthesis he recommends for standard use proves not to be the best model. He is

relieved to have just completed his three years as a clinical director. A hint of revenge is revealed as he explains that if he returns to the role *he would probably give management a harder time, now that he had three years experience.*

These are examples of where clinical directors have acted and tried to do what they felt is right, but they have lacked the sensitivity to understand the impact of their actions. In the second example the surgeon naively thought he would change behaviour by using a hard budgetary measure. He has not discussed his approach with the executive and does not appear to have thought through the consequences of his action. Certainly he is not used to seeking other peoples permission before he makes decisions in his clinical role. Also, he has made a management decision which affected his colleagues, something he is quite unused to doing. What is also unusual for him was that it is quite a long time before it is known that it is not the right decision. He is also exposed to some embarrassment in front of all his colleagues, something that is unlikely to happen in his clinical role.

- Theme five
  Providing team leadership with sensitivity - Providing leadership with little sensitivity

5.3 DEVELOPING CONTRASTING THEMES - PERCEPTIONS OF THE MANAGEMENT ROLE

The next three themes relate the individual's views of management and managers. Again contrasting patterns are seen in the data as the analysis evolves.

Management - described as complex

Broader issues of staff motivation and organisational culture are seen as a key component of the management role. The second quotation here is from an individual who is clear about his position as a role model.

I see myself as responsible for the recruitment and welfare of the staff. I have an important role in maintaining the morale of the staff, particularly the junior staff (doctors).
You need to keep everybody enthusiastic about achieving our goals. I am a player/manager I can demonstrate I am working hard in my clinical director role and my clinical role. You try to get, that hackneyed phrase, the culture right, but it can feel like trying to get your football team to play hard in the last half hour of the game when they are five nil down.

Management is complex. The decisions are often more difficult to implement than clinical work. For example, the problems are trickier. Take the colposcopy service. You gets lots of blurb sent down that lands on your desk and you have to try and address the standards and make sure you deliver a service to those standards. That's much more difficult than doing 10 terminations.

Some of the complexity is described earlier in the concept of capturing the role, for example the ability to network and sound out opinions. *I chat to a variety of people you can always say "Look I am going to do this, what do you think?" I suppose if I am being immodest I am quite good at networking*

Management - Described as a Simple Concept

Some recognise the people skills required in management and these are easily acquired or perhaps innate as others suggest.

You need common sense and an ability to get on with people, apart from that anyone can do it. You don't need any particular training or qualification.

Management - unstructured, not real work

Other views acknowledge that the role is unstructured and compare it to the clarity of the clinical. Seeing clinical work as 'real' work.

Management is not a particularly structured situation. I think it puts a lot of clinicians off, they see it as rather woolly. Whereas doing an operation on someone, that's real work.
Management has little substance, it is very woolly and difficult to describe. Most managers' time is spent in meetings that seem to achieve little. (in contrast) I am quite efficient clinically, I can see patients quickly and sort them out when I get to them. I actually enjoy it and see the necessity of it.

- ### Theme six
  ### Management is complex - management is simple, it is not real work

Management –An Innate Skill

This simplistic and straightforward approach to management gives rise to the following views that are expressed by quite a large number of individuals in this research. The belief that the skills are innate is sometimes mixed with almost a sense that surely some training must be necessary, but most are unsure about what that training could be.

I think you can either be a manager or not. I think you can learn the skills to make you a better manager. One is not better than the other because of their skills, but because of their approach and that is something you learn from when you are a baby.
*I think people can do it (*the CD role*) well naturally, but I think some management training is important, throughout your clinical role you are training, you are being trained all the time, so I think that is a major difference.*
You can be given all the skills to sack someone, but if you cannot do it, all the book learning is no good.

Management - is learned

There are different views expressed about how one learns to be a manager. Few of the individuals in this sample have undertaken much management training. One individual does relate his formal study to the ability to think like a manager.

I don't think it is the sort of thing you can get out of a book or somebody telling you what to do. I think having a sort of mentor to learn from is a benefit. Someone you can discuss things with, someone who is more experienced. Part of it is finding your feet, seeing how things tend to work, seeing what the pecking order is, that sort of thing.

One CD clearly demonstrates his view that different mindsets are required for the two elements of the dual role. He relates his recent experience in studying for a law degree. He believes he became able to think in management mode by learning the principles of management, through lectures and talking to people and working on examples.

*After a few days you begin to think like that (*in the management role*), but within 24 hours of getting back into clinical mode it would fade away. It was a different way of thinking about things.*

Another way of learning is expressed by someone whose predecessor was removed the management role.

I did learn from my predecessor. I learned how not to do it.

- Theme seven

  Management is innate - Management is learned

Respect for Managers

The first individual quoted here, like several of his colleagues, admits to having an empathy for his colleagues in management. Colleagues being a term usually reserved for consultant colleagues. Elsewhere in his interview he demonstrates confidence and leadership in the management role. Others express trust and respect for the managers.

Being a clinical director has given me far more insight into the corporate realities and I think, dare I say this, some of my clinical colleagues are not being objective, they are not living in the real world. I think we work together in great empathy here. I have great respect for my colleagues in management.

You need to gain the trust of others. This is not easy, but it is achieved by many managers here.
Being involved at a senior level broadens your understanding of the pressures on the system and all the political interference.
I have a respect for the senior managers. It is a privilege to be involved and lead your part of the service.

Cynicism

The strength of support for managers in the trusts far outweighs any hints of criticism. Any disrespect for managers is rare in this sample. Only one view was expressed that one CE was seen by a number of his managers as fairly brutal with some individuals being frightened of him.

A few individuals viewed some of the processes with cynicism. If there is some truth in what is being said in the following quotation it could account for some individuals just going through the motions in how they perform the role.
I am not sure what I do sometimes. I do feel as if we are being wheeled out there, to be in meetings, to make sure that you are seen to be having shared responsibility for the decisions across the Trust, then to be moved back into the cupboard again afterwards to get on with it. They can then say "you were there when the decision was made" "Was I, oh right". I probably have a reputation for being cynical, but I really do think there is an element of that.

Another hint of cynicism with a touch of rebelliousness is seen below.
After the review we were sent a list of things we had agreed to do. One was to cut the workload to meet our cloth. We cannot do that, if blood is taken from a patient you cannot refuse to analyse it. So I tipp-exed (white fluid used to paint over words) *that one out, signed it and sent it back. I thought that was quite good* (said with a feeling of triumph). *I don't know if anyone will notice until the next review.*

- Theme eight

Respect for managers - cynicism

5 4 DEVELOPING THEMES- PERCEPTIONS OF THE INDIVIDUAL'S AWARENESS IN THE ROLE

This part of the analysis develops themes relating to the individual's observations of what occurs in the performance of the dual role and their recognition of the differences in how they take up the two elements of the dual role.

Self Awareness/work patterns

Some individuals express an awareness of their behaviour in the dual role.

I am a good delegator in the clinical director role simply because I am one of other good people that do things better than me. But I am medically hubristic enough to know perfectly that there is nobody who does the medical things better than me. I am not good at handing things over.

Delegation happens in both roles, there are things I cannot delegate in both roles. I try and delegate as much as possible, but with patients it's safety. You can't delegate because of safety. With the clinical director role you have to do things because you hold that role, you might not do something as well as someone else, but you have to be there because you are the CD.

CDs manage relationships in different ways. In this example it is an older consultant who like a number of his senior colleagues appears to be more politically astute in using their power in less direct ways in the management role, than they would in the professional role.

The manager chairs all our meetings. My colleagues felt it was strange at first, but it allows me to listen and take part in the debate. We can push things through easier that way. I guess they know what I want really.

Self awareness/behaviour

An SLC provides an insight into how the behaviour to different patients can change and draws a comparison with the management role. The SLC discusses the differences in his cardiologist colleague's approach to his patients. The SLC then acknowledges his behaviour changed with cardiac patients. This lengthy quotation, is

repeated as a good illustration of the thought some individuals give to observing and seeking explanations for their behaviour. These insights appear to be rare.

On Tuesday afternoon the cardiologist does the clinic and he turns the desk around. He does it every time. He sits on the other side of it and has it as a barrier. I turn it back again as I find it totally unacceptable to do that in my diabetic practice. It may not actually be differences between us as doctors, but differences between specialties. In cardiology you are in charge. The patient can't have a do it yourself coronary bypass. The patient has to have confidence to put their life in this bloke's hands. Whereas I am asking patients, to do quite ridiculous things, like stab their fingers, stab themselves, stop eating things they love. It's a completely different ball game. But, I find also, in my general medical field, that I behave quite differently when I see a diabetic patient, I sit on the bed with them, at their level and talk to them as I am talking now. When I see a cardiac patient, you know I am standing up at the bedside and I tell them what is going to happen. If the patient is also diabetic, I then sit down to talk about diets and insulin and their treatment. This all came about because of this absurd business of changing the desk around. I realised that I changed my behaviour, it was quite a revelation to me. In my management role I'm much more in my seat than standing up.

This seems a subtle and important distinction where a consultant feels the need to change his behaviour towards different groups of patients. In the management role this individual talks about persuading and negotiating with individuals to change much as he describes with the diabetic patient. He is not in a telling mode.

One consultant makes the point that in his CD role *he has to lead his department, maintain motivation and morale and get the work done without reducing people to tears.* In his clinical role *the consultants to whom he provides a service are not worried about tears amongst the staff they just want the results.* This observation links to the need to lead with sensitivity and an awareness of the impact of your behaviour on others. There is also a link with the important difference between the elements of the dual role, the professional role being concerned with tasks and the management role with relationships.

Switching behaviours between the elements of the dual role is acknowledged as difficult. No comment is made here about this individual's success in this aspect of the role, but there is recognition a change is needed. This reinforces the views expressed of a different mindset in the professional and the management role.

I think there is a great discrepancy between the problems that you are asked to deal with in the CD and clinical role. They range from the huge strategic picture, such as the hospital being under threat to very minor clinical event which is never the less important to the individual. Seeing both these as equally important and switching between the roles is difficult. You have to change the way you think and the way you behave.

The recognition of the many considerations in which the two elements of the dual role are different were seen earlier in the analysis when individuals talked about the difficulties in switching between roles. Different roles are seen to drive different behaviours, but some seem more sensitive to and able to adjust their behaviour.

- Theme nine

  Self Awareness - work patterns and behaviour

Awareness of power relationships

Power is a two edged sword in the dual role. The power and autonomy individuals have as a clinician acts for them in some circumstances and not in others.

Politically sensitive

A concept given under the taking charge role is seen again here when looking at individuals self awareness. CDs manage relationships with colleagues in different ways. In this example it is an older consultant who like many of his senior colleagues is more likely to gain respect from colleagues when trying to implement change. It is still, however, no easy task. Here this consultant is being politically astute in using his power in a less direct way and appears to hand control to the manager.

The manager chairs all our meetings. My colleagues felt it was strange at first, but it allows me to listen and take part in the debate. We can push things through easier that way. I guess they know what I want really.

Protecting a powerful position

As seen earlier in the analysis one of the greatest challenges in the dual role is that of influencing consultant colleagues. This is particularly difficult if the individual is younger and seen as more junior than his colleagues.

The individual quoted above recognises this power he has in his clinical role.
I have a very wide choice I can treat what I like I am very lucky in that respect and that's a heck of a privilege to have and I am very aware of that and not to abuse it.

He has less than 10 years consultant experience and works as the only consultant in his specialty. He does everything he can to avoid having a consultant colleague in his specialism. He wishes to remain in charge and believes it is better to have *a happy family rather than an unhappy marriage. I want harmony in my life I want to come into work and be happy. I am going to be here for 20 years. I feel as if I am looked on as the leader of my department simply by people's attitude towards me.* This individual appears to seek control as head of the family, but is keen to show he is does not covet control in all aspects of his life. He continues by saying.
Some people like to be total control freaks, they like to know that if anything goes wrong they have got membership of the AA, the RAC, Green Flag and just about everything else, the Catholic Church probably and yet they have just brought a new car and nothing is likely to wrong anyway. I drive around in an old Volvo with 197,000 miles and it breaks down and we sort it out, but maybe it's just personality. I am not too much of a control freak. I like a bit of mystery, adventure. I like to go out on my own to see how far I can go before I need help.
This individual appears to be very satisfied with leading his own department and specialty and does not want the challenge of working with a consultant colleague. As a young consultant, if he had an older more experienced consultant as a colleague this could reduce the freedom and control he now enjoys.

Struggling with power

The problem of being a young 'junior' consultant is explained by a CD who faces problems and appears unable to act and was referred to earlier in the analysis as having little political sensitivity. He also appears to believe that to *lay down laws* would solve the problem.

I think too many rules would be a bad thing. On the other hand there are those that if you don't lay down laws will play the system. I found a few problems which are difficult to deal with especially as a newish person. I certainly don't have the authority to tell my more senior colleagues what they should or shouldn't be doing.

My colleagues have been here for quite a few years and for them the status quo is quite pleasant. I would like to move to a new status quo which may not be as pleasant for some people, but would be better for the department. This is difficult to do. I am surprised at the power they display by just digging their heels in and refusing to change.

There is a strong sense of hierarchy and resistance to change felt particularly by the 'younger' consultants. This individual is frustrated trying to change rotas within the department which would increase efficiency. He is unable to obtain consensus as some individuals will not a regular half day off when they want it. This change is not implemented. In more serious circumstances of disciplinary issues this CD feels unable to act.

In the clinical director role I have found that people can get away with unsafe practice and it is difficult to do much about it if it is a consultant colleague. If it is a junior colleague it is easy, you just tell them you will not cover for them if they do that, you are on your own. As a clinical director I cannot tell my colleague to stop doing something especially if he has been in the job fifteen years longer than me. The only way I have been able to deal with this is to tell junior colleagues not to do it and copy the letter to all consultants. I find that ludicrous.

- Theme ten

  Awareness of power relationships

  Politically sensitive

  Protecting a powerful position

  Struggling with power

5.5 AN OVERVIEW OF THE CONTRASTING THEMES

Contrasting Themes on the Approaches to the Role

- Theme one

  Strategic Leadership – Manager or Representative
- Theme two

  Communication Proactive - Reactive
- Theme three

  Involvement and seeking control and loosing control – calm/laid back
- Theme four

  Having confidence, positive and rebellious stances – Lacking confidence, self effacing
- Theme five

  Providing team leadership with sensitivity – Providing leadership with little sensitivity

Contrasting Themes on Perceptions of the Management Role

- Theme six

  Management is complex – management is simple, it is not real work
- Theme seven

  Management is innate – management is learned
- Theme eight

  Respect for managers – cynicism

Themes on the Individual's Awareness in the Role

- Theme nine

  Self awareness – work patterns and behaviour
- Theme ten

  Awareness of power relationships

  Politically sensitive

  Protecting a powerful position

  Struggling with power

5.6 EXPLORING THE THEMES

At this stage it is timely to be reminded that this study is concerned with the perceptions of the individual. The statements are the individual's views of how they take up and approach the role. The research is focused on the perceptions of behaviour in the role.

The themes are explored from the data shown earlier. These are then illustrated with details of individual profiles.

Taking charge

The first five contrasting themes are about the approach to how the role is taken up. As the views and contrasting approaches emerge they appear to be around a dimension that is named here as **taking charge** of the role.

Having developed the themes across the data they are related back to the individuals i.e. where did these contrasting themes form patterns in individual profiles and where is there not a pattern. Also, are there linkages between themes. Some patterns and linkages are clear others are blurred. For example those who in theme one describe the role as strategic and articulated leadership qualities are more likely to be proactive in their communication style, they often have a need to be in control and usually feel confident in taking up the role. There are those in this pattern who provide leadership that embraces the concept of a corporate role with a responsibility for influencing others working with directly them and all around them. In this group there is some blurring between those who clearly see the role as one of strategic leadership and others who are less certain about their strategic contribution.

There is a sense of individuals with this profile taking charge of the role, moving it forward in a proactive and determined way. They are leading a team and working with a range of individuals around them. This pattern is described as **high on taking charge** of the role.

While patterns emerge individuals do not all fit neatly into a particular pattern. There are those who share many of the characteristics described above, but act with little sensitivity. This pattern would appear as behaviour where individuals are proactive, want to be in control, are confident and yet have problems in implementing changes. Many find change not easy to implement but individuals with this pattern go boldly into action and are surprised when the outcome is negative. When this happens there was a sense of a loss of control.

These individuals do embrace the role. They describe, with strong feelings, a desire to lead and deliver change. They have a rational and logical approach to management tasks that show little understanding or astuteness in managing relationships particularly with colleagues. This is still a proactive and determined style that is also seen as **high on the taking charge** approach.

Another pattern of behaviour is linked to the themes this is where individuals describe the role in terms of management rather than leadership, delivering or managing an agreed change. This style is more difficult to see clearly. With a few individuals they seem to drift into a leadership role at some stages of the interviews. Other individuals play the role of a representative. Again a few stray between describing themselves as representing colleagues and yet having some responsibility to manage their part of the service. There are, however, those who clearly sit in the representative role, seeing themselves as a communication channel between their colleagues and management and not including themselves as a part of management.

Those with this general pattern of behaviour tend to be reactive rather than proactive in their communication style, communication being less linked to action, but more to passing feedback from one group to another. The approach for many in this group appears as relaxed and laid back. For some in the representational role there is also a particularly heavy reliance on the manager who supports or in some cases appears to manage the directorate or care group. Here there is limited contact between them. There is a calmness of approach in the descriptions of the role and also in the tone and manner during the interviews. A few are confident in the role as they interpret it, while others are less confident. The less confident approach is either one that appears as an uncertainty about their ability, or one that is concerned and wary about

relationship with their colleagues. Where there is consciousness about working in a team situation the role is espoused as one of team membership rather than team leader.

This general pattern differs from those described earlier. It is a more reactive cautious approach and is defined as **low on taking charge** in the role.

It is recognised there are some individuals whose approach is less clear than others and there is some blurring across the themes. A further complexity exists which may explain some of the blurring. An example of this is where an individual talks clearly about taking charge in the role. He describes being in a strategic leadership role, being proactive, confident and taking the service forward. This is, however, a description of one part of his role, that of leading his own specialty. He also describes a different approach that relates to the part of his role where he is the CD for other specialties. Here he talks of being a representative and acting only as a communication channel for colleagues. In this individual we see him taking up the role and being **high and low on the taking charge dimension**. Indications of this difference are evident to some extent in a several individuals, but certainly not in all cases where individuals mange across specialties.

Managerial alignment

Themes five to ten are contrasting themes on the individual's perception of the management role and on the individual's awareness in the role. There are linkages between these themes across the data and in the individual profiles. Relationships are seen between the themes on the taking charge dimension and themes five to ten. These themes are considered as another dimension and named **managerial alignment.**

There is perhaps a natural and expected tendency for those who saw the management role as simple to think anyone could do it and that people were either born with the ability to perform a management role or not. These individuals usually made little comment or response concerning their own self-awareness in the role. Usually they were not politically astute in managing colleagues and others. Sometimes they were aware of the political issues, but struggled with power relationships and were often

unable to resolve problems. This was the group where the few unfavourable expressions about management were made. This particular pattern showed little empathy or understanding of the complexity of management and was less skilled politically than others, being regarded on this dimension as **low on managerial alignment.**

The other strongest pattern across these themes is almost the opposite where individuals saw management as complex. This group usually recognised some training and development was needed, but still struggled with knowing what would be helpful for the role. Viewing the role as complex linked to a respect for managers which was common in this sample. These individuals were more likely to talk easily about their behaviour in the role. Also this group were generally astute in how they managed the power relationship between them and their colleagues and other groups. This group are regarded as **high on managerial alignment.**

Relationship between taking charge and managerial alignment

The next stage of exploring the themes is to consider the relationship between the two dimensions and the themes within them. The first five themes are concerned with approaches to the role that are seen along a dimension of **taking charge**. The next five themes are concerned with views of the role and self-awareness and seen along a dimension of **managerial alignment.**

Patterns are seen where individuals are either seen as high or low on taking charge, but there are also individuals where the pattern is less easy to discern and they are elsewhere along the dimension. This is similar for the dimension of managerial alignment.

There are individuals who are **high on taking charge who also had a pattern of being high in managerial alignment.** These individuals are in a strategic leadership role, they are proactive, confident and more at ease with an understanding of the complexity of management and the political environment. Others were **high on taking charge and low on managerial alignment.** They took charge of the role, but experienced negative outcomes in implementing change. These individuals viewed the management role as simple and they confidently tried to effect change only to find

the outcome they wanted was not achieved. In these circumstances it was their surprise in the outcome that is linked to a lack of awareness of the complexity of management and the attitude and power of colleagues.

