

Middle Managers' Roles after a Hospital Merger

Abstract

Purpose: Mergers are important and challenging elements in hospital reforms. We study the social aspects of management and the roles of middle managers in the aftermath of a hospital merger. Especially, we investigate how professional staff and middle managers perceive their relationships with top managers several years after the merger.

Design/methodology/approach: A survey was made among the professional staff in two merging hospitals units six years after a merger. Based on the main findings from this survey, a follow up interview study was made with a group of middle managers.

Findings: The management practices were diagnostic with few interactive or communicative activities. The respondents expressed that mistrust developed between the staff and the top management, and a lack of involvement and interaction lead to decoupled and parallel organizations. Social controls, based on shared norms, had not been developed to create mutual commitment and engagement.

Practical implications: Policymakers should be aware of the need in profound change processes not only to change the tangible elements, but to take care of changing the less tangible elements such as norms and values. Professionals in hospitals are in powerful positions, and changes in such organizations are dependent on trust-building, bottom-up initiatives, and evolutionary pathways.

Originality/value: The paper addresses the need to understand the dynamics of the social aspect in managing hospitals as knowledge-intensive organizations when comprehensive restructuring processes are taking place over several years.

Keywords: middle managers, hospitals, mergers, management practice, decoupling

Introduction

Mergers have become an important element of public hospital reforms, and the implementation of such a structural change is challenging both for the service producers and for the restructuring of organizational forms and management practices. The last twenty years have seen the implementation of a large number of hospital mergers, mostly driven by financial pressures (Bazzoli *et al.*, 2004). Much of the research in this area is done in the USA, where large hospital enterprises have a longer history. In Europe, hospital mergers gradually became more common in the UK and Scandinavia during the late 1990s. Since then, mergers of hospitals in Europe have been studied by several researchers (Choi and Brommels, 2009; Geisler *et al.*, 2010; Solstad and Pettersen, 2010; Choi *et al.*, 2012; Giaque, 2016; Jonasson *et al.*, 2018), as the implementation of these restructuring efforts has turned out to have unexpected and often dysfunctional effects.

In the case of hospitals, a merger results in the need for coordination of hospital services between heretofore autonomous units. These coordination challenges require new forms of management practice and new governance arrangements. Earlier studies within the public sector have underlined a need to better understand how human resources are managed under such major change initiatives (Pettersen and Solstad, 2014; Mussari and Ruggiero, 2017). These studies found that key actors participating in organizational changes are heavily influenced by social aspects, which affect organizations' ability to facilitate common understanding between groups of actors. Against this background, we focus especially on the social aspects and the role of middle managers in the aftermath of hospital mergers. Our argument is that these aspects, including the perceived trust relationships among middle managers as mediators between top management and the professional staff, are of special importance in obtaining organizational goals in professional organizations like hospitals.

Mergers can take a variety of forms. In this paper, we study a horizontal merger in which two full-scale hospitals were merged with a third large university hospital into one unit. This new organization was much larger than the pre-merger organizations (Holm-Petersen *et al.*, 2017). As the two smaller hospitals were effectively taken over by the large one, we chose to focus on these, since most of the profound structural changes were observed here. The new organization was more hierarchical and centralized, which generally leads to longer control spans (Jonasson *et al.*, 2018).

The merging hospitals had to go through major change processes, and successful implementation meant managing changing lines of authority, developing management structures for a larger organization, and creating new management practices and larger control spans. In such larger organizations, the top management seems to be less visible throughout the organization; furthermore, employees often perceive that top managers do not have the relevant insight and tacit knowledge to coordinate activities (Holm-Petersen *et al.*, 2017). When the merging units are also spread over a large geographical area, the large distances have, in general, been found to reduce employees' involvement and to reduce the direct communication between managers and employees (Cummings, 2008). Consequently, we can expect that larger organizations established by mergers might create physical and perceived barriers between managers and professional staff.

Against this background, we focus on the social aspects of management after a merger that requires the integration of previously independent hospital units. Our research question is how middle managers perceive their role as mediators between top management and the professional staff in the aftermath of a hospital merger. We define middle managers by their functions (Wooldridge *et al.*, 2008) in terms of their relations with the top management.

Mergers can be understood by how employees place themselves in relation to their managers.

Furthermore, middle managers' perceived participation in decision-making processes and their roles as mediators will illuminate how the merged hospital functions in relation to vertical coordination from top management to the clinical sub-systems. In this study, we therefore concentrate on whether professional staff perceive themselves to be integrated with their top management, and how the middle managers themselves think they interact with the top management. We chose the budgeting process as the empirical setting to study these relationships.