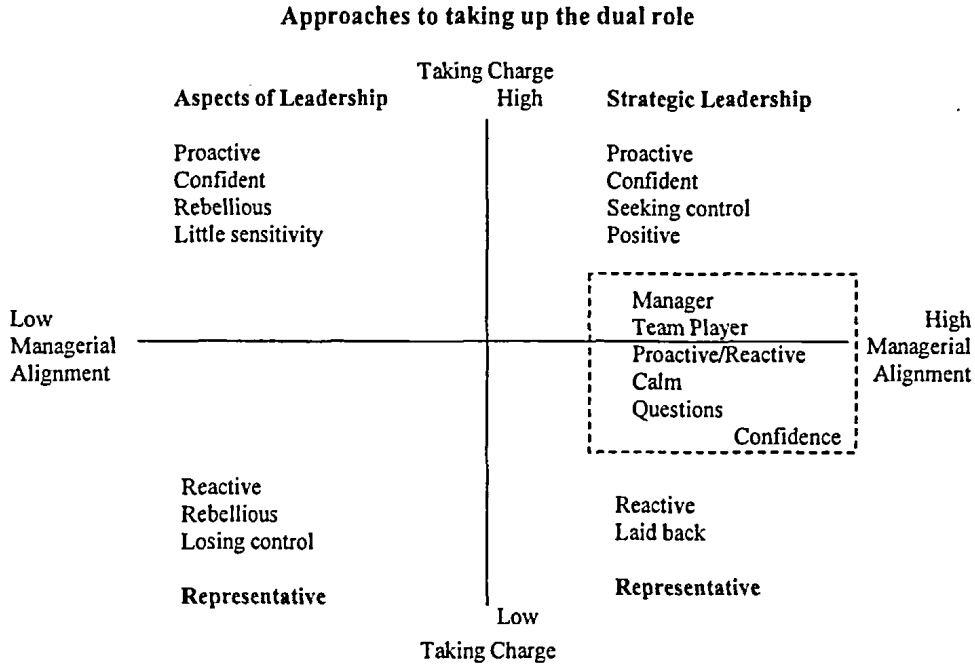
Some individuals are **low on the managerial alignment and low on taking charge.** It is clear these individuals were in a representational role and low on the taking charge dimension. They saw themselves acting purely as a communication channel between their colleagues and management and were often *'just doing their turn'*. The dimension of managerial alignment is less clear as there is an element of opting out and not getting involved in the complexity of the management role. These individuals do not display corporate behaviour. They do not align themselves with management and stay clearly with their professional colleagues. What is clear was that they are not high on managerial alignment.

A few individuals are **high on managerial alignment and low on taking charge.** There is no clear evidence of this combination in any one person. However, it applies to some individuals for part of their role. This is referred to earlier where individuals were both high and low on taking charge. There were individuals who were high on taking charge and articulated a high self-awareness and political sensitivity in the part of their role where they were managing their own specialty. They did not lose this when they moved to a low taking charge representational role for managing other specialties.

There are a significant group of individuals who are **high on managerial alignment and medium on the taking charge** dimension. These individuals who are one step removed from the high on taking dimension and take up the role with more moderate behaviour. They articulate a listening, questioning and flexible approach with a more calm style than those described as high on taking charge. Their approach can be highly politically astute.

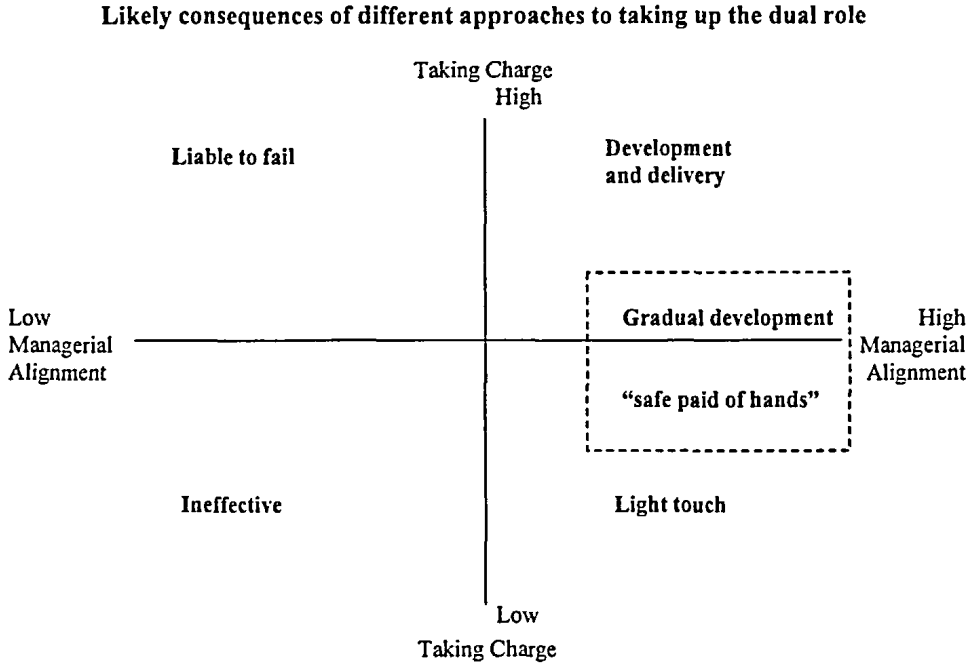
These dimension are illustrated in Fig.5.1 below. The figure shows the dimensions of taking charge and managerial alignment and plots the approaches associated with the first five contrasting themes. The themes associated with the dimension of managerial alignment impact on the approaches to taking charge.

Fig. 5.1 Approaches to Taking up the Dual Role



The approaches are shown to have different consequences. These are shown in Fig. 5.2 below. Those who are high on taking charge and low on managerial alignment are most likely to fail due to their lack of sensitivity blocking their success in implementation and also their ability to learn from the experience. Those who are high on taking charge and high on managerial alignment are likely to succeed in shaping the development and delivery of their area of responsibility. The group who are moderate on taking charge and high on managerial alignment make gradual progress with sensitivity. The individuals who approach their role in part on high managerial alignment and low on taking charge adopt a light touch in representing others with sensitivity. Those low on managerial alignment and taking charge are likely to be ineffective and have little input or awareness of their impact.

Fig. 5.2 Likely Consequences of Different Approaches to Taking Up the Dual Role



To illustrate these dimensions individual profiles were tested against the dimensions. The following extracts from individual profiles are referenced as shown in chapter 3 and show where they align on the dimensions. This followed by a map of the spread of profiles around the dimensions which are representative of the sample as a whole.

High taking charge/High managerial alignment (3B)

This is an experienced individual who has the largest directorate, Medicine, and although he talks of being overwhelmed, he appears not stressed like some of his colleagues. Although he has a rather relaxed manner he displays a confident style and clearly takes control of his directorate. He places an emphasis the need for verbal communication. He takes a corporate approach and is full of respect for the senior managers.

Sometimes Lord knows where you are going.

It doesn't actually get me down, it gets others down, I have done it for so long. Some of the dealing with my junior colleagues is to tell them it's not that difficult.

You need to be very tactful with colleagues they all have different views.

One of my roles is to keep my colleagues talking to each other and therefore keep them talking to the nursing staff who have a hell of a job to do.
You have to keep talking to people, cajoling them, solving problems.
You have to sell decisions to your colleagues that might not benefit the directorate, that can be difficult.
No.3 Site B – Medical Specialties, Consultant 21 years, CD 4 years.

High taking charge/High managerial alignment (4A)
This individual takes a leadership role and acts strategically when he describes some of his achievements. He leads with a confident style and is a proactive communicator and talks in the first person.
. . . fellow consultants are great motivators, they are generally full of drive and want to move things forward. They don't like the financial problems, but I have to make clear the reasons why I make decisions . . . some will disagree and I have to make them realise what they are seeking is unachievable in the short term at least.
I believe you need a confidence in your team, but do not allow yourself to be sidelined.
I believe I am approachable and people do not see me as an ogre. That is an assumption, but a lot of people do come and talk to me. Most of my communication is word of mouth. I am not terribly good with the paperwork.
I do change my style sometimes when discussions are going nowhere and I stop a meeting.
I have started to change things and would like to see some things through before I step down or up!
No.4 Site A – Surgery, 11 years a consultant, 4 years a CD

High taking charge/low managerial alignment (8B)
This example from the individual quoted earlier (concerning the standardisation of the use of prosthesis) who initiated change by changing the budget he allocated to colleagues. He expected them to change their behaviour as a result and was surprised when they did not. This is an individual who takes charge, but appears to be low in understanding the management role and lacking in ability to act astutely and manage his colleagues. He shows a fighting spirit.

I would never have said things like adjudicating and sorting out grievances would come my way, but you have to get on with it.
You tend to be in the first line of attack.
The first year I did achieve a lot and changed a lot, but there was a heavy penalty, because there was a lot of resentment generated.
It's bloody mindedness, they (clinical colleagues) don't like being told what to do ... you are never in a position to dictate to them.
Now, I might be a bit more stroppy when agreeing to the management's objectives which are largely political and not always putting the patient first.
No.8 Site B – Trauma and Orthopaedics, 10 years a consultant, 3years a CD

Moderate to low taking charge/moderate to low managerial alignment (2B)
This individual had tried to deal with some disciplinary issues with a colleague and found it extremely stressful. He felt there was more to be done in the role, including further disciplinary issues but he has chosen to resign from his CD role. Although a consultant himself, he was surprised by the power of his colleagues to successfully resist and avoid, what he felt are valid serious issues. His family believed the stress in the role had changed him and he felt he could not and does not want to continue.

This experience had brought disillusionment.
They expect you to take responsibility for the department without providing you with the where withal to provide a safe service.
You are expected to take more and more responsibility for more and more shoddy practice.
His own morale was low.
I see myself as a go between clinicians and management. I am trying to manage, but really feel unsupported. We don't really seem to be involved in major corporate decisions.
He acknowledged the fact that as a relatively recently appointed consultant it was difficult to 'manage' his colleagues
No. 2 Site B – Anaesthetics, 2 years a consultant and 1 year a CD.

Moderate/high taking charge/high managerial alignment (7A)

This individual seeks to understand how she can perform better in the role. She appears to have developed her thinking about the broader possibilities in the role. She takes a team approach and brings a caring attitude to the role.

I initially saw it as a support role and I now I think it is a lot more than that.

In part it's direction and innovation. It's strategy as well as support. It is not just about getting the building blocks ... I see our horizons can be broader.

I have no role model for the job. I would love to have had a shadow period because I was very much in the dark. There is a kind of lack of confidence, but I am more confident now.

I am going to give my staff the security of not having a guilty conscience of all the work that is not being done.

I need to hear what is being said in the department to voice an opinion, otherwise it would be a personal opinion rather than a spokesman for the department. You have to listen and take ideas on board.

*Non-medical staff talk to me freely in the coffee room where I am ***** (first name).*

I do not attend their communications as I think if I was there it was alter what was said.

No. 7 Site A – Radiology, 10 years a consultant, 5 years a CD.

Low taking charge/Moderate managerial alignment (6A)

This CD was always willing to share the ideas he had about his own approach and appeared clear it was a representational role. He also readily talked and reflected on his own style.

It is an important role to represent you colleagues

I think they feel I speak fairly for us all

You must not try and take over the administration

It is important not to dabble in the technical side of management

We are worried that other parts of the hospital might take resources from us

Getting us to do this job is a cheap way of getting us involved

You get all sorts of things thrown at you, I probably could do it, but perhaps not quite as confident (as the clinical role*).*

I'm a cautious, reserved person, because I tend to sit back and think about things.

I tend to listen more, go away and think about it, worry about it, mull it over. I am not a good front person.
I worry about, again insecurity, are you fulfilling what people want.
No.6 site A- Childrens and Womens Services,12 years a consultant and 3 years a CD

Low Taking charge/low managerial alignment (8A)

This individual described his role as representational, he says he tried to stay calm, but seems less laid back than his colleagues in a representational role and does not feel in control. He tended to blame the system and his colleagues at times. This approach and behaviour could be described as losing control or becoming a victim. He was very aware that he does not want to upset colleagues as he will soon return to being a consultant with a colleague in the CD role.

It is difficult to make them understand unless you get really unpleasant with them (of GPs).
I react with sympathy most of the time (to colleagues), but sometimes I get pissed off with them. My sister says a more grotty, unfriendly, miserable group of people it is difficult to consider (referring to colleagues in his own area of responsibility).
It is extraordinarily reactive like you wouldn't believe.
I think we act as a rubber wall and a sounding board, I don't particularly like this part of it, to act as the dog to be kicked, often people just come with gripes about intra colleague relationships.
There have been things I would have insisted on, but I have little support.
It feels very threatening, he starts off being aggressive, then there is a chit chat, . . . then there is how you are going to control workload. Then something nice to end, you know you've just sunk the ship with all hands lost, but he sends you out with a smile (The Chief Executive and the review process. This is the only person who referred to this Chief Executive's style as threatening.).
No. 8 Site A –Pathology, 11 years a consultant and 4 years a CD

Moderate and low taking charge/high managerial alignment (9B)

This individual takes moderate charge of his own specialist area where there are several sub-specialties, but resists takes little charge of other areas which are still within his portfolio of responsibilities. This is a determined person who does all he

can to remain the only consultant in his specialty. There is some caution here because of the temporary nature of the role.

Change is difficult and enormously complicated when it involves consultant colleagues.

I am a great believer in evolution rather than revolution. There is always a bit of a trade off. If I come up against a brick wall I don't push too hard. I am not a career NHS manager. I may have to live for another 20 years with different CDs.

I will push very hard if there is an issue of patient safety or if someone is mal treating another member of staff.

One of the nice things about working in this unit is it works as a very happy family.

I like to have a hands off approach to management. There are senior clinicians and nurses and technicians who now how to run their own areas. (He takes less charge outside his own 'family'. This places him on two places on the dimensions).

I am actually quite lucky here the senior management are very, very good. There is a lot of mutual trust and respect.

No. 9 Site B - Head and neck services, consultant 5 years, CD 2 years

Moderate to low on taking charge/moderate on managerial alignment (6B)

It is more difficult to place this individual on the dimensions. He was just *'taking his turn'* in the role. He acknowledged he was in charge, but showed little motivation for the role. He was not confident in the role and cautious in his approach. He had long standing personality problems with his colleagues. It was clear he would rather do his clinical role than undertake some management tasks.

I like to be around the show, to show that I care, that somebody cares.

Somebody has to be the final arbiter, I guess that has to be me.

There has to be some leadership in direction. We meet as a cabinet and the consultants have a large input.

Staff need to know someone is in control.

I meet regularly with Margaret and we discuss a bit of strategy

We are a fairly hum drum unit. We deliver babies and take out uteruses.

We've had some difficulty getting funding for the more exciting slightly frivolous more interesting stuff which is important to attract staff and keep the registrars happy.

The (management) problems are trickier. Take the colposcopy service. You gets lots of blurb sent down that lands on your desk and you have to try and address the

standards and make sure you deliver a service to those standards. That's much more difficult than doing 10 terminations.

No. 6, Site B – Obstetric and Gynaecology, 16 years consultant, 3 years CD.

Here it is necessary to mention the difference between sites. The role at Site C was called a Senior Lead Clinician (SLC) and described in job descriptions as a strategic leadership role. It differed, however, from sites A and B as there was no responsibility for staff or budgets, other than small medical budgets. There were many similarities in how the role was taken at all three sites, but the language of being a representative was far stronger at site C. However, a representative at site C was seen as someone who was proactive, confident, sought control of the situation and was positive, but was a communication channel with a belief of having influence strategically. This profile could not be plotted on the dimensions as his different responsibilities reduced his capacity to 'take charge'.

The following example is from site C.

Does not align with the dimensions (1C)

I must represent my colleagues views on matters of surgery.

I must not let my personal thoughts interfere with this, that would be incorrect.

I pass information up to them they pass information to me.

When someone (on the board) comes up with a daft idea clinically, I can say 'That's a daft idea and that won't work'.

My role is to look at the operational implications of changes.

I don't actively get involved in the ongoing problems unless the general manager asks me to.

You need confidence in your colleagues.

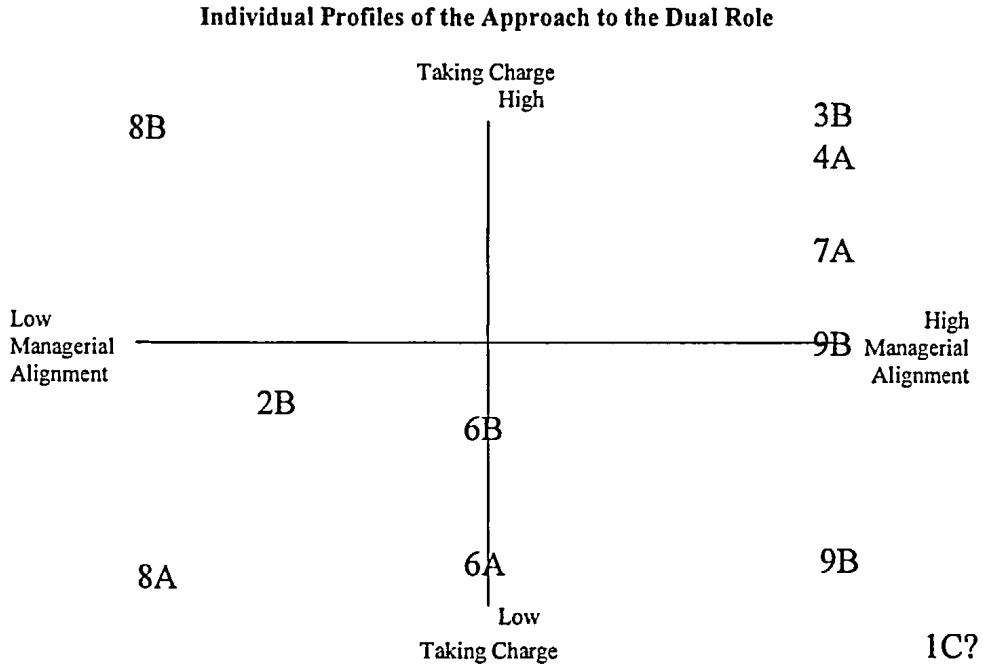
If your colleagues won't back you and it really came head to head, I think you would probably win the day.

This is a role which influences strategic decisions, but enables you to keep out of the budget responsibilities. I can stand up for the patient.

No. 1, Site C – Surgery, 22 years a consultant, 2 years SLC.

The individual profiles outlined above are plotted on the dimensions in Fig. 5.3 shown below.

Fig. 5.3 Individual Profiles of the Approach to the Dual Role



Note 9B appears twice as explained in his profile

5.2 DIFFERENCES BETWEEN THE SITES

This research is concerned with how individuals take up a specific role. It does not address the link between how the role is taken up and the organisational context. However, during the interview process differences were noticed. These were evident as the interviews were undertaken site by site, the tapes were listened to and analysed by site so differences were evident to me as the researcher. The method of coding the base data allows the differences to be reviewed by site. These differences are not evidenced here by site or explored in any detail, attention is drawn to the idea of contextual differences only for the purpose of highlighting issues for future research.

All three sites have a commitment to the involvement of clinicians in management. However, at site A there is a much stronger feeling, than at sites B and C, that this is a strategic and a general management role. Also, there is stronger sense of responsibility than that expressed at other sites. Almost all the CDs talk about some form of stress in the role. At site B the issues of managing colleagues is the issue at the top of most individual's agenda. Views are expressed that this is a strategic role, but here more individuals talk about it being a management or representative role. Site C is an interesting comparison and chosen as the structure is different and yet the role is still described as a strategic leadership role in job descriptions and by the Chief Executive and Human Resources Director in my discussion with them concerning access for the research. The SLC role at site C is described by them as a leadership role, a managerial role and representative role, but in reality is an advisory role with no general management accountability. Feelings of a shared responsibility for solving problems are evident, but there is no actual accountability for the problems to be owned by the SLCs. The SLCs act as a communication link between the consultants, the senior management team and the board. They were introduced to improve relationships between consultants and management. The structure is said to be the Trust's version of the clinical director model. There is one admission of enjoying the influence that comes with the role which is referred to as *'SLC muscle'*, but there is no wish to take on budgetary or staff responsibility. The SLC's comments in the analysis do not reflect a high level of respect or regard for management. This is in contrast to the views held at sites A and B where the views of senior management are generally very positive.

6 FINDINGS AND DISCUSSION

6.1 INTRODUCTION

This chapter describes and interprets the research findings. These are discussed with reference to the literature review and the contribution this research is making to existing knowledge. Some findings and interpretations from earlier research are either confirmed or challenged.

To set this chapter in context the questions are revisited.

Research questions

Primary question

How do clinical consultants take up the dual role of strategic leadership and clinician?