The research question is addressed through a survey of the professional staff in the smaller hospitals six years after the merger in order to include a large number of respondents. Based on the main findings from this survey, we followed up a year later with interviews with the group of middle managers to study their perception of their role. The survey includes doctors and nurses, and the interviewees comprise the managers of a clinical department in the two small hospitals. Our focus is on how the professionals in the two smaller hospitals perceive their position in the new larger organization, as most of the structural changes were implemented in the two smaller hospitals. This hospital enterprise was established in 2007, when our two case hospitals were merged into the university hospital, which is geographically far away. The top management team is located in this larger hospital.

Both the survey data and the interviews indicate top-down management practices. Even after six or seven years, the professional staff and middle managers in the distant and smaller hospitals seemed decoupled (Fiss and Zajac, 2006) from the top management situated in the university hospital. Structural changes had been made in the managerial sub-systems, but these changes had not been translated into action systems in the clinical life of the smaller hospital units. As the middle managers in these smaller units felt that they were not involved in the budgeting process, changes in the managerial sub-systems at the top level may not have

been integrated into the clinical action systems, as expressed here by the middle managers close to the professional staff. One main implication from our study is that the role of middle managers as mediators between top management and the professional staff is of key importance when structural changes are to be translated from top management to the clinical action systems governed by professional staff. The argument is that the middle managers are an important doorway to structural change in the aftermath of a hospital merger.

The paper is organized as follows. First, the theoretical framework is described. Second, the empirical setting and the research methods are presented. Third, the findings are highlighted and discussed, and the conclusions are presented.

Theoretical framework

Mergers entail complex and radical institutional changes, and they are dramatic for the actors involved. The merger process is challenging because the new, merged organization is very often geographically dispersed (Lounsbury, 2007, 2008), and one of the partners—most often the largest unit—may dominate, by, for example, hosting the top managerial team and the administrative functions. This is the case in our study. Consequently, our theoretical framework draws on contributions from the management control literature, as, broadly speaking, the main elements within this literature are coordination between managers and professional staff, and how coordination is perceived by the actors. We therefore begin with the concept of management control and continue with the roles of middle managers. Lastly, we focus on hospitals as knowledge-intensive and professional organizations.

The concept of management controls

Our focus is on management practices and control challenges in merged hospitals as these are perceived by key actors in the smaller hospitals, which underwent the most profound changes. Here, we broadly define management practices as the systems and activities that managers introduce in order to motivate employees to attain the organization's goals. In the literature, we find several approaches to the concept of management practices and control. One classic approach is that of Hopwood (1974), who introduced administrative control, social controls, and self-control. These concepts are aligned with Malmi and Brown (2008), who developed a comprehensive and conceptual model of controls.

Administrative control comprises a cybernetic approach with plans, budgets, policy documents, and recruitment policies (Abernethy and Chua, 1996; Malmi and Brown, 2008) to guide employees' actions. Social controls are based on shared norms to create mutual commitment and engagement (Abernethy and Chua, 1996; Hopwood, 1974). In line with Malmi and Brown (2008), social controls are included in the concept of cultural control. Hospitals are knowledge-intensive organizations and are strongly governed by their professionals' competences and norms (Kurunmaki *et al.*, 2003; Pettersen and Solstad, 2014), which belong to social controls. Research has included trust as an important element of social and cultural controls. Tomkins (2001: 165) defines trust as "the adoption of a belief by one party in a relationship that the other party will not act against his or her interests". Trust is developed by learning, experience, and shared norms and values (Cäker, 2008). In professional organizations such as hospitals, the concept of competence trust is introduced (Cäker and Siverbo, 2011). Competence trust comprises the medical professionals' knowledge, experience, and values that facilitate delegated responsibilities to organize and perform the day-to-day work. In three case studies, social controls, defined as competence

trust, were found to be a key management approach at the operational level in hospitals, as activities are interdependent and are characterized by high complexity and mutual adjustment (Cäker, 2008).

Consequently, trust is key to coordination of the interdependent relationships that exist in and between clinical departments (Carlsson-Wall *et al.*, 2011). Self-control is based on individuals' perceptions and values. Professional self-control based on clinical norms and values is inherent in good patient care (Abernethy and Stoelwinder, 1995). We base our empirical study and analyses partly on these elements of trust and self-control as important management tools in motivating professional staff in their clinical work.

The role of middle-managers and management practices

In hospitals, as knowledge-intensive organizations, middle managers' role as mediators in change processes is important (Giauque, 2016). Moreover, middle managers are in key positions because, as change agents, they are expected to translate the structural changes into practices (Balogun and Johnson, 2004). They are mediators between the top managers and the clinical staff (Llewellyn, 2001; Kurunmaki *et al.*, 2003; Giauque, 2016; Nzinga *et al.*, 2019). Middle managers cope with the conflicting expectations of what to prioritise in their managerial activities (Olsen and Solstad, 2017). Meyer (2006) studied middle managers in a post-merger situation and proposed a more complex view of middle managers' interventions. Our study follows up by applying a broad view of middle managers' practices. We focus on the two small units merged into the university hospital, as these units had to go through the most profound changes to adjust to the new practices.

Management practices can underpin or hamper the kinds of control mentioned above. Here, the middle managers as mediators between top management and the professional staff play an

important role in linking management practices with clinical activities. Formal and cybernetic approaches by managers are found to motivate administrative controls, whereas more lateral, informal, and non-managerial approaches performed by the managers, such as dialogues and personal involvement, support social controls (Nyland *et al.*, 2017). This research is developed from the work of Hopwood (1974) and is supported by Simons (1995, 2000), who distinguishes between two main management practices. According to Simons (1995), managers can use diagnostic or interactive practices. A diagnostic management system is designed to monitor, provide feedback, and act in the case of deviations from the agreed upon objectives and action plans (Simons, 1995, 2000). Such an approach can be aligned with the concept of administrative or cybernetic controls (Malmi and Brown; 2008; Nyland *et al.*, 2017).

Interactive management controls performed by managers, on the other hand, are based on continuous dialogues with their colleagues (Simons, 1995). In an interactive approach, managers are in close and two-way coordination with their employees as mediators, and they have a hands-on attitude to daily activities in order to adjust to and organize interactive processes. With reference to the need for social controls and self-control in hospitals (Kurunmaki *et al.*, 2003; Pettersen and Solstad, 2014; Nzinga *et al.*, 2019), we can argue that interactive management practices performed by the middle managers are well aligned with hospitals' dependence on the high performing professionals who coordinate daily activities in the clinics.

Diagnostic management emerges as top-down processes to realize an adopted strategy or action plan, while interactive management systems are characterized by more bottom-up processes in which managers actively participate in dialogue with employees. In this respect, interactive and dialogue-based management practices are found to respond most adequately to

strategic uncertainties related to profound changes in organizations such as mergers. Thus, managers who are associated with interactive management practices are in our case expected to cope most adequately with the profound organizational changes and uncertainties that actors in the smaller hospitals must react to in their search for solutions. Research shows that such learning activities to cope with uncertainties are well supported by building trust between the group of professionals and their managers (Brown *et al.*, 2011).

Merger processes are challenging and create uncertainties among employees at all levels, and interactive managerial practices, according to literature, are most relevant for building trust among professional groups. Trust-building is found in the literature to be a key element in handling uncertainty and, as such, trust is seen as a prerequisite for adequate organizational learning in situations with uncertainty (Simons, 1995). Managers' practices can strengthen lateral relationships by using interactive controls, which include dialogue and face-to-face interaction which promote trust-building activities (van der Meer-Kooistra and Scapens, 2008).

Hospitals as knowledge-intensive and professional organizations

Professionals are the 'gatekeepers' of a hospital's core activities regarding patients. Mergers, as reforms to initiate internal organizational changes, should then not only generate changes in the tangible elements of the organization, such as management structures, system designs and management controls: changes should also be implemented by the key actors and translated into clinical decisions by the professionals themselves. These less tangible elements in hospitals, which govern the professionals' actions, are necessarily affected if organizational changes are to be implemented into service-producing activities (Broadbent and Laughlin, 2005; Solstad and Pettersen, 2010). The norms and values belong to the organization's interpretative schemes, which are found in cultural elements of the organization (Malmi and

Brown, 2008. If the less tangible elements in the organization are split into sub-systems, the process of organizational learning to cope with uncertainties following structural changes can be obstructed and changes may not take place in the professional action systems.

Consequently, changes might happen in the managerial sub-systems, including changes in managerial practices, but these may not necessarily be translated into the clinical action systems. When changes are observed in the managerial sub-systems but not in the clinical action systems, this is in line with the concept of decoupling, which “is not simply a binary choice (i.e., say vs. do), but can be more nuanced and may involve multiple ways of presenting and justifying organizational actions, with some justifications more likely than others to be decoupled from real changes” (Fiss and Zajac, 2006: 1187).