Subsidiary questions

1 How do individual's describe the professional and the strategic leadership elements of the dual role?
2 What similarities and differences are seen between the two elements of the dual role from the analysis of question 1?
3 How do individual's understand what is expected of them in the professional and strategic leadership elements of the dual role?
4 Why do individual's take up the dual role?
5 What are the main challenges of the dual role, where is there conflict and where is there congruence?
6 Do individuals actually see the two elements of the dual role as separate or is the dual role actually seen as one role?
7 What similarities and differences do individuals believe exist between the professional and the strategic leadership/management elements of the role?

Responses to address the primary and subsidiary questions were analysed and are reported in chapter 4 and 5.

The analysis has provided an in depth account of the perceptions of individuals who perform this dual role. The frameworks used to structure to parts of the interviews provided individuals with an opportunity to give a detailed account of each element of the dual role and discuss the meanings they put on it.

It does not take too much understanding or research to appreciate that the clinical role is different from the strategic leadership role. Before this study we could have predicted that how the dual role is taken up and made sense of by individuals would vary. This was reinforced by earlier research. These variations would be the result of a range of influences including the individual's career history and experience, their personality, their motivation for taking the role, the type of management role and the context of the role. While acknowledging the complexity of the dual role and the influences on it, this was not a search for universal solutions, right or wrong or better or worse ways of performing the role. The research set out to develop a deeper understanding of the dual role. It is confined to understanding the perceptions of the individuals in the dual role.

The fieldwork for this research has explored one of the most important roles in the largest organisation in the western world. Structurally the role is at a critical boundary between service delivery and the management of the National Health Service in England. The fascination for me about the role is that the individuals are senior doctors who practice at the 'coal face' of service delivery in their clinical role and, at the same time, are asked to contribute to the strategic leadership of their organisation in their management role. These two elements form what is referred to in this study as the dual role.

There is some common ground across the literature domains considered in this study which reinforces the importance of this research. Examples of this are the strategy and leadership researchers where an emphasis is placed on the importance of the behaviour of key individuals in organisations (Bartlett and Ghoshal, 1995; Bennis, 1994.). Research into the role of clinicians in management leads to the belief that the role of the clinical director is potentially of great significance in enhancing the organisation's strategic management capability (Harrison and Miller, 1999). This belief links to the importance of key individuals in the organisation and the concern

not to marginalise clinician managers (Schneller, 1989). Leadership researchers and those using a role theory perspective recognise the positive significance of sharing and meeting expectations within the workforce (Gabarro, 1988; Kotter, 1988; Tsui, 1984; Willcocks, 1996). One objective of this research seeks to understand how individuals do or do not consider the expectations of others.

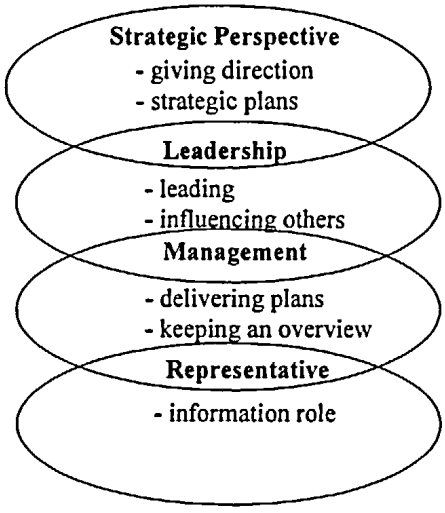
6.2 FEATURES OF THE ELEMENTS OF THE DUAL ROLE

At the first stage of the analysis an overview of the strategic leadership, or as it is more generally referred to the management role, shows a range of descriptions. The roles were described nationally and locally in job descriptions as broadly similar and yet they were described by individuals using a mixture of terms.

Fig. 4.1 shows some individuals described the role as a strategic role. Their descriptions included the language of strategic planning where they were involved in areas of strategy, strategy formulation and implementation (Andrews, 1971, Huff and Reger, 1987; Johnson and Scholes, 1999). Descriptions also covered leadership with the role of leading others and influencing people (Chemers, 1993). Others described the role in more managerial terms of delivering plans and keeping an overview of what was happening. Others were more distant from any decision making and described the role as passing information, primarily between senior management and their consultant colleagues. Descriptions of what managers do embraces many of the terms associated with decision making and interpersonal roles (e.g. Mintzberg, 1980, Hales, 1986). In my research, although there was some overlap in the areas described above, there was a 'hierarchy' of perspectives as depicted in Fig. 4.1.

Fig. 4.1 Overview of the CD/SLC Role

OVERVIEW OF THE CD/SLC ROLE



In contrast an overview of the professional role was a clear description of tasks associated with their own identity. "I am the . . ." was the clear and consistent view. This alignment of the role with their own identity depicts the clinical role as a vocation giving a stability of personality and a career as a vehicle for self-realisation (Arthur et al, 1989).

These first impressions provide a starting point to understand how the individuals in this research take up the dual role. The findings add to the existing understanding of how the dual role is taken up by learning from individuals in some detail how they experience both elements of the role. Earlier accounts of the clinical director role have not put together a sample of individual's accounts of their experience in both elements of the role. For example, with an understanding of the NHS Fitzgerald and Sturt (1992) acknowledged, what they referred to as, some specific hurdles (section 2.2.2) to be overcome for consultants taking on a dual role. The hurdles are ones that could be readily seen by researchers working in this area as being issues for many consultants. They are not challenged, but are added to by evidence in this research. My study highlights the difficulty of making statements about the dual role which apply to all individuals. There are diverse views across the population, these do form patterns, and statements can be made about groups of individuals and sometimes the views of the majority, but there always appears to be exceptions. This makes it important to understand the individual and their context when choosing them for the role and seeking to harness their commitment to drive the organisation forward. Evidence of the differences between the specialties, explained later in this chapter (section 4.12), shows where even the seven broadly defined hurdles outlined by Fitzgerald and Sturt do not apply to all specialties and individuals. For example, the hurdle of developing skills in team building and teamwork (section 4.12). In my study this is viewed, by those in the sample, as already well developed in pathology where teamwork has been seen as essential for many years. Examples are given of a great self-awareness of where teamwork has and has not worked and the reasons for it. In another specialty, anaesthetics, where teamwork is seen to be important, a team spirit is not in evidence (section 4.12). Great stress was felt by an individual who was a clinical director for the anaesthetic service. He could not understand the uncooperative attitude of his colleagues. These two examples highlight the problem

of generalising about the dual role. However, there are patterns in how individuals see elements of the role that allow our understanding to progress.

A summary of the features of the elements of the dual role are straightforward for the professional role, but less so for the management element of the role. The higher level of abstraction in section 4.5 summarised the features in Table 4.10 as follows: -

Table 4.10 Summary of the Dual Role

CD/SLC Role	Clinical Role
The role is not well defined	Part of individual's personal identity
Vague understanding of the content of the role	Clarity of role content
Concerned with communication and maintaining relationships	Clear responsibilities
Few clear boundaries	Highly specialist and communication is focused
Confidence levels differ	Confident in their capabilities in the role
Little or no training	Approved to perform the role through long training
Short term	Long term

These features are illustrated through the quotations below and show the vagueness and lack of clarity and training in the management role make the role feel quite stressful for many of the individuals. This is not anything unusual, the fragmented nature of the management role with its many communication episodes is well understood (Mintzberg, 1973; Hales, 1986). In contrast, the perceived value of the professional role and confidence shines through. Actual quotations make the elements of the role come alive and give a sense of how the role is experienced in the individual's everyday lives.

Representative quotations of the features of the management role are as follows: -

- *There is little clarity about the role.*
- *You do it how you want to.*
- *You rely on good support.*
- *It is based around meetings.*
- *There is a lot of communication, talking and paperwork.*

- *You can feel on shaky ground in the role.*
- *It can be quite stressful; it is a different stress to the professional role.*

Representative quotations of the professional role are as follows: -

- *There is a sense of personal identity associated with the role.*
- *It is work that really counts.*
- *There is role clarity.*
- *It is a practised and familiar role.*
- *Time spent is well justified.*
- *Work can be done efficiently.*
- *The role is planned and well focused.*

The differences in how the two elements of the dual role feel can be seen from the summary and the quotations. The professional role is experienced with a sense of individualism, confidence and purpose. The management role is ambiguous and less bounded. Some individuals cope and sometimes enjoy the ambiguity and poorly defined management role, others are frustrated by the lack of focus and perceived waste of time in the myriad of communications.

With this understanding of the dual role developed from the analysis in chapter 4 section 4.4. we move on to discuss the path often followed in a professional clinical career and a management career in the NHS. The management of the boundaries between the elements of the dual role are discussed later in this chapter.

The element given the title of a strategic leadership role, but often referred to in broader terms as a management role in this study is relatively new in organisational terms. As stated in chapter 1, the role is a consequence of the change in philosophy in the NHS introduced by the Griffith's Report (1983). A key feature of this report was the involvement of clinicians in management. Clinicians were to be embraced in a general management structure. This was a departure from the old 'silo' structure where professionals reported to professionals up though the hierarchy.

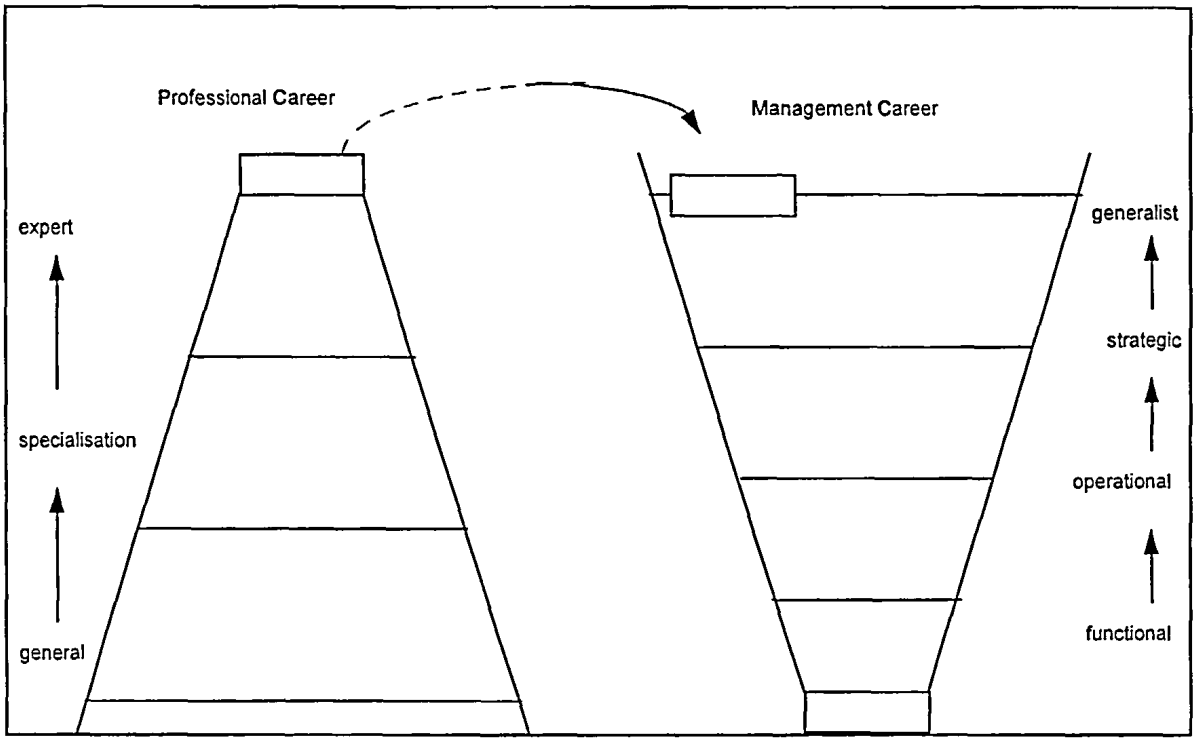
In broad terms there were two paths or routes to senior and influential positions the NHS. These were:

A. The pursuit of a management career which started from a generalist perspective, or one which was developed through a functional route to a generalist where knowledge and skills were acquired which increase in scale and scope as the career develops. In the NHS many senior managers came through the national management training scheme and developed generalist careers straight from university.

B A professional career in the NHS was, and still is, associated with the core business of the organisation. These are careers where clinicians (doctors, nurses, physiotherapists etc.) rise through their own professional hierarchy. Their career usually follows three years or more of professional training that is applied and developed through employment and further study. In the case of a doctor reaching consultant status this period has been around 15 years. Professional training usually starts as a general training in that profession. The career route often narrows and takes a specialist route from which an area of expertise is developed. In the NHS, this resulted in climbing a professional hierarchy. Some management experience could be gained through managing people in their own profession, but a professional and general management role was not open to clinicians in the pre mid 1980s organisational structures. Consultants could and still can choose to rise through a professional route by developing their teaching and research and seeking professorial status. These posts are usually only available at large metropolitan teaching hospitals.

These two career routes are represented in Fig. 6.1. The professional career develops into an expert role with a narrowing in the focus of the role. Whereas, the management career is one which progresses by taking a broader perspective as the role develops. The image depicted in this figure is described below and emerged during the analysis of the data.

Fig. 6.1 The Path to Role Duality



Weight, 2000

The consultant who takes on a management role is jettisoned into a senior level position with little, or more likely, no preparation. There is little evidence of any development being offered in this research with many feeling unsure what is required. Although he or she may have been in the organisation for many years, often he or she has little understanding of what happens outside their own small area of expertise. From the data we find that some CDs see these characteristics in their colleagues. With the learning from their own history and experiences, they are asked to add a quite different role to their daily working lives. Some individuals see similarities between the two elements of the role, but the majority do not. They continue working as a highly skilled professional and take on board a much broader, ambiguous, and often poorly defined strategic role. This is the path to role duality and it is understanding the challenge of taking up the dual role that is at the heart of this research.

How is the leap into the dual role experienced by individuals? The leap is sometimes articulated in the interviews as resulting in frustration and stress. Others appear to manage the change with understanding and a pragmatic approach. The features of the elements of the dual role summarised earlier in this section and the differences

between them explored in section 4.9, endorse the view of the professional role as one which is focused, clear and seen from an expert perspective. In contrast, the management or strategic leadership role is broad with less well understood processes and outputs.

The choices available to those in the role allow individuals to shape the role as they wish. Role theorists would assert that individuals are often governed by their awareness of the role and by the expectations others have of them in a role (Biddle, 1979). While there is some evidence in my study that individuals consciously admit performing to conform to others' expectations, this is rare and sometimes done to gain freedoms. Stewart (1982) placed emphasis on choices in the role as the key element for managers to accommodate conflicting expectations. Effectiveness in a role is argued (Tsui, 1984 and Willcocks, 1996) as managing the expectations of the role set. In my study, exercising choice appears to be related to a personal preference of how to perform the role, and importantly how to cope in the role. Little thought is consciously given to the expectations of others, as shown in Table 4.13, section 4.8.

The challenge of the leap from professional role to combining it with a strategic leadership role cannot be underestimated. Dawson et al (1995) found that many CDs felt catapulted into the job and daunted by the extent of role. As individuals in my study described both elements of the dual role, differences became clear which went to the very heart of how both roles are viewed.

These features are captured in Fig. 6.1, above as a neat, bounded, focused professional role swimming in a pool of little understood generalist uncertainties.

6.3 EXPECTATIONS IN THE DUAL ROLE

In viewing the dual role though the lens of role theory a new perspective is taken by considering both elements of role. Here individuals are performing two roles and the 'social scripts' (Biddle and Thomas, 1966) for these elements are quite different. Some see the elements of the role as integrated whilst others see them as separate or segmented. However, quite different pictures are painted of the elements of the role in this section. Findings here are from the understanding of how individuals perceive the expectations others have of them. These are detailed in sections 4.5 and 4.6 and the summary repeated below in Table 4.13.

Generally the expectations others have of the CDs and SLCs were not consciously considered by most of the individuals, but the question was found interesting and caused some soul searching particularly in the management element of the role.

Table 4.13 Summary of Approaches to Managing Expectations in Both Elements of the Dual Role

Expectation of:	Approaches/Expectations in the CD/SLC Role	Approaches/Expectations in the Clinical Role
Overview	Intuitively reading the message A passive approach No thought given to others expectations	Clear cut, no debate
Chief Executive	Muddling through Being pragmatic No news is good news Linking to role clarity Using the review process Experiences - Positive - Negative - Cynical - Fear -Token involvement	Little clue Measured through complaints

CDs and SLCs	Protect their survival Mutual support	Not mentioned
Consultants	Problem solver Communicator Being a communication channel Listening to the individual's view Being a mediator Using caution and not asking about expectations Using your own experience	To be clinically competent To achieve results Building positive relationships and improving relationships Learning together
Junior doctors	Not mentioned	To help them and teach them
General Manager	Having regular contact Giving support Giving freedom	Not mentioned
Nurse Managers and Nurses	Little contact Close contact, proactive approach Appreciation of power distance	Unsure what they expect Leadership and patient management and advice Own professional standards.
Clerical and other professional staff	Little or no understanding	Not mentioned
Chairman an Trust Board	Little understanding	Not mentioned
Health Authority	Not held in high regard Not mentioned	Not mentioned
Patients	Probably unaware of the role	Cared for competently Information and advice
External relationships	Little contact	Not mentioned
Themselves	Fulfilling her own criteria	Own professional standards

6.4 MOTIVATIONS FOR TAKING UP THE DUAL ROLE

The motivations for accepting the dual role are varied. They divided into two categories which polarise around those who have chosen or been chosen for the role and those who have accepted the role reluctantly. The Chief Executives influence is dominant with the views of the consultant body taken into account.

Their motivations are summarised as follows:-

Positive acceptance	Reluctant acceptance
Chosen by the Chief Executive	*Asked by the Chief Executive*
My colleagues chose me	*My colleagues volunteered me*
It was a new challenge	*It was my turn*
It was the right time	*The only one who would do it*
There is only me, it is an opportunity	*I was the only one my colleagues would accept*

The reasons may appear similar, but behind these are more detailed explanations that separate the willing volunteer from the dragooned recruit. For many these motivations drive the way they approach the role and their attitude towards it.

Most of these reasons have been evidenced in previous research (Burgoyne and Lorbiecki, 1993; Dawson et al, 1995; Cavenagh and Dewberry, 2000), confirming that in these samples time does not appear to be changing the motivations for taking up the role. The widely shared view that the Chief Executive plays an important role in deciding and agreeing who takes up the dual role appears, at least in this sample, to be a shift from the consultant body being the dominant influence.

6.5 DIFFERENCES BETWEEN THE PROFESSIONAL AND THE STRATEGIC LEADERSHIP ROLE

Differences between the professional and the strategic leadership elements of the role are obtained from responses to questions about each role and the individuals' own views of the differences. These are summarised as shown in Table 4.14 and follow the order of the analysis in section?

Table 4.14 Differences Between the Strategic Leadership (CD/SLC) Role and the Professional Clinical Role

No.	Focus	CD/SLC Role	Clinical Role
1	Type of role	Secondary	Primary
2	Area of responsibility	Broad	Narrow
3	Primary function	Managing Relationships	Undertaking tasks
4	Expectations	Unclear	Clear
5	Mindset	Management	Medical
6	Focus	Groups	Individuals
7	Capability	On the job learning	Training/experience
8	Delegation	Essential	Not available
9	Communication role	Peer/manager - Group	Expert - Individual
10	Influence	Cajoling, persuading	Respect – expert view
11	Problem solving	Disordered	Rational, logical
12	Decision making	Consensus	Autonomous
13	Results/Outputs	Not always clear	Easy to see
14	Corporacy	Expected	Little requirement
15	Learning and review	Unique situations	Able to replicate
			Weight 2000

Each of the differences in Table 4.14 are described below.

1 Type of role

The strategic leadership role is seen as secondary to the professional role. This is not surprising as medicine is their chosen career and not management. This is also a temporary role and usually only lasts for a few years.

2 Area of responsibility

In the strategic leadership role the responsibility is seen as broad at all three sites and at sites A and B encompasses a directorate with responsibility for business plans and staff and expenditure. Responsibility in the clinical role is seen as narrow with responsibility for their own actions and decisions. The scale and scope of the responsibility in the management role is seen as an important differentiating issue. The complexity of a role with a number of specialties other than their own is difficult. First, because individuals knew little about them and are not confident in managing them and second, because this is culturally alien for them. A strong characteristic of the professional career is the acquisition of knowledge (Carr-Saunders and Wilson, 1933; Goode 1969; Ovretveit, 1992). Consultants are used to giving 'expert' opinions based on their knowledge, they are not used to challenging or offering views on other colleagues' areas of expertise. For many, this difference is a source of stress which reveals the uncertainty and lack of confidence often found in the management role.