A merger is an external disturbance (Jonasson *et al.*, 2018; Mussari and Ruggiero, 2017; Ernst and Schleiter, 2018), and the way the merged organization is structured and managed will affect changes in the less tangible parts of the merged hospital. These less tangible parts are the norms, values and beliefs guiding the core activities. These are the professionals’ values, which are mostly motivated by social controls and self-control (Hopwood, 1974; Abernethy and Stoelwinder, 1995; Kurunmaki *et al.*, 2003; Pettersen and Solstad, 2014). Since these less tangible parts are considered as cultural integration processes (Ernst and Schleiter, 2018), changes are complex and will take time. In line with the arguments of Jonasson *et al.* (2018), we need to examine how such changes are implemented at different organizational levels. In this study, we do this by studying how professional staff and middle managers close to the clinical activities perceive their relationships, with a focus on the managerial practices as defined above.

Theoretical approach: a summary

Above, we have presented a broad approach to management control and practices, focusing on a hospital, which is a professional organization where social and self-controls play dominant roles. In such organizations, middle managers are mediators between the top management and the professional staff when it comes to implementing structural changes such as mergers. When structural changes are made—tangible in organizations—the middle managers have to translate these changes into the less tangible part of the organization, including the professional norms and values. From the management control literature we know that those managers associated with interactive practices are most able to translate changes into clinical activities. These lateral management practices are positively related to trust-building in organizations.

Research methods and empirical data

Research setting

The hospital sector in Norway, as in most other countries in Europe, has undergone continual reorganization since 2002. The Hospital Enterprise Reform, introduced in 2002, gave rise to the need for a restructuring of the hospital sector with the aim of reducing budget deficits and gaining control of rising expenditure. The Hospital Enterprise Reform was built on the assumption that larger organizational units with delegated autonomy and responsibility would lead to better management and efficiency (Department of Health and Social Affairs, 2001). As a result of this reform initiative, regional health authorities were established to govern the hospital sector on behalf of the state, and many independent hospitals were merged into larger hospital units. In addition, a new management structure was established, under which the top management have overall responsibility for managing the hospital enterprise.

The setting of the case study is a merged hospital enterprise in Northern Norway. This merger took place in 2007. Two hospitals (Hospital 1 and Hospital 2) were merged with the largest university hospital in the region (Hospital 3). Hospital 1 is situated 300 km from this main hospital, while Hospital 2 is situated 249 km from it. The merged hospital enterprise in this study has 6,000 employees in total, and each of the three merged hospitals houses full-scale services, including emergency and intensive care units, and various specialized functions. However, Hospitals 1 and 2 are small units compared with the large university hospital. Documentary studies on the merger process from 2007 onwards described a situation characterized by strategic uncertainty and imbalanced relations between the three previously independent units.

Research methods

In order to understand how the professionals and managers perceived their situation some years after the merger was implemented, we conducted a qualitative case study (as defined by Yin, 2014). As a starting point, we reviewed the existing literature on management control and practices to gain a deeper insight into the areas relevant to our research question. The theoretical framework was then translated into empirically derived concepts, which were operationalized into questions that allowed us to analyse the respondents' answers.

The study was performed in two phases. First, a survey was carried out during spring 2013, six years after the merger. A questionnaire was sent to professionals in the two merging hospitals (Hospitals 1 and 2). A total of 196 respondents implies an actual response rate of approximately 40 per cent, as a large number of professionals (approximately 25 per cent, according to the administrative department) are on leave, not at work or abroad at any one time. Consequently, we analyse the data as trends. Table 1 presents the descriptive statistics as background for the interviews. The survey data are used to underpin the findings from our

interviews with middle managers. The respondents to the survey answered according to a five-point Likert scale. Table 1 summarizes the alternatives agree/partly agree ('agree') and disagree/partly disagree ('disagree'). The focus of the survey was management practices and involvement as perceived by the respondents. The main concepts were involvement, information, communication, trust/mistrust and distance.

Phase two of the study took place during spring 2014. Based on the general picture derived from the survey, interviews were conducted with six clinical middle managers in Hospitals 1 and 2. Interviewees were selected strategically based on their seniority (they had worked for many years in the hospitals and in their clinical positions). The interviews lasted from 1 to 1.5 hours and were carried out in the offices of the middle managers. In these interviews, we focused on the main trends derived from the survey to get a deeper understanding of these trends. We concentrated on concepts such as management practices, the perceived communication between top management and middle managers, perceived geographical distance, control spans, and indicators of competence trust/mistrust. The interviews were recorded, transcribed, and sent back to the informants for validation. Then the data were coded by using the concepts from our semi-structured interview guide. Then the findings were compared and contrasted by the authors. In this paper, the author has translated the quotations from Norwegian to English, which, of course, may imply some translating bias. The interviewed managers were all very experienced, as they had all worked for five or more years as managers in the hospitals.