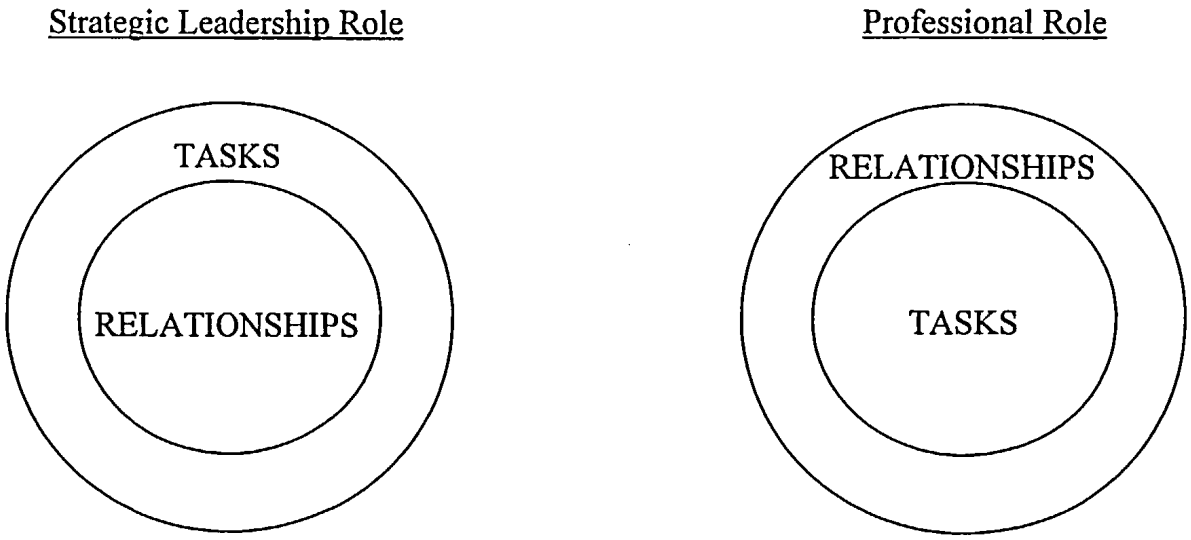
3 Primary function

Managing relationships is the key function to achieving the management role. For many, but once again not all, the most difficult relationship is the one with their consultant colleagues. This concurs with findings with other studies (Dawson et al, 1995; Buchanan et al, 1997; Hearing et al, 1999). Whether the role is seen as one of leadership, managerial or a representational role, there is a need to align the consultant body of opinion with the direction of the organisation. The clinical role is not devoid of the need to manage relationships, but at the heart of the role is the task to be undertaken.

A fundamental difference between the two roles is the focus on task in the clinical role and on relationships in the management role. It is the tasks of the clinical role that are described with ease and clarity. It is the tasks that are self evident, e.g. an out-patient session, reporting on pathology samples. At one level, the nature of these

tasks are understood by those in and outside the profession. What is actually done and how it is done is only well understood by the individual in the role and a few professional colleagues. It is knowledge where the strongest emphasis is placed on the nature of a professional career (Millerson, 1964; Goode, 1969; Moore, 1970; Torstendahl, 1990; Ovretviet, 1992.) The long professional training is centred around clinical tasks, it is achievement of the tasks that is rewarded. In contrast, the management role is usually described as a set of 'things to be done'. In this element of the role the most common of these is going to meetings and communicating with others. These activities are often described as tasks, however, what actually has to be achieved is far less well understood. This element of the role is primarily concerned with managing relationships which is a process that is difficult to articulate and rarely mentioned in the clinical role. Fig. 6.2 depicts this difference showing relationships at the heart of the strategic leadership role and tasks on the periphery and the reverse for the clinical role.

Fig. 6.2 Differences in the Primary Functions of the Strategic Leadership (CD/SLC) and Professional Clinical Roles



Weight, 2000

Many large studies in the leadership literature distinguish between those with a task style of leadership and those with a relationship style. In different studies, these terms are couched in slightly different language, but broadly demonstrate a similar concept.

Many are in the era when researching 'style' was particularly prevalent. Examples are: initiating structure and consideration (Stogdill and Coons, Ohio studies, 1951); production oriented and employee oriented (Michigan studies, Katz and Kahn, 1964); autocratic and democratic behaviour; (Tannenbaum and Schmidt, 1958); concern for production and concern for people (Blake and Mouton, 1964). While valid criticisms of large scale surveys are recognised, they have a value in identifying concepts and constructs which can inform research using different methodologies (Avolio et al, 1999). In the small sample of my research, links can be seen to concepts from large scale surveys. Managing relationships is fundamental to the concept of emotional intelligence where recent research (Goleman 2000) offers an understanding of the capabilities which contribute to different leadership styles.

The concept of seeing the task and relationships styles as differences in the primary function of the two elements of the dual role could be a contributory factor to the different ways the dual role is taken up. This may account for some of the views of the 'managerially mystified' who have to make the leap from the well practised and reinforced task driven role to one where relationships are critical.

In reviews of the research (Filley et al, 1976; Hamner and Organ, 1978) the participative (relationship) style was associated with greater satisfaction on the part of subordinates than the more non-participative (task) style. This could be seen to relate to the role theory perspective of effectiveness being linked to the meeting of others expectations (Tsui, 1984). In my study the managerially enlightened group, while not explicitly seeking to meet the expectations of others, do have a sense of the need to build positive relationships to create an ownership of decisions.

The emphasis on relationships reinforces research describing the fragmented and ad hoc nature of the role of the management role with its high level of verbal communication (Mintzberg, 1980; Hales, 1986). Hales (1986) commented that no study at the time of his research had compared managers to non-managers. My study goes someway towards this by comparing the views of individuals who take up the manager and non-manager role simultaneously. Viewing the two roles in one person eliminates many variables that would exist if two people were considered e.g. different personalities, different contexts.

4 Expectations

Looking at the dual role through a role theory perspective leads us to consider how the two elements of the dual role are shaped by who is seen to have an expectation of them in the role. It is acknowledged that how roles are taken up in society are also determined by social norms, demands and rules, and the individual's particular capabilities and personality (Biddle and Thomas, 1966). Aspects of personality are not the subject of this research. The other determinants are only viewed through an understanding of their professional career characteristics.

Expectations people have of individuals in the clinical role are thought to be known as the role is well practised and understood. Expectations in the management role are less clear, partly because the role is not clearly defined. The issue of power is seen to play its part here. In the clinical role individuals are the expert and have power through knowledge and status. In the management role they are more amongst equals.

5 Mindset

The issue of there being a medical mindset and a management mindset is raised when the idea of the dual role being one integrated role or two separate roles was discussed. This presented problems for some in the dual role. This is discussed further on page ?

6 Focus

The focus in the strategic leadership role is seen to be on groups of individuals. The broader focus is about populations of patients, staff and other stakeholders, whereas the focus in the clinical role is on the individual. This is seen to bring a difference to how issues are approached with some consultants feeling they have a strong advocacy role for the patient. These individuals feel a tension and stress when being called upon to make corporate decisions that conflict with the needs of individual or groups of patients. This tension is described further in point 14 below.

7 Capability

Here the contrast is vast with the clinical role being developed through long training and experience, with hurdles at every stage. The strategic leadership role is entered

into with the job description bringing scant clarity to what appears to be a rather nebulous set of responsibilities. Interviews for the role often seemed little more than a social chat and training for the role is very limited. Individuals struggle to understand what training in the role would be helpful, as little discussion has been entered into about what is actually required in the role. It is really a question of learning on the job with little guidance. There appears to be quite a paradox here, on the one hand consultants are told it is an important role and yet when they take it up so little of what is familiar to them about entering a role is present. The management role is a role full of ambiguity and for some it is a total mystery!

The four clusters of professional career traits (section, 2.5.3, Fig. 2.8) drawn from earlier research, provide an understanding of the medical career that is reinforced through the perceptions of individuals in this research. Perceptions of clinical work are seen as "work that really matters", "having status", being "intellectually challenging" and development in the role is via "a series of steps you progress through overtime with approval to move forward". The organisational independence created through the acquisition of professional knowledge and skills does not stimulate a movement of those with consultant status around the country. The independence this capability gives them is more associated with their autonomy and status in the trust where they normally remain for many years.

8 Delegation

The perception is there are people who are well qualified to do the management role and sometimes they have better skills at some of the 'softer' skills than consultants. Delegation in the clinical role is seen as not available because the consultant believes nobody can do the job better.

There is also evidence that time constraints alone make delegation essential.

9 Communication role

The nature of the key communication episodes in the clinical role is perceived to be primarily on a one-to-one basis whereas in the strategic leadership role it is primarily the group situation. In earlier research, the professional role is seen as predominantly working as individuals and concerned with the short term, the management role as

working with groups and concerned with the longer term (Burgoyne and Lorbiecki, 1993; Hearing et al, 1999). My research agrees with the former difference, but sees little evidence of individuals perceiving the second difference.

The communication role of the clinician is that of the expert. What is sought from the clinician is advice and opinion from an expert. Communicating in the strategic leadership role is with peers or people they manage or who are subordinate to them in the hierarchy. The nearest description of the perceived relationship with the executive is that of peers.

10 Influence

Influence in a clinical communication is an interaction where respect is expected for professional expertise. This style can be directive or seen as directive as often answers or solutions are sought. Influencing in the strategic leadership role is done by cajoling and persuasion, especially with consultant colleagues and this is a much longer process which requires different skills. Some find this slower route frustrating.

11 Problem solving

The clinical process of problem solving is one which is seen as rational and logical, positions can be stated from a professional perspective. Problems may not be solved, but options offered. The management process of solving problems of a strategic nature appears disordered by comparison. Arguments are marshalled often from incomplete information. Decisions may be politically driven from a national or local level and personal agendas not often understood. This disordered process with unclear results or outputs affirms the recognition that strategy is an "on-going, messy, incomplete process" (Huff, 1998).

12 Decision making

The view is that decision making in the strategic leadership role can be a long tortuous process as consensus is sought. Consensus is often seen by clinicians as the only approach when working with colleagues. Some feel the need to obtain 100% consensus, others implement decisions with a majority in favour.

13 Results/Outputs

Results and outputs from the clinical role are easy to see and sometimes this could be the case in the strategic leadership role. However, often the results from the time investment are less clear. Executive meetings are cited as an example where periods of up to 6 hours appeared to produce few tangible outputs.

14 Corporacy

Encouraging corporate behaviour in a strategic role, where individuals are responsible and rewarded for delivering results in a particular area of the business is problematic in many organisations. Rewarding individuals for performance in their own area of responsibility and then asking them to behave corporately and perhaps give up something for the greater good defies a rational logic. In the strategic leadership element of the dual role there is an understanding that corporate behaviour is expected. However, first there is little clarity about what behaving corporately actually looks like and second, for many, there is little desire to find out or take on any additional work or responsibility. For some individuals, a genuine interest in management drives them on and discussing the broader organisational issues at executive meetings is seen as a valid and stimulating role. For others, they see no reason or value in expressing a view unless they have an expertise in the area under discussion. In reality, they feel frustrated when people who are not an expert in the subject decide to offer an opinion. This is not a question of there being no reward for their corporate contribution, it is a different way of thinking. It is about not discussing issues outside your own area of expertise. Some admit to using the executive meetings as mental space to think. Scribbling notes in meetings is described as a behaviour designed to appear as compliance in the role, seeming to pay attention and listen.

The problems of behaving corporately are linked to those of implementing organisational change; the feelings of frustration with the system and not wanting to change with perceived political whims. Others think their reluctance to change is linked with their medical training and background, where there has to be evidence before change occurs. The final reason rests with a few who believed a reluctance to change is just 'bloody mindedness' on the part of their colleagues.

Further examples of the issues associated with taking a corporate perspective are given in section 4.13.

Previous research (Buchanan et al, 1997; Thorne, 1997) sees a corporate perspective as important and ownership of corporate decisions as long overdue (Dawson et al, 1995). This point may be difficult to achieve as several individuals in my study agree that being corporate is culturally alien behaviour for consultants. Burgoyne and Lorbiecki (1993) may be arguing a similar point when they state that for the CD model to be sustainable, a way of reconciling medical need with available resources has to be found elsewhere in the system. It is the tension between the needs of the individual patient versus the population as a whole that can create an internal conflict for the individual in the dual role. Earlier research (Ham and Hunter, 1988) highlighted the stress caused by such conflict.

15 Learning and review

My research does not set out to consider how individuals learn. However, an unexpected and new insight is the perception of the differences in decision making and learning in the elements of the dual role. The analysis revealed explanations of how learning can take place relatively easily in the clinical role as it can be replicated time and time again, often with exactly the same information. This is more than just saying individuals have experience and are practised at the role, it is about being able to revisit and review decisions. This replication allows individuals to check their understanding and the understanding of others of particular decisions. This could be reviewing a pathology slide, an Xray, a patient with a chronic disease. In contrast, many circumstances in the management situation are seen as unique, for example, a situation when an individual is considering how to obtain consensus for an idea in a meeting or group situation. The variables would come together at a point in time in a way that would be difficult, if not impossible, to replicate. Therefore, the learning from one experience could not necessarily be transferred to another situation. It is the realisation and acknowledgement that it is the uniqueness and transient nature of the experience that differentiates management from the clinical role. This belief contrasts with the 'management is common sense, just do it' approach.

This insight brings us back to the centrality and the primary function of the two elements of this role. What is it the individuals are learning about? It could be argued that those with direct patient contact might see a uniqueness in every relationship with a patient. But it is not the interaction that is central to the role, this is not what the training and apprenticeship is about. It is the diagnosis and treatment, that is central to the role, that is what really matters to a consultant. In contrast, what is central to the strategic leadership role is the communication, the interaction between individuals and groups. It is the ability to harness the energy of others to deliver results that is at the heart of the role, not the quality of the business plan or policy documentation; others can, and often are, delegated to do produce these. It is learning to take up the 'softer elements' of the management role that is the real challenge for many individuals.

Concluding comment

The differences between the two elements of the role described here and shown in Table 4.4, of this section have not been expressed in a similar way in previous research into this role. The differences expand on the picture of a much clearer professional role than the broader strategic leadership role seen in earlier findings. Links are shown with the research reviewed in chapter 2.

6.6 SIMILARITIES BETWEEN THE PROFESSIONAL ROLE AND THE STRATEGIC LEADERSHIP ROLE

Similarities between the professional role and the strategic leadership elements of the dual role are less evident (Table 4.15). A few individuals feel there are no similarities. The following similarities are often the views of one or just a few individuals. Responses are expressed as the result of a direct question about the similarities in the role.

Table 4.15 Similarities Between the Strategic Leadership Role (CD/SLC) and the Professional Clinical Role

Similarities Between the Two Elements of the Dual Role

- The dual role is merged into one.
- Leadership and a presence is required. You have to be there for both roles.
- Listening and knowing when to act are skills for both roles.
- Consulting and directing are styles used in both.
- Delegation can occur in both roles, but for different reasons.
- Intuition is required for both roles.
- Accountability and loyalty.
- There are targets to be met.
- Emotion is stimulated by successes in both roles.

One other important similarity is recognised from asking questions about each role. Choice is available to individuals in both roles. This choice often related to what they do and how they do it. In the clinical role there is clinical autonomy which brought freedoms and responsibilities. Some consultants could control the level of their work by deciding which patients to see and how many patients to treat. Other consultants are driven in part or in total by the demands of their colleagues. In the strategic leadership role individuals feel they had a wide choice in how they perform the role. There is a great deal of praise for the support they receive in the role, without this many could and would not consider doing the role. There is less agreement about the choice available to change and develop their area of responsibility. Here constraints are normally related to the lack of resources and not a question of a lack of authority.

6.7 THE DUAL ROLE – IS IT TWO ROLES OR ONE?

Given the differences and similarities between the two main elements of the dual role the following question is asked and discussed.

Is the strategic leadership role seen as a separate appendage tacked onto the clinical role or are these two elements integrated and seen as part of one role? This question is related to the question of where is there conflict or congruence between the roles. Also the concept boundary management and integrated and segmented roles (Ashforth et al, 2000).

Earlier research appeared to find some consensus amongst CDs with their identity in the dual role viewed as 'two separate lives' operating in a 'parallel reality' (Thorne 1997). In my research the above question produces responses that span the spectrum of views from the two elements of the role mesh together well, to the diametrically opposed view that the two elements are entirely different. By understanding these views in more detail it could be seen that individuals are talking about different aspects of the role. Areas of where the role is viewed as separate and areas where it is viewed as integrated are considered next.

6.7.1 Areas of separation

Strategic thinking

Strategic thinking as described here is something that individuals in many organisations find difficult, switching from the operational, the doing action oriented mode to the contemplative strategic thinking mode. Performing in this mode is especially difficult when there is pressure on the action and task driven part of the role. There is also a sense of recognisable and understandable achievement in performing the immediate, easily counted and measured duties. Switching between being action oriented and contemplative and reflective is seen as very difficult. It is difficult to do and easy to avoid as the outputs are less tangible. The strategic role is seen as a different way of thinking, you need space and time to think about the longer term implications of decisions and to consider the options. This thinking process could be about introducing new ways of working, new standards, new capital developments, considering some corporate issues. These issues would normally

affect groups of people. Included in the thinking process is the feasibility of implementing strategic decisions. The strategic role is usually linked to political priorities, money and budgets, it is about a few imperatives and some possibilities and options. This whole thinking process is said to require a different management mindset to performing the clinical role. As this is such a different way of thinking, for many it needed to be consciously 'switched on'. Separate personal and mental space is needed to do this. Some are able to do it in what is perceived as a boring meeting, but often creating this space encroaches on professional development and personal and family time.

This contrasts with the medical mindset of clinical role, referred to earlier, which is linked to individuals, to patients. The role is tangible and it has a sense of reality about it. The experience is there in front of you, it is immediate, it is a one to one relationship (even if the patient is not actually present or alive!). The procedure is about a person. Money is rarely viewed as a consideration, you decide and act.

Role theorists assert that behaviours are linked to contexts (Biddle, 1979). Individuals in the dual role could be viewed as being in several contexts - NHS, Profession, Specialty or the Trust. Possibly there is an unconscious recognition of being in two contexts for this part of the role.

6.7.2 Separation → Integration

Strategic negotiation and implementation

Negotiation and discussion of strategic issues takes place in a variety of settings. The nature of the discussion and role played by the CD or SLC varies according to with whom the discussion takes place.

The Executive

Discussions with members of the senior executive team take place on a one to one basis. This contact is sought by individuals who appear politically astute. The usual forum for discussion, which brings a mixed reaction from the CDs and SLCs, are the executive meetings. Here the strategic considerations and the operational implementation issues of meeting targets and budgets are brought into clear focus. Often the meetings receive a bad press from the CDs and the SLCs, they are seen as

too long and achieving little. In this forum, the negotiation and discussion is perceived to be amongst peers, with the recognition that collectively the clinicians are a powerful group of people and having them on board with decisions is important to the trust and certainly the Chief Executive. The CDs appear quite clear what the Chief Executive expects from them, that is to deliver the trust's objectives. How to deliver these is less well understood. In executive meetings most CDs and SLCs see themselves in 'management mode', with the professional and management roles being quite separate. Some see themselves in the management role, but also always there to represent the patient. It is recognised there is often a conflict between organisational needs and individual or groups of patients needs. This can lead to an inner conflict for those in the dual role.

Consultant Colleagues

It is at the stage of strategic negotiation with colleagues that the role starts to be described by many as a leadership role. Also, as individuals come into contact with colleagues during their clinical role some have a sense of an integration between clinical and the strategic leadership roles.

The perceived mismatch and difficulty around this relationship is one seen in the analysis of expectations. The perception of the consultant's expectation is that their colleague, now a CD or SLC, will be able to influence the executive to give them what they want, or at least see their point of view. In contrast, the perception of the executive's expectation is that the CD will keep the consultants in line and get them on board with what they want. Here there is a clear tension for the CD or SLC.

Some see they need to be active at all times gathering intelligence, being aware of behaviours and changes in behaviour, sensing the mood and attitude to issues of those around them. This awareness enables them to pre-empt resistance and build ownership for decisions. Those who see themselves in a representational role mention little about gathering intelligence in behavioural terms; they see the role as collecting the views of their colleagues. Here there is a much more rational linear approach of taking soundings and representing those to the senior management at executive meetings, and there is also reporting back to their colleagues after meetings.

This is the role described by the SLCs and the view of some CDs. This is more likely to be perceived as a much more empathetic style.

What is clear about the CD and to some extent the SLC role is that the relationship with colleagues is the most difficult one to manage. Consultants will rarely challenge the clinical views of their colleagues as the professional bond is strong and, as mentioned earlier, colleagues do not openly criticise each other. To switch from this situation to the CD or SLC role where a style of negotiation has to place which challenges the status quo and seeks changes, is often quite daunting. This requires well attuned interpersonal skills and respect from colleagues which normally comes with seniority in the role. Added to this, the CDs and SLCs usually feel on more shaky ground than in their clinical role as far as understanding the complexity of the management issues, although some do not see the role as complex. To admit they don't understand the issues, may seem like failure in itself, especially when often the issues are not technically complex, but seem sociologically difficult to achieve. It is also possible that if the issues are technically complex they may be outside the CDs area of expertise. These problems are quite stressful and place a particular strain on individuals who have a strong commitment to carry through difficult issues.

Negotiation with others

Negotiation on strategic issues by CDs and SLCs is very limited outside the trust. Internally interaction on strategic issues with other staff is either quite limited or virtually non-existent. However, as part of a leadership role some saw the morale of staff as an indicator of how well they were functioning in the CD role. These individuals aimed to create an atmosphere where there was regular and informal contact with a broad range of staff. Creating a climate in the CD and SLC roles where there is open and honest feedback on strategic and operational issues was a challenge. Here the history is important, in the clinical role the consultant had for many years been accustomed to very little dissent from his views on the way forward. The aligning of staff behind his or her views has been, usually justly, deserved by virtue of training, experience, status and power conferred on the role. For staff to see and respond to them in what they see as a different role could be a long process and may, as some individuals reflected, take as long as the time the CD or SLC is in post.

6.8 ROLE CONFLICT

Examples of role conflict, as defined by Kahn et al (1964), have been seen at various stages in the analysis and discussion. These have emerged from understanding the differences in the elements of the dual role and the perceived expectations others have of the CDs and SLCs. In taking up the dual role, new levels of complexity face the CD or SLC. Examples of the types of role conflict that is experienced are summarised below in Table 4.16 and examples shown in section 4.10.

Table 4.16 Summary of the Perceptions of Role Conflict

Area of Conflict	Outcome
Work overload	Results in behavioural change and stress
Strategic versus operational	The operational tends to take priority
Inability to respond	The planned nature of the clinical role can make it difficult to respond to the management role
Pressure to be fair	To clinical and management colleagues
	To the patient and the management needs
	To the Dean and management colleagues
Managing the tension	Meeting the pressures of the two elements of the role simultaneously

Many view the dual role as one which takes them away from their clinical role and their professional development which they regret. Work overload is seen as a major barrier to performing the dual role (Dawson et al, 1995). My research would agree with this, but pressure was felt more acutely by some individuals than by others. There was the least pressure at site C where there was no responsibility for budgets or staff.

Person role conflict (role violates values, conflict of priorities, difficulty in deciding which pressures to deny, part of role overload with inter-sender conflict). There is an internal struggle within the individual of meeting the conflicting demands of the two elements of the dual role.

Inter-role conflict (pressures associated with membership in one organisation are in conflict with pressures from membership in other groups). This conflict is experienced by CDs and SLCs who as members of the consultant body in the Trust are then seen to align themselves with management. The extent to which there is conflict between consultants and management varies from organisation to organisation. Part of the reason for introducing SLCs into one site is to improve relationships between consultants and management. Some SLCs and CDs feel the dual role had isolated them from their colleagues.

Sent role conflict (simultaneous occurrence of two or more sets of pressures where compliance of one would make more difficult compliance with the other). This is the first and most mentioned conflict for the CD and SLC. Accepting the strategic leadership role makes it more difficult to meet the pressures of the clinical workload.

This type of conflict is experienced by CDs and SLCs where the executive expect them to deliver targets and the consultants expect them to fight for reducing or changing the targets or obtaining more resources. This is the conflict between organisational/business needs and patient care which can be used as a smoke screen and mask for a reluctance by consultants to change.

Intra-sender conflict (different prescriptions and proscriptions from one member of the role set which are incompatible). This is a familiar conflict in the public sector that often comes from pressure to increase quality and reduce costs. There was evidence of individuals feeling a conflict between competing demands as a result of work overload, but this was not attributed to one person sending out conflicting demands. Pressure is more often attributed to the system or external influences.

The increasing clinical demands and the less familiar management requirements present very different priorities. From earlier stages of the analysis we learn that for some individuals there is no other person to undertake some of their clinical commitments. Others feel they cannot expect colleagues to take on extra work because they have a management role. Some do manage to shed a small amount of clinical work and one individual shares the remuneration for the management work with his colleagues. The specific nature of the clinical role and less tangible nature of

the strategic leadership role makes a comparison between time spent on one rather than the other almost impossible. The frustration of spending half a day in a meeting which appears to achieve little when clinical work is piling up is very stressful for some individuals. Achieving value for time is the critical factor.

Those who see the CD or SLC role as primarily one of manager or representative rather than a leadership role appear to experience less stress by distancing themselves from the conflict.

6.9 THE CHALLENGE OF MANAGING DIFFERENT SPECIALTIES

Differences in the specialties and how they are and can be managed are recognised by almost everyone. Managing specialties other than your own is seen as particularly challenging. Many acknowledge differences in their specialty and directorate and the differences faced by their colleagues. There are views that those specialties who have managed their own department for many years, e.g. pathology and radiography find the few differences to the past in the directorate model. It is believed a proactive team working in pathology brought efficiency whereas the lack of team work in surgery is seen to bring inefficiencies. Where work is done by an individual, e.g. reading Xrays or slides there is a flexibility that allowed CDs to play a fuller management role and, for example, attend management meetings at short notice. The larger the directorate the more difficult it is to manage and most felt managing services outside their own specialty are particularly difficult. Behaviour can be different when managing their own specialty to when they are managing other specialties.

The individualistic nature of specialties like surgery make corporate behaviour quite difficult to either do or be interested in. Being invited to give views on areas where clinicians have no expertise is just not in their frame of thinking. A frustration expressed by some CDs is the resistance of their colleagues particularly in some specialties to change. A rational well founded and argued case did not necessarily win them over. This resistance reflects a point made earlier, that the bloody mindedness of colleagues is a barrier to progress. Awareness of the impact of their own behaviour on others comes through these responses as it has earlier in the analysis. However, an interesting example of a self-observed change in behaviour in a clinical role led an individual to consider his behaviour in his management role.

Certainly there are things to learn from approaches in different specialties. Some of these appear to be driven by the nature of the service, others seem to reinforce the view that stereotypes do exist.

Examples of the differences are shown in section 4.9 and Table 4.17 repeated below.

Table 4.17 Challenges of Managing Different Specialties

Summary of the challenge of managing different specialties

- Some specialties are described as follows:
  - Run like a business
  - Flexible and undertake most of their work at anytime.
  - Located together and form an identity
  - Plan, share and review their work as a team
  - See each other all the time and can interact
  - Find it difficult to act a team
  - Act as individuals
- Managing multiple specialties is a challenge
- Large directorates are difficult to manage
- An individual can behave different in different specialties

Dawson et al (1995) identified younger individuals in the 'unfashionable specialties' who were eager to embrace what they saw an alternative source of power. There are no younger individuals in this research in these specialties, but younger individuals in other specialties appear to use the power of the role, but they can be ineffective. There is no evidence of their eagerness to embrace power in a new role per se, their behaviour appears to be the style they normally use. This may have accounted for their surprise when the outcome was not as they predicted or wished. Willcocks (1996) makes a similar point about gaining power as Dawson in stating that directorates who embraced managerialist perspectives may do so because they belong to specialties that have more to gain politically from being a managerialist culture. This may be true, but there is no evidence to support this view in my research.

To move away from this guarded approach of not naming these less attractive specialties, my experience tells me these include pathology. Making this assumption, it is interesting to contrast research (Ong, 1998) which compared clinical management in surgery and pathology. Here, in pathology, reasons of experience and having to compete externally are given for the awareness of the importance of strategic management. The existence of an internal coherence and collective perspective on their own service had not been achieved in surgery. While the new approach had

been defined, the cognitive shift in surgery had not been accepted. My research would agree with Ong's findings that the particular experience in the pathology department is seen of benefit when acting in a strategic role, whereas in surgery, the individualistic approach and lack of teamwork does not prepare individuals for a broader role. In my research, it is in surgery where changes across the directorate have had negative outcomes.

6.10 APPROACHES TO TAKING UP THE DUAL ROLE

While we can see patterns in how individuals take up this dual role, throughout the findings there have been different perceptions. The final stage of the analysis was built on reviewing the data for themes. There were contrasting themes that related to approaches to the role and others that related to perceptions of the management role and the individual's awareness in the role. The contrasting themes aligned along a dimension described as 'Taking Charge' and the themes relating to perceptions of the management role and the individual's awareness in the role aligned along a theme described as managerial alignment.

Contrasting Themes on the Approaches to the Role

1 Strategic Leadership – Manager or Representative
2 Communication Proactive - Reactive
3 Involvement and seeking control and loosing control – calm/laid back
4 Having confidence, positive and rebellious stances – Lacking confidence, self effacing
5 Providing team leadership with sensitivity – Providing leadership with little sensitivity

Contrasting Themes on Perceptions of the Management

6 Management is complex – management is simple, it is not real work
7 Management is innate – management is learned
8 Respect for managers – cynicism

Contrasting Themes on the Individual's Awareness in the Role

9 Self awareness – work patterns and behaviour
10 Awareness of power relationships
Politically sensitive
Protecting a powerful position
Struggling with power

Theme one distinguishes between the strategic leadership and management perspectives, the former concerned with shaping the direction of the organisation and the latter with keeping the organisation on the right road, moving it along, but not necessarily changing it. Terms associated with this align to the descriptions of

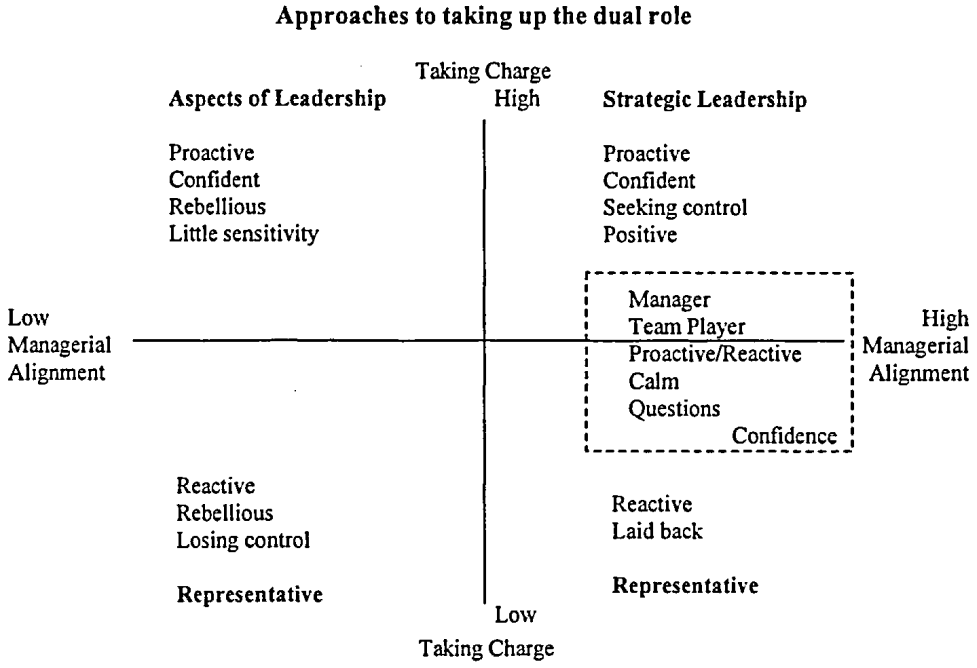
transformational and transactional leadership (Kouzes and Posner, 1995). Transformational is probably an exaggeration for what those in the dual role describe as strategic, but in their context given the national framework in which they operate local change can feel significant. Kakabadse and Kakabadse (1999) in their research inform us that a mixture of transformational and transactional leadership is required. Signs of this combination are seen in a few individuals who make changes and progress gradually with political sensitivity. The representative role is in part related to Avioli et al's, (1999) extension of transformational and transactional leadership to passive leadership. Some individuals in this sample go even further in being passive and take little responsibility. Themes 2-5 relate to contrasting behaviours associated with taking up the role.

Themes 6-8 reflect the contrasting views individuals have of management. The complexity of management is recognised by some, others struggle to see it as real work. Its 'woolyness' contrasts with the clinical role that is seen as real work. Along with Galton (1870) and Carlyle (1907) there is a view that the management role is innate. Others see there is a need to learn the role, but what development is needed is more difficult to articulate. There is often a struggle to understand what training is needed for the role. Generally this sample had positive views of management, but there were still contrasting cynical views.

The final two themes relate to views the individual's self awareness in the role and how they deal with concepts of power in their working relationships. These themes are seen as important in leadership roles (Bennis, 1994; Golemam, 2000).

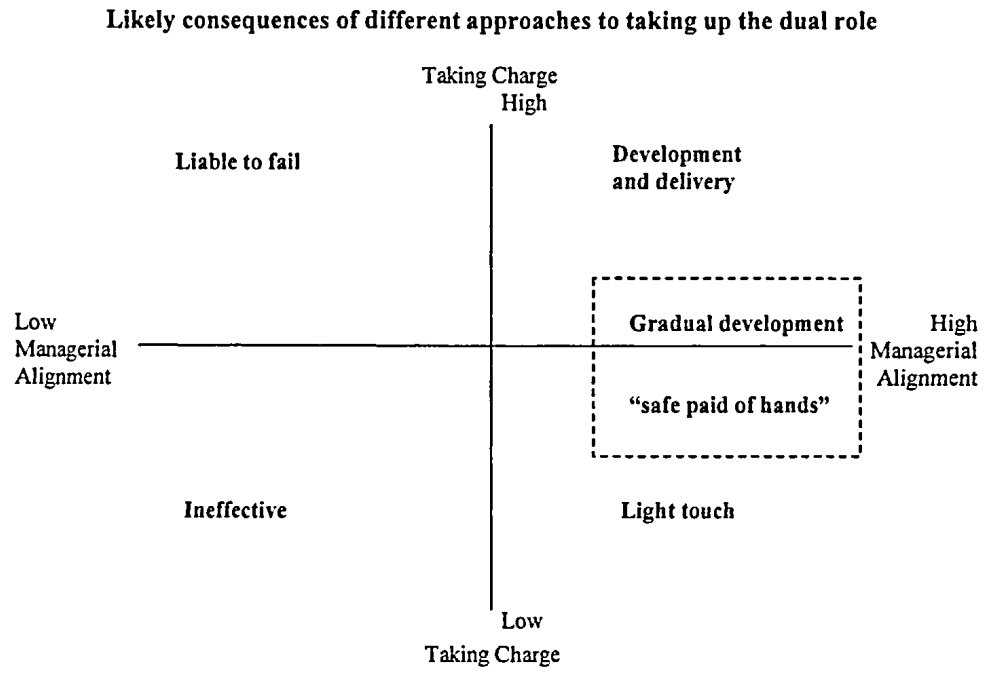
Relationships were found between the contrasting themes and the other themes and are described in Figs. 5.1, 5.2 and 5.3 below. Individual characteristics were formed from the coded data and expressed along dimensions. These are shown and described in chapter 5.

Figure 5.1 Approaches to Taking up the Dual Role



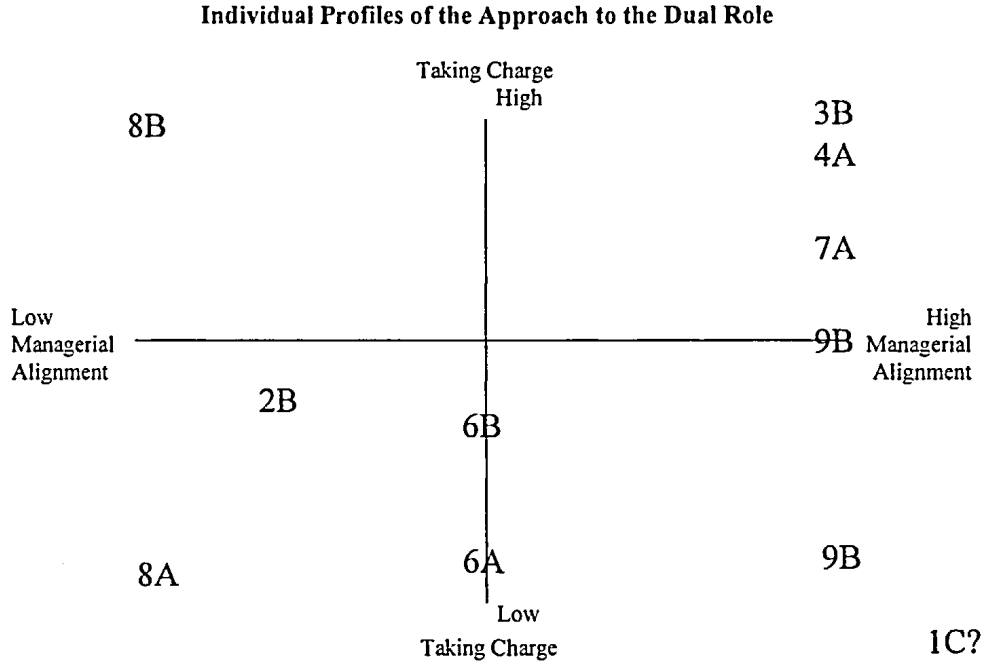
In the interviews individuals give accounts of how they take up the role and their experiences in the role. These experiences are seen as the consequences of their approach and are described chapter 5, and shown in Fig. 5.2 below.

Fig. 5.2 Likely Consequences of Different Approaches to Taking up the Dual Role



Individual profiles were tested and plotted on the dimensions. Ten representative profiles are shown below in Fig. 5.3. These demonstrate the spread of profiles. One profile was outside these dimensions as expressed here, but others fitted well into the model.

Fig. 5.3 Individual Profiles of the Approach to Taking Up the Dual Role



Note: 9B shows twice

6.11 ROLE CONTEXT

The three sites were chosen in this study for their similarity in the type of services they deliver and their situation as typical 'middle England' acute trusts. The involvement of clinicians in management in two of these sites followed the traditional clinical director model, with clinical directors having responsibility for staff and budgets in their directorate. The third site had appointed senior lead clinicians without these responsibilities, but in common with the two other sites there was an espoused strategic leadership role with the role being seen as the equivalent of the clinical director model in that trust. From the analysis there are different views of the role across the three sites and within each site. Clearly the third site is different and the senior lead clinicians primarily see themselves as a communication channel to link management and the consultants. At this site they are trying to develop an appraisal system and are finding it very difficult to identify, in a way that could be measured, what the SLCs actually do. The SLCs do not want budgetary responsibility and yet the CDs at the other sites felt this was an integral part of the dual role. Although how the role is seen and taken up varies across the sites, there is little evidence to set apart the two sites with the clinical director model. As explained earlier, these are two sites where the Chief Executives are positive about the involvement of clinicians in management and generally the clinicians have a respect for management.

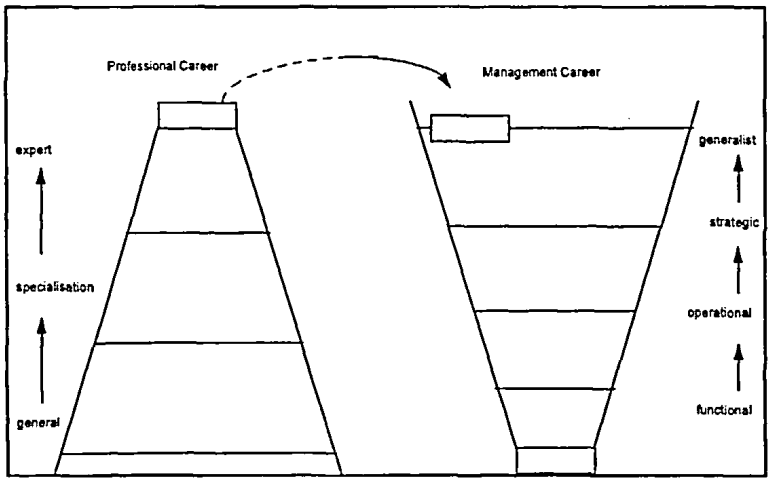
7 CONCLUSIONS

7.1 CONTRIBUTION TO KNOWLEDGE

The title of this thesis, 'The Challenge of Role Duality' is understood by exploring the perceptions of individuals in the dual role of professional and strategic leadership. The primary research question - How do clinical consultants take up the dual role of strategic leadership and clinician? is addressed through a role theory perspective and the findings contribute to the understanding of how individuals take up roles. Role concepts and frameworks are applied to aid the understanding of both elements of the role. It is clear, in this sample, that whatever central government decrees, local job descriptions espouse and earlier research promotes, the dual role is taken up in a number of different ways within and across NHS Trusts.