Some critical reflections can be made on the research methods. First, the interviews were with only a few persons, although very experienced key actors, and we build on their interpretations in order to analyse the research findings. Furthermore, we have included the middle managers' voices, which may be biased in respect of practices and functions. On the

other hand, we consider these middle managers to be major informants and the most important mediators between the top management and the professionals when it comes to the change processes following the merger initiative.

Empirical findings

Data from the survey are presented as background for the interviews with the middle managers. The aim was to gain a deeper insight into how middle managers perceive their role as mediators between top management and the professional staff in the aftermath of a hospital merger. We structure the empirical discussion according to the main concepts in the theoretical framework.

The role of the middle manager and decoupling from the top management

Our theoretical framework implies that the top management in hospitals, as professional organizations, should motivate their middle managers and professional staff by social controls and self-control, which are part of the interactive management practice. Managers associated with interactive management practices are typically characterized by respondents that say they know their top managers, they feel informed by them in their daily work, and they feel informed about key decisions. In other words, such managers are visible among the staff.

As can be seen in Table 1, most respondents in the two merged hospitals did not know their top managers, which indicates that they have not met them. Furthermore, almost half of the respondents perceived that they were not well informed by the top managers about key decisions (43% in Hospital 1 and 42% in Hospital 2). In Hospitals 1 and 2, 48 per cent and 40 per cent respectively said that they were not informed about issues that affected their daily work. These findings indicate that the top management was not associated with interactive

management practices. In general, the survey indicates distance between top managers and the professionals in the two units that were merged into the university hospital. Please see Table 1.

{Insert Table 1 here}

This sense of distance between the professionals and top management also features in the interviews with the managers. The top management team was situated in the university hospital, and it was located far away from the clinics. In the interviews, we focused on the middle managers' involvement in the budgeting process, as budgets are a main strategic decision. Two of the managers running large clinics in the local hospital units gave these responses:

The clinic is given a budget... how can I feel responsible and feel ownership of a budget when I am not involved? (Informant 1, Hospital 2)

Funding comes to me through a budget that I am not involved in. (Informant 2, Hospital 1)

These quotations indicate that middle managers' involvement was low, which supports a picture of the budget process as a top-down process with little interaction or mutual adjustment. From the next quotations, we understand that the respondents perceived the existence of sub-systems, where there is a feeling of 'us' and 'them':

They control their business, and then we get some directives. (Informant 1, Hospital 1)

They work with the budget, but we have the responsibility. (Informant 2, Hospital 2)

Top-down administrative controls and perceived sub-systems indicate a decoupling of top and middle managers and can support the observation that although tangible elements such as organizational structures have been changed, these changes are not translated into the clinical department at local levels, because the middle managers have not translated the administrative and tangible structures (budgets) into their clinics.

Larger control spans and sub-systems

Mergers are often associated with a larger control spans, as the number of levels of control increases when organizations become larger. This is also the situation in our case.

It has become an extended line of management, and it has become much harder to communicate. (Informant 3, Hospital 1)

Four of the middle managers agreed that they had less freedom in their managerial practices than before the merger. One manager said that she had very restricted freedom within the budget frame, as she could only decide on the use of the staff and not on the costs of other kinds of activity.

I'm just delegated authority to manage this with staff availability... (Informant 2, Hospital 1)

The larger control spans implied feelings of decoupling between the top management and the middle managers. There were also signs of mistrust:

I'm not a part of the CEO's team, so I feel that I am far down in the hierarchy when it comes to involvement and influence. (Informant 1, Hospital 1)

I'm very frustrated that the line of authority has become so long following the merger. I have to push upward all the time... (Informant 3, Hospital 2)

These quotations illustrate that the governance structure—the tangible element—had been changed and that management practices had become centralized after the merger. These long control spans reduced the middle managers' abilities to act as mediators between the top management and the staff in the local clinics. When the situation is characterized like this, we find sub-systems in the merged organization. Such sub-systems hamper organizational learning (Broadbent and Laughlin, 2005; Solstad and Pettersen, 2010) and changes in the less tangible parts of the organization will not take place. These less tangible elements include the professional norms that guide the healthcare professionals' social and self-controls, which are important in knowledge-intensive organizations such as hospitals. These quotations from key informants also indicate a degree of mistrust, which will strengthen the split between top management and middle management.

In the interviews, the informants were asked about their perception of cooperating with their distant top managers. A general impression from the interviews is that the geographical distance was translated into mental distance.

Certain persons are sitting far away and high up and make the decisions...

(Informant 1, Hospital 2)

They are actually far away ... and it actually feels very far away. (Informant 2, Hospital 1)

Geographical distance was perceived as a barrier that hampered communication.

Consequently, management controls were mostly perceived as diagnostic and cybernetic from the top downwards, and there were few direct and interactive controls (Simons, 1995, 2000):

They are peripheral... it seems like 'out of sight out of mind'... as if we don't exist.

(Informant 2, Hospital 1)

I hardly know my clinical superior. (Informant 2, Hospital 2)

The mental distance was perceived as having no one to speak to, which gave an impression of isolation among the middle managers.

There's no one to call or speak to—or discuss things with, to put it that way.
(Informant 3, Hospital 2)

As seen here, we find both physical and mental distance between the top and middle management in the two merged hospitals. The large distances were combined with a sense of imbalance between the smaller and the large hospital units. In the hospital that did not house the top management team before the merger in 2007 (Hospital 1), the informants agreed that the university hospital (Hospital 3) was favoured when decisions were made.

My experience is that there are problems in relation to many things, and little understanding. Many of those working in [Hospital 3] have little understanding of how we work here. (Informant, 3 Hospital 1)

There is a lot of focus on the hospital where the top managerial team is located.
(Informant 2, Hospital 1)

They have a larger budget than us. There are such big differences that you almost would not think that it could happen... and then they have a deficit, while we manage to keep within the budget. In my opinion, this is because the top management team and the clinical superiors are geographically located in [Hospital 3]. (Informant 1, Hospital 1)

In Hospital 2, the smallest hospital, the middle managers in 2014 felt that they were treated unfairly compared with both Hospital 1 and Hospital 3 (the university hospital):

[Hospital 1] has a larger budget than us. Obviously, they are larger than us, but they are not double the size even though they have twice as big a budget. ... It does not feel fair. (Informant 1, Hospital 2)

We feel like a 'little brother' to both [Hospital 1] and [Hospital 3]. (Informant 2, Hospital 2)

I feel they have more resources in [Hospital 1]... we also feel that [Hospital 3] is given priority compared to us... they already had and retained several chief physicians and several medical specialists, and this has been maintained since the merger. (Informant 3, Hospital 2)

These quotations illustrate that the middle managers in Hospital 2 perceived that they were treated unfairly in terms of resource allocation, as they thought that the other two units received more funding from budget decisions. This perceived imbalance created mistrust, which still existed several years after the merger took effect. Consequently, based on our theoretical approach, we can argue that middle managers who were feeling mistrustful towards the top management may not be motivated to act as mediators with their staff to develop positive attitudes and change norms following the merger.

Decoupling hampers competence trust and trust-building

In the survey, we asked whether the professionals trusted their top managers, which indicates the degree of trust-building activities within the merged hospital. Please see Table 1 for the responses. Here, most respondents (78 per cent in Hospital 1 and 63 per cent in Hospital 2) indicated that they disagreed with the assertion that 'no hospital is favoured when decisions are taken by the top management'. This implies a perceived mistrust between the professional staff and the top management.

Furthermore, we asked about the perceived effect of geographical distance when it came to horizontal cooperation in the merged hospital. The perception of distance may also indicate the degree to which the merger has affected clinical practice (the less tangible elements). Here, 66 per cent of the respondents in Hospital 2 and 75 per cent in Hospital 1 believed that geographical distance hampered cooperation between the hospital units in the merged hospital (see Table 1). These answers motivated us in the second phase of the study to go deeper into the question of how middle managers, as mediators between the top management and the professionals, perceived their involvement after the merger. If these managers felt that the geographical distance was a barrier to managing their clinics, the less tangible elements in the hospitals—the interpretive schemes in the distant hospital units—may be decoupled from the merging initiative. Consequently, organizational sub-systems may have developed during the seven years since the merger was formally implemented.

In the interviews with the clinical department managers, we asked about the perception of trust with the administrative top managers in the merged hospital. The middle managers were distantly located from their top managers. Obviously, this distance affected the informants:

I feel a bit of mistrust towards my superiors. (Informant 1, Hospital 1)

But I can remind them that 'you must not forget us, and you must remember'. And they're trying to calm us down by saying 'we know you're there, and we have you in mind all the time'—but I don't get that impression. (Informant 3, Hospital 1)

Sometimes we feel that they do not know what they are talking about. They are not in contact with reality. (Informant 2, Hospital 2)

And they come from [Hospital 3] to look over what we have done—they do not trust what we say (Informant 3, Hospital 2).