This research contributes to the existing body of knowledge by adding a new understanding of how this dual role is taken up. Confirmation of earlier research and minor contributions are reported in the previous chapter. The research design adds to earlier research into this dual role by exploring perceptions of the professional role and the strategic leadership role in depth. An understanding of the leap from the professional role to the dual role emerges from an understanding of the two career paths and the analysis of data from the descriptions of both elements of the role. Fig. 6.1 is repeated here to depict this transition.

Fig. 6.1 The Path to Role Duality



Weight 2000

Descriptions of what taking up the dual role feels like in the individual's everyday life conjures up the picture of the neat bounded, focused professional role swimming in a pool of little understood generalist uncertainties.

Comparisons of the demands, constraints and choices in both elements of the role show the contrast between the task driven environment in the clinical role and the relationship driven environment in the management role. Perceptions of the expectations others have of them and the approach they take in both elements of the role strengthens the role depicted in Fig.6.1. Different expectations show the clearer cut nature of the understood nature of the clinical role, compared to the ambiguity of the management role. Perceptions of the expectations show how two key relationships are constant (Chief Executive and consultant colleagues), but the expectations are different. As seen in this study, the misalignment can lead to a conflict and dilemma about how to behave which becomes stressful. Details shown in the findings are articulated for the first time in empirical research into this dual role. Some of the detail offers insights for further research suggested in the final section of this chapter.

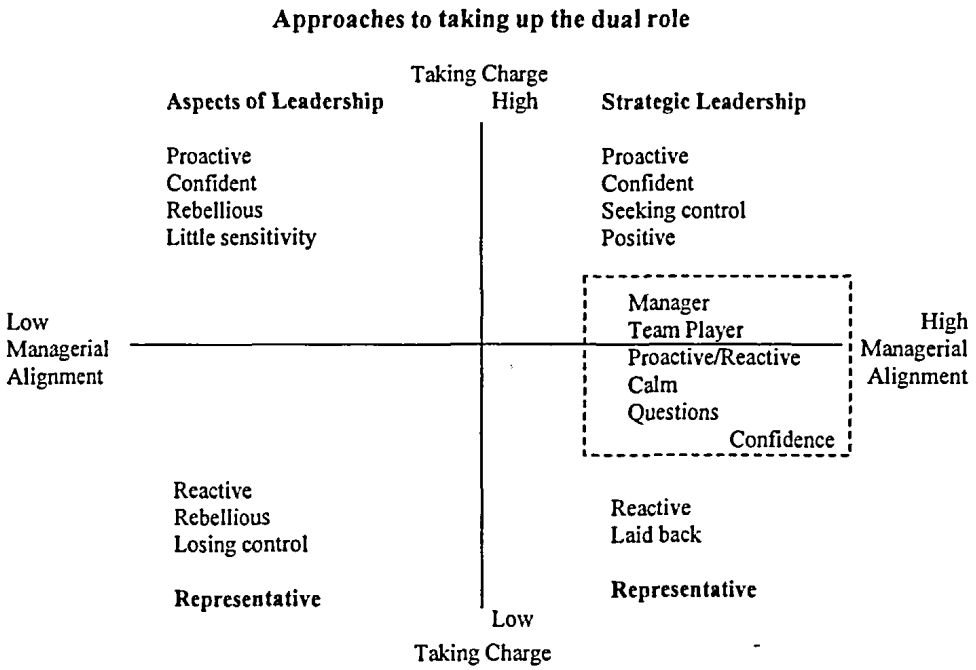
This study contributes to research on transition between roles. Studies into managing multiple roles of work and family show that the challenges produce role strain in some individuals (Pearlin, 1989; Young and Kahana, 1989) and role enhancement in others (Crosby, 1991; Parris Stephens et al, 1995). Although in different contexts, both reactions are evident in this study. Role transition between different work roles is seen through how individuals manage the boundaries between the roles. Earlier research in broader arenas (Adams, 1976; Friedman and Podolny, 1992; Troyer, 2000) highlights the tensions between autonomy and role clarity for those who need to meet the demands the customer and the organisation. Troyer (2000) predicts more conflict for those who work with customers as organisations continue to grow unless their roles become well defined and rigid. Data from my study shows great choice and autonomy available in this dual role. Only one individual sought to clarify the role and ask if he was performing it well. All others appeared to use the lack of role clarity and their autonomy to allow them to perform the role as they desired. An argument for more rigid roles in an NHS context may destroy an important feature of

the role for those who seek the role and those who are 'volunteered' for it. Fitzgerald and Sturt (1992) argue for more clarity in the clinical director role to increase effectiveness. There is a balance to be struck between clarity to be supportive and clarity to be controlling. Recent trends, discussed in the final section, to exert more central role could mean even less enthusiasm for the role.

The ease of transition across role boundaries and inter-role conflict has a relationship with flexible and permeable nature of the boundaries and the contrast in role identities. Through an argument built around propositions and earlier research, Ashforth et al (2000) state that high segmentation (thick boundaries) of roles decreases the blurring of roles, but increases the magnitude of change between roles. In contrast, integrated roles (low segmentation, thin boundaries) increases the blurring of roles, but decreases the magnitude of change between them. This research has not set out to delineate the roles in quite the meanings behind these terms. There is, however, evidence that individuals differ in the way they place 'thick' or 'thin' boundaries around the elements of the dual role. It is also possible to divide the management role into areas where there is 'thick' or 'thin' boundaries with this role.

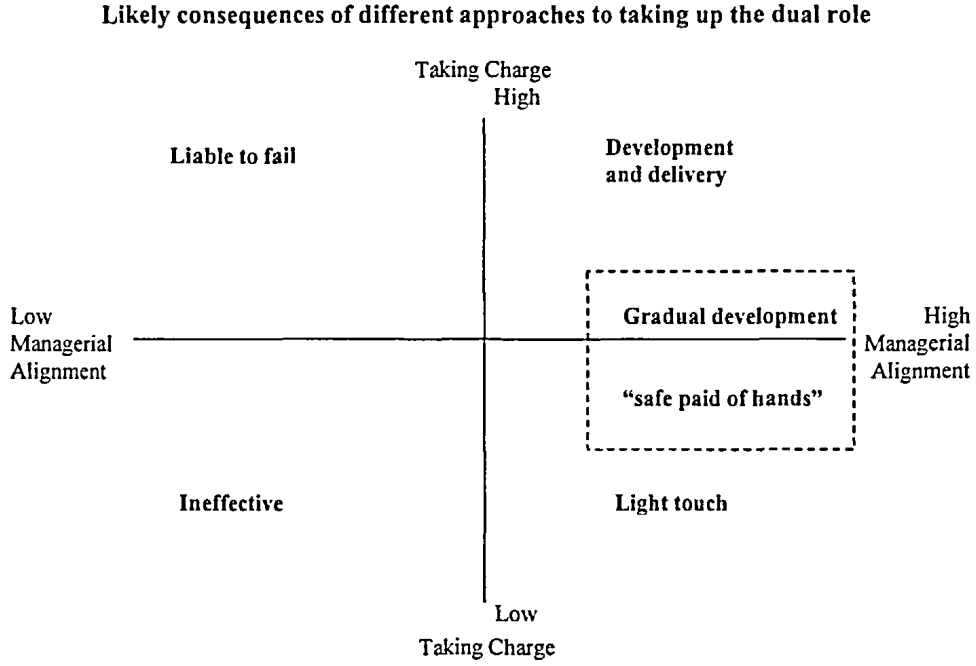
The heart of the research question is how individuals take up the dual role. The findings from this study show that the role is assumed in different ways which form patterns along two dimensions, the dimension of taking charge and the dimension of managerial alignment (Fig. 5.1). The combination of being high on taking charge and high on managerial alignment shows some leadership characteristics (Bennis, 1994; Kouzes and Posner, 1995) and capabilities now labelled as emotional intelligence (Goleman, 2000). The latter capabilities of self-awareness and some of the social awareness and social skills are less evident in those who are regarded as low in managerial alignment and leading with 'little sensitivity'.

Fig. 5.1 Approaches to Taking up the Dual Role



In the interviews individuals give accounts of how they take up the role and their experiences in the role. These experiences are seen as consequences of their approach and are described in Fig. 5.2 below.

Fig. 5.2 Likely Consequences of Different Approaches to Taking Up the Dual Role



The contribution made by these findings will advance our understanding of the role in a way that is very different to many studies that have viewed the role from the perspective of identifying training needs. This research looks at how the role is taken with an emphasis on understanding both elements of the dual role.

7.2 CONTRIBUTION TO PRACTICE

This research adds an understanding of how individuals take up this particular role that plays an important part in the delivery of services to NHS hospital patients in England. Individuals in the dual role struggle with the role's complexity and conflicting demands. Chief Executives and others working with them appear to wrestle with how to engage clinicians in the management process. Findings from this research, should for the first time, provide empirical evidence of how individuals take up both elements of the dual role.

Sharing an understanding of the different approaches to the dual role and their consequences may allow individuals in the health community to talk more freely about the conflicts and dilemmas in the dual role. The problem of moving into a role that is alien and ambiguous appears to suit some individuals and not others. Choosing a clinician to participate in a strategic role requires sensitivity and respect to be developed between senior management and the clinician. When in the role the clinicians require self-awareness of the impact of their behaviour in the role. Feedback is generally neither invited nor given to develop self-awareness.

More fundamentally there needs to be an agreement about the nature of the role. In this study, although the role is espoused to be a strategic leadership role at all three sites, it is clearly seen as quite differently within and across the three sites. Little discussion between those around the individual clarified expectations and the clinicians were only able to make assumptions about the role. Clarity of the role and the expectations of the individual, when offered as support and not control, in the role would help to avoid many of the stresses. Some individuals appear to take charge of the role with commitment and interest, while others almost avoid the role and are probably ineffective. This range of behaviours occurs within the three trusts. It appears the clinicians through the choices available to them are allowed to make what they want of the role. Is this the optimum way to manage the situation or the only way clinicians and Chief Executives can survive together? Perhaps the challenge of role duality rests not so much with the individual, but more with those around him or her. This could be another area for further research.

7.3 LIMITATIONS OF THE RESEARCH

The research has increased knowledge about how consultants take up the dual role of clinician and manager. Nevertheless, it is important to recognise a number of limitations which may limit the findings. It is the choices that are made and the limitations the choices impose that place boundaries around the research

It is acknowledged that there is researcher-induced bias throughout the study as I defined the topic, selected the appropriate literature, designed the study, found the sample, interpreted and analysed and interpreted the data and presented the findings. Earlier explanations and those in this section provide an assurance that within the ownership of this responsibility a process of informed thought and deed has guided me to produce a valuable piece of research.

Lincoln and Guba (1985) say that trustworthiness is needed in qualitative research and proposes the conventional formulations are replaced with new terms that are a better fit with naturalistic epistemology; these are credibility (in place of internal validity); transferability (in place of external validity); dependability (in place of reliability) and confirmability (in place of objectivity).

The small sample may be seen as a limitation given the large size of the population who undertake a similar role. However, the interpretation placed on the research question being the desire to access the perceptions and meanings individuals give to both elements of the dual role led to the necessity to limit the size of the sample. The aim is to give a rich account of how individuals describe the dual role. With the level of meaning required from the individuals questionnaires were ruled out. It was felt questionnaires, while allowing a larger sample, were unlikely to gain the level of openness needed to gain a new level of understanding and knowledge. Guba and Lincoln (1981) state "the ability to tap into the experience of others in their own natural language, while utilising their values and beliefs frameworks is virtually impossible without face-to-face contact and verbal interaction with them". It is unlikely the small size of the sample limits the credibility of the process and findings as some findings confirm the earlier research that is built on in this study. The limited sample size is balanced with the benefits of a design with one meeting and two taped

interviews with each individual. Interview data alone should only be relied upon if the research has enough relevant background to be sure they can make sense of interview conversations (Dexter, 1970). The context of the research was understood through my knowledge of the NHS and locally through meetings with the Chief Executives and reading documents concerning the plans and structure of the trusts. Meeting the interviewees on more than one occasion also allowed for meanings to be clarified.

Transferability has been aided by the choice of three sites that deliver a similar acute hospital services to their local population. These sites represent the majority of the NHS Trusts in England. It is accepted the Chief Executives all had a positive and encouraging views about the involvement of clinicians in management. While their views may not be shared by all Chief Executives, their interest made them receptive to this research. They readily gave their permission for the clinicians to be approached. With permission from a senior individual there is a danger of an elite bias. With this particular group this is unlikely. Clinical consultants are not known for their deference to hierarchy or authority. Generally they are assertive and not afraid to share their views. For the same reason it was not thought necessary to heed the warning of Miles and Huberman's (1994) that informants may bias their responses to be amenable to the researcher. Many of the comments in the analysis demonstrate an open approach. Any sense of guardedness from the individuals was very limited. It is accepted that the positive views of the Chief Executives about the involvement clinicians in management may have influenced the positive feelings the clinicians had about management. A further positive perspective on transferability is that all the CDs and SLCs in the trusts participated in the research. Samples in earlier research have often not obtained 100% coverage. There is therefore no bias of interviews being selected or opting out, once the trust was identified as 'typical' and willing to participate.

A bias generated because of the particular characteristics of the interviewee and interviewer can occur in several ways. As King (1994) says "there is no such thing as a 'relationship-free' interview". It is the nature of the relationship and thinking through the consequences a particular set of dynamics that is important in the research

design and during the research process. According to Oakley (1988) "in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own identity in the relationship". As a practising manager in the NHS for many years and leaving at a senior level and now an academic I was likely to have some credibility with this audience. Although the relationship between managers and clinicians is not always positive, this sample expressed views of respect for managers in their trusts. My career history working with clinicians as a manager and in a management development setting helped me develop a rapport with the interviewees. I had also taken time ensure I was up to date with events nationally and acquire an understanding of their local situation. This was acknowledged and appreciated because interviewees did not have to translate the NHS language for me.

Another potential barrier is being a female interviewer when interviewing men. The men could have felt less comfortable about talking to a woman than a man; having a 'female' style of speaking and questioning (Tannen, 1991), it might have made it more difficult to elicit information from them. There was a possibility they might not be honest and want to impress and not admit any concerns or weaknesses. Only one interviewee was female, so there was little opportunity for me to compare the aspects of gender bias in this respect across the sample. The interviewee with the one female could also have been biased as it was a female to female interview. The clinical consultants working life is dominated by relationships with predominantly male colleagues and many female staff, the latter often being where there is a hierarchical relationship the consultant being the 'senior' person. This bias is a difficult for me to assess. It is, however, one that I gave thought to and planned the interview process with an introductory meeting to establish credibility and rapport. As explained in chapter 3 the research design was planned to establish credibility in the approach and the methods. This was seen as a very important criterion with this group of interviews. My view is that I had very little indication of reluctance to what I judged as an open and honest approach. The research design appeared to stimulate genuine interest and curiosity. The choice of a research design where I met each individual on

three occasions provided the opportunity to check any concerns regarding interpretation.

The interviews were conducted over a relatively short period of time and are a snapshot of the interviewee's experiences and meanings. It is possible to surface meanings in discussion at a point in time. The research does not set out to track experiences over time, but has the advantage of being within a similar time scale in the local and national context of changes in the NHS. A discussion of how new national initiatives could affect this dual role are discussed in the next section concerning future research.

As dependability is built in the sampling and interview process the choices and the limitations the choices impose on the research continue with the move into the interpretation and analysis phase. A limitation here may be the fact that only myself as researcher carried out the research. While this is not ideal, the PhD process makes this unavoidable. Once more the fit between some findings and the existing literature suggests the inter-rater reliability for the analysis has not had a too untoward effect on the research findings. Also, my knowledge of the context makes me able to understand what is being said. I recognise this will be through my own mindset and there needs to be a conscious concern and awareness of my own feelings during the analysis. I was reminded of this when responses surprised me and when an aspect of the analysis revealed something I knew had not been found before.

The coding framework was first aligned to parameters that had credibility in earlier studies and viewed roles through the theoretical perspective of this research. Links between the defined codes and the findings are made explicit and referenced from the analysis to the findings bringing confirmability to the research. The process of coding and interpreting the meanings is described. Although when undertaking this study I felt a confidence about my understanding of the context this was strongly tempered by a nervousness that I would not be objective. An understanding that it was inevitable I would influence the research brought some comfort. Although Eisner and Guba and Lincoln differ in significant aspects of their theories, they share the premise that human knowledge is literally constructed during enquiry and hence is inevitably

entwined with the perceptual frames, histories and values of the inquirer (Greene, 1994).

7.4 THE FUTURE

7.4.1 Suggestions For Further Research

The research questions of this study have brought a deeper understanding to the dual role by exploring both elements of the dual role. Also, an understanding of how individuals take up the 'management' element of the dual role has been conceptualised. In the introduction to this study, I wondered if the findings from it would be able to be generalised outside the context of the NHS. Research is urged with other professionals, particularly lawyers in a similar public sector setting or perhaps wider to look at other professionals in different contexts. Lawyers are cited only as the characteristics of their profession and the medical profession are seen as similar in the literature.

This research was conducted in three sites and differences are noted in the thesis where they might be worthy of further research. These include management being held in higher regard at two sites than the third. Stress in the role is experienced more at one site than the other two. Given that the regard clinicians have for senior management is seen, in this research, to have a relationship with how the role is taken up, this could provide an interesting further study.

Findings from this research are confined to a small sample size. Quantitative methods could be developed from some of the findings and views of a wider sample taken to seek the range of responses and possibly look for contextual or demographic similarities or differences.

From this study it is seen there is a range of likely consequences to the different ways the role is taken up. Why these differences occur is not known. More research is recommended on how to seek this understanding and maximise the contribution clinicians and other professionals can make to the management of their organisations. Finding an effective balance between real involvement with responsibility and authority and a more advisory role remains a challenge.

7.4.2 The Impact of Current Changes on the Role of Clinicians in Management

Several times in this study, reference has been made of the slowness of the medical profession to respond to change. The professional career with its hierarchy and status, and the concept of a job life for NHS doctors remaining largely intact. Changes in medical training are happening slowly, with isolated examples in England of a part common curriculum in undergraduate training for health professionals including medical training. The benefits of this multi-professional training will take many years to filter through and impact on the current culture in NHS trusts. Postgraduate medical training remains focused on a single profession approach.

There are, however, other changes taking place in the NHS that will impact on the role of clinicians in management. In this study we learned of some concerns over the role of clinical governance. It was agreed by some respondents there were benefits to patient safety by providing national standards in relation to the delivery of clinical care, but it was seen there could be a stultifying effect on innovation in the NHS. The Government has set up a number of mechanisms to support the clinical governance agenda and the management of risk in the NHS. These have implications for clinical practice and those in leadership roles in the NHS. The Commission for Health Improvement (CHI), National Service Frameworks (NSFs), Total Quality Management (TQM), The National Institute for Clinical Excellence (NICE) and the Performance Assessment Framework all have a high profile. The freedoms and choices expressed by so many individuals in this research about how they take up the clinical director role, or its equivalent, may well be curtailed by the controlling hand of government as there is increasing pressure to deliver to national standards. History, however, is testament to the power of the medical profession getting 'good deals' for doctors in the NHS since its inception in 1948.

It is interesting to try and understand the impact of these recently introduced nationally controlling initiatives with the current restructuring of the NHS designed to shift the balance of power and place decision making with local management. Will the role of clinicians in management be enhanced or eroded as the balance between national and local management is fought out? One fact remains, that in NHS

hospitals consultants still control the much of the workload by their energy and commitment to the clinical role.

APPENDIX A

NUDIST CODING

QSR. NUD IST Power version, revision 4.0.
Licensee: Cranfield School of Management.

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(4 1 9 1) /expectations/CD or SLC role/general manager/support
(4 1 9 1 1) /expectations/CD or SLC role/general manager/support/pride
(4 1 9 1 2) /expectations/CD or SLC role/general manager/support/protection
(4 1 9 2) /expectations/CD or SLC role/general manager/freedom
(4 1 9 3) /expectations/CD or SLC role/general manager/regular contact
(4 1 10) /expectations/CD or SLC role/external
(4 1 11) /expectations/CD or SLC role/themselves
(4 1 12) /expectations/CD or SLC role/Overview
(4 1 12 1) /expectations/CD or SLC role/Overview/reading the message
(4 1 12 2) /expectations/CD or SLC role/Overview/networking
(4 1 12 3) /expectations/CD or SLC role/Overview/passive approach
(4 1 12 4) /expectations/CD or SLC role/Overview/not considered

(4 2) /expectations/CLINICAL ROLE
(4 2 1) /expectations/clinical role/consultants
(4 2 1 1) /expectations/clinical role/consultants/clinically competent
(4 2 1 2) /expectations/clinical role/consultants/results oriented
(4 2 1 3) /expectations/clinical role/consultants/building positive relationships
(4 2 1 4) /expectations/clinical role/consultants/improved relationships
(4 2 1 5) /expectations/clinical role/consultants/learn together
(4 2 2) /expectations/clinical role/SLCs
(4 2 3) /expectations/clinical role/Chief Executive
(4 2 3 1) /expectations/clinical role/Chief Executive/competent, work hard
(4 2 4) /expectations/clinical role/Nurses
(4 2 4 1) /expectations/clinical role/Nurses/unsure
(4 2 4 2) /expectations/clinical role/Nurses/availability, advice
(4 2 4 3) /expectations/clinical role/Nurses/leadership
(4 2 4 4) /expectations/clinical role/Nurses/valued
(4 2 5) /expectations/clinical role/Patients
(4 2 5 1) /expectations/clinical role/Patients/Cared for competently
(4 2 5 2) /expectations/clinical role/Patients/Information and advice

(4 2 6) /expectations/clinical role/junior doctors
(4 2 6 1) /expectations/clinical role/junior doctors/training and support
(4 2 7) /expectations/clinical role/others
(4 2 8) /expectations/clinical role/own department
(4 2 9) /expectations/clinical role/oneself

(5) /DIFF BETWEEN SPECIALTIES
(5 1) /diff between specialties/Like a business
(5 2) /diff between specialties/flexibility and location
(5 3) /diff between specialties/teamwork
(5 4) /diff between specialties/individualism
(5 5) /diff between specialties/multiple specialties
(5 6) /diff between specialties/size
(5 7) /diff between specialties/stereotypes
(5 8) /diff between specialties/influencing

(6) /CD AND SLC AND CLIN. SIMILARITIES
(6 1) /CD and SLC and clin. similarities/one role
(6 1 1) /CD and SLC and clin. similarities/one role/contrasting view
(6 2) /CD and SLC and clin. similarities/leadership and presence
(6 3) /CD and SLC and clin. similarities/listening and acting
(6 4) /CD and SLC and clin. similarities/consulting and directing
(6 5) /CD and SLC and clin. similarities/delegating
(6 6) /CD and SLC and clin. similarities/intuition
(6 7) /CD and SLC and clin. similarities/accountability and loyalty
(6 8) /CD and SLC and clin. similarities/targets
(6 9) /CD and SLC and clin. similarities/emotion

(7) /CD OR SLC AND CLIN. DIFFERENCES
(7 1) /CD or SLC and clin. differences/Type of role
(7 2) /CD or SLC and clin. differences/Area of responsibility
(7 3) /CD or SLC and clin. differences/Primary function
(7 4) /CD or SLC and clin. differences/Expectations
(7 5) /CD or SLC and clin. differences/Mindset
(7 6) /CD or SLC and clin. differences/Focus
(7 7) /CD or SLC and clin. differences/Capability
(7 8) /CD or SLC and clin. differences/delegation
(7 9) /CD or SLC and clin. differences/Commun. role
(7 10) /CD or SLC and clin. differences/Influence
(7 11) /CD or SLC and clin. differences/Problem solving
(7 12) /CD or SLC and clin. differences/Decision making
(7 13) /CD or SLC and clin. differences/Results,output
(7 14) /CD or SLC and clin. differences/Corporacy
(7 15) /CD or SLC and clin. differences/Learning and review

(8) /CD AND SLC AND CLIN. CONFLICT
(8 1) /CD and SLC and clin. conflict/work overload
(8 1 1) /CD and SLC and clin. conflict/work overload/consequences of overload
(8 1 1 1) /CD and SLC and clin. conflict/work overload/consequences of overload/behavioural change
(8 1 1 2) /CD and SLC and clin. conflict/work overload/consequences of overload/professional development
(8 2) /CD and SLC and clin. conflict/person role conflict
(8 2 1) /CD and SLC and clin. conflict/person role conflict/strategic versus operational
(8 2 2) /CD and SLC and clin. conflict/person role conflict/inability to respond
(8 3) /CD and SLC and clin. conflict/inter role conflict
(8 3 1) /CD and SLC and clin. conflict/inter role conflict/pressure to be fair
(8 4) /CD and SLC and clin. conflict/sent role conflict

(9) /ROLE DEVELOPMENT
(9 1) /Role development/innate
(9 2) /Role development/perplexed
(9 3) /Role development/learning from the clinical role

(10) /CORPORATE ROLE
(10 1) /corporate role/committed
(10 2) /corporate role/little interest
(10 3) /corporate role/insight
(10 4) /corporate role/difficulties
(10 4 1) /corporate role/difficulties/challenging colleagues
(10 4 2) /corporate role/difficulties/implementing change
(10 4 2 1) /corporate role/difficulties/implementing change/cynicism
(10 4 2 2) /corporate role/difficulties/implementing change/influencing colleagues
(10 4 2 3) /corporate role/difficulties/implementing change/use of power
(10 5) /corporate role/taking up the role
(10 5 1) /corporate role/taking up the role/reluctant acceptance
(10 5 2) /corporate role/taking up the role/positive acceptance
(10 5 3) /corporate role/taking up the role/perception of others

(12) /APPROACHES
(12 1) /Approaches/Providing strategic leadership
(12 2) /Approaches/Manager or representative
(12 3) /Approaches/Communication
(12 3 1) /Approaches/Communication/proactive
(12 3 2) /Approaches/Communication/reactive
(12 4) /Approaches/InMovement and seeking control
(12 5) /Approaches/Losing control
(12 6) /Approaches/calm laid back
(12 7) /Approaches/Having confidence
(12 8) /Approaches/Positve stance
(12 9) /Approaches/rebellious stance
(12 10) /Approaches/Lacking confidence
(12 11) /Approaches/self effacing
(12 12) /Approaches/Providing team leadership
(12 12 1) /Approaches/Providing team leadership/with sensitivity
(12 12 2) /Approaches/Providing team leadership/little sensitivity

(13) /MANAGEMENT EXPLORED
(13 1) /Management explored/described as complex
(13 2) /Management explored/described as a simple concept
(13 3) /Management explored/unstructured, not real work
(13 4) /Management explored/an innate skill
(13 5) /Management explored/is learned
(13 6) /Management explored/Respect for managers
(13 7) /Management explored/Cynicism

(14) /SELF AWARENESS
(14 1) /Self awareness/work patterns
(14 2) /Self awareness/behaviour
(14 3) /Self awareness/Power relationships
(14 3 1) /Self awareness/Power relationships/politically sensitive
(14 3 2) /Self awareness/Power relationships/Protecting a powerful position
(14 3 3) /Self awareness/Power relationships/Struggling with power

REFERENCES

Aanstoos, C. M. 1987. A comparative survey of human science psychologies. *Methods*, Winter, 1,2, pp 1-36. In Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Abel-Smith, B. 1964. *The Hospitals 1800-1948*, Heinemann, London. In Allen, D. 1995. Doctors in management or the revenge of the conquered: the role of management development for doctors, *Journal of Management in Medicine*, 9 (4): 44-50.

Abramis, D. J. 1994. Work role ambiguity, job satisfaction and job performance: Meta-analyses and review. *Psychological Reports,* 75: 1411-1433. In Tubre, T. C. and Collins, J. M. 2000, Jackson and Schuler (1985) Revisited: A Mata-Analysis of the Relationships Between Role Ambiguity, Role Conflict and Job Performance, *Journal of Management*, Vol.26, No.1, 155-169.

Adams, J. S. 1976. The structure and dynamics of behaviour in organisational boundary roles. In M.. D. Dunnette (Ed), Handbook of Industril and Organisational Psychology, pp 1175-1199, Chicago: Rand McNally.

Allan, P. 1981. Managers at Work: A Large Scale Study of the Managerial Job in New York City Government. *Academy of Management Journal*, 24(3), pp 613-619.

Allen, D. 1995. Doctors in management or the revenge of the conquered: the role of management development for doctors, Journal of Management in Medicine, 9 (4): 44-50.

Andrew, K. R. 1971. *The concept of corporate strategy.* Irwin, Homewood, IL.

Ansoff, H. I. 1965. *Corporate Strategy.* Mc Graw-Hill, New York.

Armstrong, D., Bazalgette, J, and Hutton, J. 1994. What Does Management Really Mean? How psycho-analytic and systemic thinking interact to illuminate the management of institutions. Paper presented to the *International Consulting Conference*, South Bank University, London, 28-30 January.

Arthur, M. B. 1994. The boundaryless career: a new perspective for organisational inquiry, *Journal of Organisational Behaviour*, Vol. 15, 295- 306.

Arthur, M. B., Hall D. T. and Lawrence, B. S. 1989. *Handbook of Career Theory,* Cambridge University Press, New York.

Ashburner, L. and Fitzgerald, L. 1996. Beleaguered Professionals: clinicians and institutional change in the NHS. In, Scarborough, H., *The Management of Expertise*, Macmillan Press.

Ashforth, B. E., Kriener, G. E., and Fugate, M. 2000. All in a Day's Work: Boundaries and Micro Role Transitions. *Academy of Management Review, Vol. 25,* No.3, 472-491.

Avolio, B. J., Bass, B. M. and Jung, D. I. 1999. Re-examining the components of transactional and transformational leadership using the Multifactor Leadership Questionnaire, *Journal of Occupational and Organisational Psychology,* 72, pp 441-462.

Bailyn, L. 1980. *Living with Technology: Issues in Mid-Career*, MIT Press, Cambridge, MA.

Balogun, J. and Hope Hailey, V. 1999. *Exploring Strategic Change*, Prentice Hall Europe.

Bartlett, C. and Ghoshal, S. 1995. Changing the Role of Top Management: Beyond Systems to people, *Harvard Business Review*, Vol.73 Iss. 3 pp 132-143.

Bennis, W. 1994. *An Invented Life: Reflections on Leadership and Change*, Century Ltd., London.

Biddle, B. J. 1979. *Role Theory: Expectations, Identities and Behaviours*, Academic Press Inc.

Biddle, B. J. and Thomas E. J. 1966. *Role Theory: Concepts and Research*, John Wiley and Sons, Inc.

Bird, A. 1994. Careers as repositories of knowledge: a new perspective on boundaryless careers, *Journal of Organisational Behaviour*, Vol. 15, 325-344.

Blaikie, N. 1993. Approaches to Social Enquiry, Polity Press

Blair, T. 1999. Public Sector has not changed in the last 50 years. *Financial Times*, September 2nd p.1.

Blake, R. R. and Mouton, J. S. 1964. *The Managerial Grid*, Houston, Gulf.

Boisot, M. and Laing, X. G. 1992. The Nature of Managerial Work in the Chinese Enterprise Reforms: A Study of Six Directors. *Organisational Studies,* 13(2), pp 161-184.

Bowman, C. and Ambrosini, V. 2000. Strategy from an Individual Perspective, *European Management Journal*, Vol.18 No. 2, pp207-215.

Boyatzis, R. E. 1982. *The competent manager. A model for effective performance*, John Wiley and Sons.

Bryman, A. 1988. *Quantity and Quality in Social Research,* (Ch. 3 The Nature of Qualitative Research) Unwin Hyman, London.

Bryman, A. 1992. *Charisma and Leadership in Organisations*, Sage Publications Ltd.

Bryman, A and Burgess, R. G. 1994. Reflections on qualitative data analysis. In Bryman, A. and Burgess, R. G. (eds.) Analysing Qualitative Data, London: Routledge.

Buchanan, D., Jordan, Preston, D. and Smith, A. 1997. Doctors in the Process. The engagement of clinical directors in hospital management. *Journal of Management in Medicine.* Vol. 11, No. 3, pp 132-156.

Burgoyne, J. and Lorbiecki, A. 1993. Clinicians into Management: The Experience in Context, *Health Services Management Research*, Vol.6, No. 4, November.

Burrage, M., Jarausch, J. and Seigrist H. 1990. Introduction: the professions sociology and history. In Professions in Theory and History – Re-thinking the Study of Professions. Burrage, M. and Torstendahl J. *The Swedish Collegium for the Social Sciences* (SCASS), Sage Publications, London.

Butler, M. J. R. 2000. The Rise and Rise of New Public Management, unpublished PhD thesis, The University of Warwick, UK, June

Butler, M. J. R. 2001. Systematising understanding about the 'New Public Management' – Constructing a new NPM typology, Paper for the American Society of Public Administration's 62nd National Conference (Newark, New Jersey)

Carlyle, T. 1907. Heroes and Hero Worship, Boston. Adams (first published 1841). In Carr-Saunders, A. M. and Wilson, P. A. (1933). *The Professions*, Clarendon Press.

Carr-Saunders, A. M. and Wilson, P. A. 1933. *The Professions*, Clarendon Press.

Cavenagh, P. and Dewberry, C. 2000. Buggins' turn or Buggins' choice? Why do consultants choose or choose not to take on clinical director roles in trusts? *Clinician in Management*, 9: 71-78.

Chandler, A. D. 1962. *Strategy and structure: Chapters in the history of American industrial enterprise.* MIT Press, Cambridge, Mass.

Chemers, M. M. 1993. *An Integrative Theory of Leadership, In Leadership Theory and research Perspectives and Directives.* Eds. Chemers, M. M. and Ayman, R., Academic Press Inc.

Child, J. and Kieser, A. 1981. Organisation and Managerial Roles in British and West German Companies. An Examination of the Culture Free Thesis. In Dickson and McMillan, C. J. (Eds), *Organisation and Nation,* pp 51-73.

Clarke, R. W. and Lawry, R. P. 1988. The Power of the Professional Person, University Press of America, London. In Dawson, S., Mole, V., Winstanley, D. and Sherval, J. 1995. Management Competition and Professional Practice: Medicine and the Marketplace. *British Journal of Management,* 6(3), pp. 169-181.

Cowling, A. and Newman, K. 1994. Turning Doctors into Managers: An Evaluation of a Major NHS Initiative to Improve the Managerial Capabilities of Medical Consultants, *Human Resource Management Journal*, 4(4) pp 1-132.

Crosby, E. 1991. *Juggling*, New York: Free Press.

Czander, W. M. 1993. The Psychodynamics of Work and Organisations, Guildford Press.

Dawson, S., Mole, V., Winstanley, D. and Sherval, J. 1995. Management Competition and Professional Practice: Medicine and the Marketplace. *British Journal of Management*, 6(3), pp. 169-181.

Delfillippi, R. J. and Arthur, M. B. 1994. The boundaryless career: a competency-based perspective, *Journal of Organisational Behaviour*, Vol; 15 pp 307-324.

Department of Health (DOH), 1989. *Working for Patients*, CM 555 January. HMSO, 15.

DHSS, 1972. Management Arrangements for the Reorganised National Health Service, HMSO, London.

DHSS, 1976. Sharing Resources for Health in England, Report of the Resource Allocation Working Party, HMSO, London.

DHSS, 1977. Priorities In Health and Social Services – The Way Forward, HMSO, London.

DHSS, 1979. Patients First, HMSO, London.

Dohler, M. 1989. 'Physicians professional autonomy in the welfare state: Endangered or preserved?' in G. Freddi and J. K. Bjorkman (eds.), Controlling medical professionals: *The comparative politics of health governance.* pp 178-197. Sage, London.

Dutton, J., Bazalgette, J. and Reed, B. 1997. Organisation in the Mind, In Neumann, J. E., (Ed) *Developing Organisational Consultancy*, Routledge.

Easterby-Smith, J., Thorpe, R. and Lowe, A. 1991. *Management Research: An Introduction*, Sage, London.

Ellis, P. and Moffat, M. R. K. 1989. The role of the physician manager. *Health Services Management*, 85(2): pp 82-84.

Fayol, H. 1916. *Industrial and General Administration.* Translated from the French for the International Management Institute by Coubrough, J. A. (no publisher, loaned from Management Services Library, Civil Service Department, Whitehall).

Ferlie, E. 1999 The Rise of the New Public Management, unpublished Inaugural Lecture, Imperial College, UK, 9 March. In Butler 2001.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. 1996. The New Public Management in Action, Oxford University Press: Oxford.

Fiedler, F. E. 1967. *The Contingency Theory of Leadership Effectiveness*, New York: McGraw -Hill.

Fielder, F. E. 1996. Research on Leadership Selection and Training: One View of the Future, *Administrative Science Quarterly,* 41: 241-250.

Fiedler F. E. and Garcia, J. E. 1987. *New Approaches to Effective Leadership: Cognitive Resources and Organisational Performance*, Wiley.

Filley, House and Kerr 1976. *Managerial Process and Organisational Behaviour,* 2nd Ed., Glenview, Il: Scott Foresman.

Fisher, C. D. and Gitelson, R. 1983. A meta- analysisi of the correlates of role conflict and ambiguity. *Journal of Applied Psychology*, 79: 191-202. In Tubre, T. C. and Collins, J. M. 2000, Jackson and Schuler (1985) Revisited: A Mata-Analysis of the Relationships Between Role Ambiguity, Role Conflict and Job Performance, *Journal of Management*, Vol. 26, No.1, 155-169.

Fitzgerald, L. 1994. Moving Clinicians into Management. A Professional Challenge or Threat? *Journal of Management in Medicine.* Vol. 8, No.6, pp32-44.

Fitzgerald, L. and Ferlie, E. 2000. Professionals as Knowledge Assets in Organisations -- Reality, Time and Power. Paper presented at the *Academy of Management,* Toronto, 2000.

Fitzgerald, L. and Sturt, J. 1992. Clinicians into Management; On the Change Agenda or Not? *Health Service management Research*, Vol. 5, No. 2, July pp. 137-146.

Fondas, N. and Stewart, R. 1994. Enactment in Managerial Jobs: A Role Analysis, *Journal of Management Studies*, 31:1, pp 83-103.

Fontana, P. and Frey, J. H. 1994. Interviewing: the art of science. In Denzin, N. K. and Lincoln, Y. S. [Eds.], *Handbook of qualitative research,* Thousand Oaks: Sage, pp 361-376.

Friedman, R. A. and Podolny, J. 1992. Differentiation of boundary spanning roles: Labour negotiation and implications for role conflict. Administrative Science Quarterly, 37, 1, 28-48. In Troyer, L., Mueller, C. W. 2000. Who's the boss?: A role-theoretic analysis of customer work, *Work and Occupations,* Vol.27, 3, 406-427

Friedson, E. 1988. Professional Powers, University of Chicago Press, Chicago. In Dawson, S., Mole, V., Winstanley, D., and Sherval, J. 1995. Management

Competition and Professional Practice: Medicine and the Marketplace. *British Journal of Management*, 6(3), pp. 169-181.

Gabarro, J. J. 1987. *The Dynamics of Taking Charge*, Harvard Business School Press.

Gabarro, J. B. in Hambrick, D. (Ed.) 1988. *The Executive Effect; concepts and Methods for Studying Top Managers*, Jai Press Inc.

Galton, F. 1870. *Hereditary Genius*, New York, Appleton.

Gardner, H. 1983. *Frames of the Mind*, Basis Books, New York.

Gatrell, J. and White, T. 1997. Doctors and management - a model for change, *Health Manpower Management*, Vol. 23, No. 1, pp. 31-35.

Ghoshal, S. and Bartlett, C. 1995. Using people as a force for change, *People Management*, 19 October, pp 34-37.

Giddens, A. 1974. Positivism and Sociology. In Blaikie, N. 1993. *Approaches to Social Enquiry*, Polity Press p.13.

Goffman, E. 1961. *Encounters: Two studies in the Sociology of Interaction.* Bobbs-Merrill, New York.

Goleman, D. 1996. *Emotional Intelligence. Why it can matter more than IQ.* Bloomsbury Publishing Plc.

Goleman, D. 1998. *Working with Emotional Intelligence*, Bloomsbury Publishing Plc.

Goleman, D. 2000. Leadership That Gets Results, *Harvard Business Review.* March- April, pp 79-90.

Goode, W. J. 1969. The theoretical limits of professionalisation. In Etzioni, A. (Ed.). *The Semi-Professions and their Organisation, Free Press*, New York.

Gould, L. 1991. Using Psychoanalytic Frameworks for Organisational Analysis. In Kets de Vries, M. F. R. (Ed) *Organisations on the Couch*, Jossey Bass Publishers, San Francisco.

Gowler, D. and Legge, K. 1983. The Meaning of Management and Management of Meaning: a view form social anthropology. In Earl, M. J. (Ed). *Perspectives on Management. A Multidisciplinary Analysis*, Oxford University Press. pp 197-233.

Graen, G. 1976. Role-Making Processes Within Complex Organisations. In Dunnette, M. D. (Ed.), *Handbook of Industrial and Organisational Psychology*, Rand McNally, Chicago, p.p. 1201-1245.

Graen, G. and Cashman, J. F. 1975. A Role – Making Model of Leadership in Formal Organisations: A Developmental Approach. In Hunt J. G. and Larson (Eds.) *Leadership Frontiers*. Kent, OH: Kent State University Press, pp 143-165.