These responses indicate that the clinical department managers did not feel that the top management had insight into their daily work and tasks, or that the top managers trusted what they were doing. These perceptions are outlined again in these further quotations:

I think they have an arrogance that they should not have... how does my manager expect that I should have a sense of ownership, sense of understanding and sense of responsibility when I do not get help to determine anything? But I do have the responsibility. (Informant 2, Hospital 1)

I feel that we are suspicious all the time. If we could have felt confident, I think that would have been positive; we could have learned a lot and we could have felt motivated and inspired. But we feel insecure all the time in relation to what plans they have for us. (Informant 1, Hospital 2)

These two quotations illustrate that the middle managers experienced a degree of mutual mistrust with their top managers. They felt that they were being treated unfairly compared with the university hospital. These feelings can be interpreted as stemming from management practices that were administrative and cybernetic, and also organized from the top down. This paints a situation with little direct communication and few lateral relationships. The relationships are characterized as imbalanced.

Furthermore, we find few signs of involvement and interaction across geographical borders or across the hierarchy. Limited involvement is related to a lack of direct communication and fewer possibilities of social controls across borders.

Discussion and conclusions

This paper discusses how middle managers perceive their role as mediators between top management and the professional staff following a hospital merger. We also demonstrate how

professional staff place themselves in relation to the top management several years after a merger was implemented. The motivation for this study is earlier research that indicated a need to understand better how human resources are managed in such major changes as mergers (Choi and Brommels, 2009; Mussari and Ruggiero, 2017; Jonasson *et al.*, 2018).

The merging hospitals have been through major changes, and a successful implementation must deal with larger control spans, changing structures and new management practices.

Within this picture, the middle managers close to the daily life in the clinics have an important mediating function between the top management and the professional staff (Llewellyn, 2001; Kurunmaki *et al.*, 2003; Giauque, 2016; Nzinga *et al.*, 2019). Following Meyer (2006), we apply a broad perspective on middle managers' interventions by studying management practices several years after a merger. Here we rely especially on lateral and interactive approaches performed by managers, such as dialogue and personal involvement, which support social and self-controls in professional organizations (Simons, 1995, 2000; Malmi and Brown, 2008; Nyland *et al.*, 2017).

Furthermore, we build on research showing that changes are decoupled from clinical practices (Fiss and Zajac, 2006) if structural changes (tangible elements) are not translated into the professional staff's clinical work, characterized as the less tangible elements (norms and values) (Broadbent and Laughlin, 2005; Solstad and Pettersen, 2010). Here, the middle managers have a vital function as translators through interactive practices that promote trust-building (van der Meer-Kooistra and Scapens, 2008).

We find that, in our case, the management practices are diagnostic with few interactive or communicative activities. Our informants perceived that they were not well informed about decisions made by the top managers, and that the top managers had little knowledge about the

issues affecting the daily work in the distant departments. Trust, as an important element of social controls, promotes organizational learning in change situations. However, our respondents indicate that mistrust had developed between the staff and the top management, whose workplace was the university hospital. The middle managers indicated that they had not participated in the budget process, although they were responsible for running the departments within these budgetary constraints. Consequently, social controls, based on shared norms, had not been developed to create mutual commitment and engagement.

Limited ownership and a lack of involvement, including low levels of direct communication, may foster mistrust in relationships, which is the case in our study. As the activities are interdependent and characterized by high complexity and mutual adjustments in clinical departments, social controls could have been key to developing mutual commitment (Cäker, 2008). In this situation, top-down management practices were found to have a harmful effect on trust between middle managers and staff. Management practices can act as a source of trust or mistrust in a merger process (Busco *et al.*, 2006). The findings from this study indicate that the budget process did not support trust-building in the merged organization.

High quality healthcare is heavily dependent on the middle managers and their staff.

Interpersonal trust supporting competence trust is an important element in care processes.

Trust is difficult to build from a distance, and such relationships should be developed over time and should be created through direct face-to-face contact between managers and their superiors (Brown *et al.*, 2011). In our study, these processes had not taken place following the merger. The empirical findings indicate that there was mistrust between the middle managers and their top managers related to the perceived unequal allocation of the budget. More interactive management practices, including face-to-face communication, could have lowered

the tension between the managerial levels and, consequently, management practices could have been used to motivate trust-building activities.

Our data show that this merger was characterized by diagnostic management control with top-down processes, which reduced the middle managers' ability to be involved and feel motivated in the changing organization. This finding highlights the need for increased awareness by policymakers of the internal processes in hospital mergers. The concept of management controls also includes lateral and social processes, which are highly important, especially in knowledge-intensive organizations such as hospitals. Management control practices affect organizational sub-systems. In our case, parallel organizations were created, mainly because of the top management team, which did not focus on changing the less tangible elements in the organization. Thus, clinical practices were decoupled from the change efforts.