Graen, G. B. and Scandura, T. A. 1987. Toward a Psychology of Dyadic Career Reality, *Research in Personnel and Human Resource Management*, 4, 147-181.

Greenhaus, J. H. and Beutell, N. J. 1985. Sources of conflict between work and family roles, *Academy of Management Review,* 10: 76-88.

Griffiths, R. 1983. *NHS Management Enquiry*, London: DHSS.

Gulick, L. H. 1937. Notes on the Theory of Organisation. In Gulick, L. H. and Urwick, L. F. Eds. *Papers on the Science of Administration*, Columbia University press, New York.

Guba, E. G. and Lincoln, Y. S. 1991 *Effective Evaluation*, Jossey-Bass, London.

Gunz, H. P. and Jalland, R. M. 1996. Managerial Careers and Business Strategies, *Academy of Management Review*, Vol. 21, No. 3, pp 718-756.

Hales, C. P. 1986. What Do Managers Do? A Critical Review of the Evidence, *Journal of Management Studies,* 23, 1, 88-115.

Hales, C. 1999. Why do Managers Do What They Do? Reconciling Evidence and Theory in Accounts of Managerial Work. *British Journal of Management*, Vol. 10 pp 335-350.

Hall, D. T. 1976. *Careers in Organisations*, Goodyear, Santa Monica, CA.

Hall, D. T. and Richter, J. 1988. Balancing work life and home life: What can organisations do to help?, *Academy of Management Executive*, 3: 213-223.

Ham, C. and Hunter, D. J. 1988. *Managing Clinical Activity in the NHS.* Kings Fund Institute.

Hambleton, R. K. and Gumpert, R. 1982. The Validity of Hersey Balnchard's Theory of Leadership Effectiveness. *Group and Organisational Studies*, 7: pp 225-242.

Hambrick, D. C. and Mason, P. A. 1984. Upper Echelons: The Organisation as a Reflection of Its Top Managers, *Academy of Management Review*, Vol. 9 No. 2 pp 193-206.

Hamner, W. C. and Organ, D. W. 1978. *Organisational Behaviour: An Applied Psychological Approach*, Dallas: Business Publication, pp 396-397.

Harrison, R. and Miller, S. 1999. The Contribution of Clinical Directors to the Strategic Capability of the Organisation, *British Journal of Management*, Vol. 10.1 pp 23-35.

Hartmann, E. 1997. The concept of boundaries in counselling and psychotherapy, *British Journal of Guidance and Counselling*, 25:147-162. In Ashforth, B. E., Kriener, G. E., and Fugate, M. 2000 All in a Day's Work: Boundaries and Micro Role Transitions. *Academy of Management Review, Vol. 25,* No.3, 472-491.

Hearing, S., Dent, T., Swann, J., Gunaratna, I, and Ikidde, U. 1999. Maximising the contribution doctors make to NHS management. *Health Services Management Research,* 12 pp 227-231.

Heiss, J. 1968. *Family roles and interaction: An anthology*, Rand McNally.

Heron, J. 1971. Experience and Method: An Inquiry Into the Concept of Experiential Research, Human Potential Research Project, University of Surrey, England. In Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Hirschhorn, L. 1985. The Psychodynamics of Taking a Role. In Coleman, A.D. and Geller, M.H. (Eds.) *Group Relations Reader II*, A.K. Rice Institute.

Hoff, T. J. 1998. Physician Executives in Managed Care: Characteristics and Job Involvement Across Two Career Stages, *Academy of Management Proceedings.*

Huff, A. S. In Eden, C. and Ackermann, F. 1998. *Making Strategy: The Journey of Strategic Management.* Sage Publications.

Huff, A. S. and Reger, R. K. 1987. A Review of Strategic Process Research. *Journal of Management*, Vol.13 No.2, pp 211-236.

Hughes, E. C. 1958. *Men and Their Work*, Free Press, Glencoe, IL

Husserl, E. 1970. *Logical investigation.* New York, Humanities Press.

Hutton, J., Bazalgette, J. and Reed, B. 1997. Organisation-in-the-Mind, In Neumann, E. (Ed), *Developing Organisational Consultancy*, Routledge.

Ilgen, D. R. and Hollenbeck, J. R. 1991. The structure of work: Job design and roles. In M. D. Dunnette and L. M. Hough (Eds) *Handbook of Industrial Psychology:* Vol. 2 165-207 Palo Alto, CA: Consulting Psychologists Press.

Jackson, S. E. and Schuler, R. S. 1985. A meta-analysis and conceptual critique of research on role ambiguity and role conflict in work settings. Organisational Behaviour and Human Decision Processes, 36: 16-78.

Johnson, T. J. 1972. Professions and Power. Macmillan, London. In Dawson, S., Mole, V., Winstanley, D. and Sherval, J. 1995. Management Competition and Professional Practice: Medicine and the Marketplace. *British Journal of Management*, 6(3), pp. 169-181.

Johnson, G. and Bowman, C. 1999. Strategy and Everyday Reality: The Case for the Study of 'Micro-Strategy' *EGOS Conference*.

Johnson, G. and Scholes, K. 1999. *Exploring Corporate Strategy*, 5th Edition, Prentice Hall.

Kahn, R. L., Wolfe, D. M., Quinn, R. P., Snoek, D. P. and Rosenthal, R. A. 1964. *Organisational Stress: Studies in Role Conflict and Ambiguity*, John Wiley.

Kakabadse, A. and Kakabadse, N. 1999. *Essence of Leadership,* International Thomson Business Press.

Kanter, R. M. 1989. *When Giants Learn to Dance*, Simon and Schuster, New York.

Katz, D. and Kahn, R. L. 1966. *The Social Psychology of Organisations*, John Wiley and Sons.

Katz, D. and Kahn, R. L. 1978. *The Social Psychology of Organisations*, Wiley.

Kocka, J. 1988. Reported in The formation of Professions - Knowledge State and Strategy. Burrage, M. and Torstendahl, J. *The Swedish Collegium for the Social Sciences (SCASS)*, Sage Publications, London.

Kossek, E. E., Noe, R. A. and DeMarr, B. J. 1999. Work-Family Role Synthesis: Individual and Organisational Determinants, *The International Journal of Conflict Management,* Vol 10, No.2 pp102-129.

Kossek, E. and Ozeki, C. 1998. Work-Family Conflict, Policies, and Job-Life Satisfaction Relationship: A review and Directions for Organisational Behaviour – Human Resources Research. *Journal of Applied Psychology,* Vol.83, No. 2, 139-149.

Kotter, J. P. 1982. *The general managers*, New York, Free Press.

Kotter, J. P. 1990. *A Force For Change, How Leadership Differs From Management,* The Free Press.

Kouzes, J. M. and Posner, B. Z. 1995. *The Leadership Challenge*, Jossey-Bass.

Kurke, L. B. and Aldrich, H. E. 1983. Mintzberg was right! A replication and extension of the nature of managerial work. *Management Science*, 29, 975-984.

Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing,* Sage Publications Inc.

Lincoln, Y. S. and Guba, E. G. 1985. *Naturalistic Enquiry*, Sage, London.

Linton, R. 1936. *The Study of Man,* New York, Appleton Century.

Louis, M. R. 1980. Surprise and sense making: What newcomers experience in entering unfamiliar organisational settings. Administrative Science Quarterly, 25: 225-261.

Louis M. R. and Sutton, R. I. 1991. Switching cognitive gears: From habits of mind to active thinking. *Human Relations*: 44, 55-76.

Machin, J., Stewart, R. and Hales, C. 1981. *Towards Managerial Effectiveness, Applied Perspectives on the Managerial Task*, Gower.

Mahoney, T. A., Jerdee, T. H. and Carroll, S.J. 1965. The jobs of management. Industrial Relations, 4 pp 97-110. In Carroll, S. J. and Gillen, D. J. 1987. Are Classical Management Functions Useful in Describing managerial Work, *Academy of Management Review*, Vol.12, No. 1 pp 38-51.

Markey, J. P. and Parkes, W. 1989. Occupational Change: Pursuing a different kind of work, *Monthly Labour Review*, 112, (9), 3-12.

Marshall, J. and Rossman, G. B. 1989. *Designing Qualitative Research*, Newbury Park, Sage.

Marshall, J. and Stewart, R. 1981. Managers' Job Perceptions Part I: Their overall frameworks and working strategies. *Journal of Management Studies,* 18,2, pp 177-189.

Martinko, M. J. and Gardner, W. L. 1990. Structured observation of managerial work: A replication and synthesis. *Journal of Management Studies* 27:3 May pp239-357.

Mead, G. H. 1934. Mind, self and society, Chicago, University of Chicago Press.

Mergenhagen, P. 1991. Doing the career shuffle, *American Demographics*, 13 (11), 42-44.

Merton, R. K. 1957. *Social Theory and Social Structure*, The Free Press, New York.

Michaelsen, S. and Johnson, D. E. (Eds). 1997. *Border theory: The limits of cultural politics,* Minneapolis: University of Minnesota Press.

Michigan Leadership Studies. Kahn, R. and Katz, D. 1960. Leadership Practices in Relation to Productivity and Morale, Cartwright, D. and Zander, A. (Eds) Group Dymanics: Research and Theory, 2nd Edition, Row, Paterson. In Robbins, S. P. 1991 *Organisational Behaviour, Concepts, Controversies and Applications*, Prentice Hall International.

Miles, M. B. and Huberman, A. M. 1994. *Qualitative Data Analysis*, Sage.

Millerson, G. 1964. *The Qualifying Associations*, Routledge and Kegan Paul, New York.

Mintzberg, H. 1973. *The Nature of Managerial Work*, Harper and Row, New York.

Mintzberg, H. 1980. *The Nature of Managerial Work*, Prentice Hall

Mintzberg, H. 1994. Rounding Out the Managers Job. *Sloan Management Review, Cambridge,* V.36, Iss.I pp11-26.

Mirvis, P. H. and Hall, D. T. 1994. Psychological success and the boundaryless career, *Journal of Organisational Behaviour*, Vol. 15, 365-380.

Moore, W. E. 1970. *The Professions: Roles and Rules*, Russell Sage Foundation.

Moreno, J. L. 1934. *Who shall survive*? Beacon, N.Y. Beacon House.

Moreno, J. L. (Ed.) 1960. *The Sociometry Reader.* Glencoe III. The Free Press. Reprinted from Who Shall Survive? 2nd Edition, 1953.

NAHAT 1993/94 *NHS Handbook*, 8th edition, JMH Publishing.

Newcombe, T. M. 1951. *Social Psychology*, New York, Dryden.

Nippert-Eng, C. E. 1996. Home and Work: negotiating boundaries through everyday life. Chicago University Press

Oakley, A. 1998. Interviewing Women: a contradiction in terms (ed. H Roberts) Doing Feminist Research, London, Routledge, 30-59. In V. Singh PhD Thesis, 1999. Exploring Male and Female Managers' Perspectives on the Meaning and Assessment of Commitment.

Ong, B. N. 1998. Evolving Perceptions of Clinical Management in acute Hospitals in England, *British Management Journal*, Vol. 9 .3 pp 199-210.

Ovretveit, J. 1992. *Therapy Services – Organisation, Management and Autonomy.* Harwood Academic Publishers, Reading.

Park, R. E. 1926. Behind our masks, *Survey,* New York, 56, pp 135-139.

Parris Stevens, M. A., Franks, M. M. and Townsend, A. L. 1994, Stress and rewards in women's multiple roles. *Psychology and Aging*, 9, 45-52. In Reid, J. nd Hardy, M. 1999, Multiple roles and well-being among midlife women: Testing role strain and role enhancement theories, *The Journals of Gerontology*, Vol. 54B, No. 6 329-338.

Parsons, T. 1951. *The Professions and Social Structure*, Essays in Sociological Theory. Glencoe III, Revised Edition.

Perlin, L. I. 1983. Role strains and personal stress. In H. B. Kaplan (Ed), *Psychological stress: Trends in theory and research*, New York: Academic Press.

Peters, T. J. and Waterman, R. H. 1982. *In Search of Excellence*, New York, Harper.

Pope, C. and Mays, N. 1993. "Opening the black box". An encounter in the corridors of health research. *British Medical Journal.* Vol.306, No.994, pp. 315-318.

Price, D. D. and Barrell, J. J. 1980. An experiential approach with quantitative methods: A research paradigm. *Journal of Humanistic Psychology 20 pp 75-95.* In Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Reason, P. 1994. Three Approaches to Participative Enquiry. In Denzin, N. K. and Lincoln, Y.S., *Handbook of Qualitative Research,* Sage.

Reid, J. and Hardy, M. 1999, Multiple roles and well-being among midlife women: Testing role strain and role enhancement theories, *The Journals of Gerontology*, Vol. 54B, No. 6 329-338.

Riordan, J. F. and Smith, R. 1995. In Simpson, J., and Smith, R. Eds. *Management for Doctors,* BMJ Publishing Group.

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In Bryman, A. and Burgess, R.G. (eds.) Analysing Qualitative data, Routledge.

Roberts, J. 1996. Management Education and the Limits of Technical Rationality: The Conditions and Consequences of Management Practice, in French, R. and Grey, C. (eds.) *Rethinking Management Education.* London: Sage. In Watson, T. J. 2001. The emergent manager and processes of management pre-learning, *Management Learning*, Thousand Oaks, Vol. 32, 2, 221-235.

Rodham, K. 2000. Role Theory and the Analysis of Managerial Work: the case of occupational health professionals. *Journal of Applied Management Studies,* Vol.9, No.1, 18.

Salovey, P. and Mayer, J.D. 1990. "Emotional Intelligence", Imagination, Cognition and Personality. In Golemam, D. 1998. *Working with Emotional Intelligence*, Bloomsbury Publishing Plc.

Sarbin, T. R 1968. Role: Psychological Aspects. In Sills, D. (Ed), *International Encyclopaedia of the Social Sciences*, Crowell, Collier and Macmillan.

Schein, E. H. 1978. *Career Dynamics: Matching Individual and Organisational Needs*, Addison Wesley, Reading, MA.

Schensul J. J. and Schensul, S. L. 1992. Collaborative Research: Methods of Inquiry for social change. In M. D. LeCompte, W. L. Millroy & J. Preissle (Eds), *The handbook of qualitative research in education* pp 161-200, Academic Press, New York.

Schneller, E. S. 1989. Role design for the clinician in management. The mandate of managed care. *Journal of Health Administration Education* Vol. 7 No. 4, pp. 683-93.

Schutz, A. 1962. Common-sense and scientific interpretation of human action, Collected Papers, Vol. 1 Ed. Natanson, M. Nighoff, pp3-47. In Bryman, A. 1988. *Quantity and Quality in Social Research*, Unwin Hyman, London.

Shortell, S. M., Morrison, E. M. and Friedman, B. 1990. *Strategic Choices for America's Hospitals*, Jossey Bass.

Silvermann, D. 1993. *Interpreting Qualitative Data: methods for analysing talk, text and interaction*, Sage, London.

Simpson, J. and Smith R. 1995. *Management for Doctors*, BMJ Publishing Group.

Slocum, W. L. 1966. *Occupational Careers*, Aldine, Chicago.

Smith, P. B. 1973. *Groups Within Organisations*. Harper and Row, London.

Stewart, R. 1976. *Contrasts in Management*. McGraw-Hill, Maidenhead.

Stewart, R. 1981. The relevance for managerial effectiveness of my studies of managerial work and behaviour. In Machin, J., Stewart, R. and Hales, C.(Eds) *Towards Managerial Effectiveness,* Applied Perspectives on the Managerial Task, Gower.

Stewart, R. 1982. A model for Understanding Managerial Jobs and Behaviour, *Academy of Management Review*, Vol. 7 No.1 pp7-13.

Stewart, R. 1989. Studies of Managerial Jobs and Behaviour: The Ways Forward. *Journal of Management Studies*. 26:1 January. pp 1-10.

Stewart, R. 1992. *Enactment in Managerial Jobs: A Role Analysis,* Templeton College, The Oxford Centre for Management Studies, MRP92/19.

Stewart, R. Barsoux, J. L., Keiser, A., Ganter, H.D. and Walgenbachh, P. 1994. *Managing in Britain and Germany,* Macmillan.

Stewart, R., Smith, P, Blake, J. and Wingate, P. 1980. *The District Administrator in the National Health Service*. Pitman, London.

Stogdill, R. M. and Coons, A. E. 1951. Leader Behaviour: Its Description and Measurement, Research Monograph No. 88, Columbus: Ohio State University, Bureau of Business Research. In Robbins, S. P. 1991 *Organisational*

Behaviour, Concepts, Controversies and Applications, Prentice Hall International.

Super, D. E. 1957. *The Psychology of Careers*, Harper and Row, New York.

Tannenbaum, R. and Schmidt, W.H. 1958. How to Choose a Leadership Pattern, *Harvard Business Review*, March-April.

Tanner, D. 1994. Talking 9 to 5: Women at Work: language, sex and power, Virago, Reading.

Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Thomas, J. B. and Mc Daniel, Jnr. R. R. 1990. Interpreting Strategic Issues: Effects of Strategy and the Information-processing Structure of Top Management Teams, *Academy of Management Journal*, Vol. 33, No. 2 pp288-306.

Thorne, M. L. 1997. Being a clinical director: first among equals or just go-between? *Health Services Management Research,* 10 pp 205-215.

Torstendahl, R. 1990. Introduction: promotions and strategies of knowledge based groups. In The Professions in Theory and History, Torstendahl, R. and Burrage, M. *The Swedish Collegium for the Social Sciences* (SCASS), Sage Publications, London.

Triest, J. 1998. The Inner Drama of Role Taking in an Organisation. Paper presented to *The International Society for the Psychoanalytic Study of Organisations.*

Trigg, Understanding Social Science Year. In Blaikie, N. 1993. *Approaches to Social Enquiry*, Polity PressCh.1, p. 1.

Troyer, L. Mueller, C. W. 2000. Who's the boss?: A role-theoretic analysis of customer work, *Work and Occupations,* Vol.27, 3, 406-427.

Tsoukas, H. 1994. What is Management? An Outline of a Metatheory. British *Journal of Management*, Vol.5 pp289-301.

Tsui, A. S. 1984. A Role Set Analysis of Managerial Reputation, *Organisational Behaviour and Human Performance*, 34 pp 34-96.

Tubre, T. C. and Collins, J. M. 2000, Jackson and Schuler (1985) Revisited: A Mata-Analysis of the Relationships Between Role Ambiguity, Role Conflict and Job Performance, *Journal of Management*, Vol.26, No.1, 155-169.

Valle, R. S. and King, M. (eds.) 1978. *Existential-phenomenological Alternatives to Psychology, New York:* Oxford University Press. In Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Van Maanen, J. (Ed.) 1977. *Organisational Careers: Some New Perspectives,* Wiley, New York.

Van Kaam, A. L. 1966. *Existential Foundations in Psychology,* Pittsburg: Duquesne University Press. In Tesch, R. 1990. *Qualitative Research: Analysis types and software tools,* New York: Falmer.

Watson, T. J. 1998. Ethical Codes and Moral Communities: the Gunlaw Temptation, the Simon Solution and the David Dilemma, in Parker, M. (ed) *The Ethics of Organisation.* London: Sage. In: Watson, T. J. 2001. The emergent manager and processes of management pre-learning, *Management Learning,* Thousand Oaks, Vol. 32, 2, 221-235.

Watson, T. J. 2000 In Search of Management (revised edition). London: Thomson Learning.

Watson, T. J. 2001. The emergent manager and processes of management pre-learning, *Management Learning,* Thousand Oaks, Vol. 32, 2, 221-235.

Watson, T. J. and Harris, P. 1999. *The Emergent Manager: Becoming a Manager in the Modern Work Organisation.* London: Sage.

Weick, K. E. 1976. Educational Organisations as Loosely-Coupled Systems, *Administrative Science Quarterly,* 21: pp 1-19.

Weick, K. E. 1979. *The social psychology of organising,* Addison-Wesley, Reading Mass.

Weick, K. E. and Berlinger L. R. 1989. Career improvisation in self-designing organisations. In Arthur, M. B., Hall, D. T. and Lawrence, B. S. (Eds.) *Handbook of Career Theory,* Cambridge University Press, New York, pp.313-328.

Willcocks, S. 1996. *PhD Thesis. National Effectiveness and the Role of the Clinical Director,* University of Lancaster.

Young, R. F. and Kahana, E. 1989. Specifying caregiver outcomes: Gender and relationship aspects of caregiver strain. *The Gerontologist,* 29, 660-666. In Reid, J. and Hardy, M. 1999, Multiple roles and well-being among midlife women: Testing role strain and role enhancement theories, *The Journals of Gerontology,* Vol. 54B, No. 6 329-338.

Zerubavel, E. 1991. *The fine line: Making distinctions in everyday life,* New York: Free Press.