The top management team kept itself distant from the middle managers. Professionals in hospitals are in a powerful position; it is therefore a challenging task for managers to change systems in clinics, as changes in such organizations are dependent on bottom-up initiatives and evolutionary pathways, or they will most often be met by opposition.

We welcome future studies in the field which include more cases and more respondents on a variety of levels in the merged organization. Such studies can fill the knowledge gap related to managing social aspects following a hospital merger.

References

- Abernethy, M.A. and Chua, W.F. (1996), "A field study of control system 'redesign': The impact of institutional processes on strategic choice", *Contemporary Accounting Research*, Vol. 13 No. 2, pp. 569–606.
- Abernethy, M.A. and Stoelwinder, J.U. (1995), "The role of professional control in the management of complex organizations", *Accounting, Organizations and Society*, Vol. 20 No. 1, pp. 1–17.
- Balogun, J. and Johnson, G. (2004), "Organizational restructuring and middle management sensemaking", *Academy of Management Journal*, Vol. 47 No. 4, pp. 523–549.
- Bazzoli, G., Dynan, L., Burns, L.R. and Yap. C. (2004), "Two decades of organizational change in health care: What have we learned?", *Medical Care Research and Review*, Vol. 61 No. 3, pp. 247–331.
- Broadbent, J. and Laughlin, R. (2005), "Organisational and accounting change: Theoretical and empirical reflections and thoughts on a future research agenda", *Journal of Accounting and Organizational Change*, Vol. 1 No. 1, pp. 7–26.
- Brown, P., Alaszewski, A., Pilgrim, D. and Calnan, M. (2011), "The quality of interaction between managers and clinicians: A question of trust", *Public Money & Management*, Vol. 31 No. 1, pp. 43–50.
- Busco, C., Riccaboni, A. and Scapens, R.W. (2006), "Trust for accounting and accounting for trust", *Management Accounting Research*, Vol. 17 No. 1, pp. 11–41.

Cäker, M. (2008), “Intertwined coordination mechanisms in interorganizational relationships with dominated suppliers”, *Management Accounting Research*, Vol. 19 No. 3, pp. 231–251.

Cäker, M. and Siverbo, S. (2011), “Management control in public sector joint ventures”, *Management Accounting Research*, Vol. 22 No. 4, pp. 330–348.

Carlsson-Wall, M., Kraus, K. and Lind, J. (2011), “The interdependencies of intra- and interorganisational controls and work practices: The case of domestic care of the elderly”, *Management Accounting Research*, Vol. 22 No. 4, pp. 313–329.

Choi, S. and Brommels, M. (2009), “Logics of pre-merger decision-making processes: The case of Karolinska University Hospital”, *Journal of Health Organization and Management*, Vol. 23 No. 2, pp. 240–254.

Choi, S., Holmberg, I., Löwstedt, J. and Brommels, M. (2012), “Managing clinical integration: A comparative case study in a merged university hospital”, *Journal of Health Organization and Management*, Vol. 26 No. 4, pp. 486–507.

Cummings, J.N. (2008), “Leading groups from a distance: How to mitigate consequences of geographic dispersion”, in Weisband, S. (Ed). *Leadership at a Distance, Research in Technologically Supported Work*, Taylor & Francis Group, New York, NY, pp. 31–50.

Department of Health and Social Affairs [Sosial- og helsedepartementet] (2001), Om lov om helseforetak m.m., (helseforetaksloven) (The Hospital Enterprise Act).

Ernst, J. and Schleiter, A.J. (2018), “Merger as field transformation: Nurses’ positioning and metaphoric journeys”, *Culture and Organization*, Published online: 15 Feb 2018.

doi:10.1080/14759551.2018.1435656, date of access; 25 September 2019.

Fiss, P.C. and Zajac, E. (2006), “The symbolic management of strategic change: Sensegiving via framing and decoupling”, *Academy of Management Journal*, Vol. 49 No. 6, pp. 1173–1193.

Geisler, B.P., Widerberg, K.F., Berghöfer, A. and Willich, S.N. (2010), “Leadership in health care: Developing a post-merger strategy for Europe’s largest university hospital”, *Journal of Health Organization and Management*, Vol. 24 No. 3, pp. 258–276.

Giauque, D. (2016), “Stress among public middle managers dealing with reforms”, *Journal of Health Organization and Management*, Vol. 30 No. 8, pp. 1259–1283.

Holm-Petersen, C., Østergaard, S. and Andersen, P.B.N. (2017), “Size does matter—Span of control in hospitals”, *Journal of Health Organization and Management*, Vol. 31 No. 2, pp. 192–206.

Hopwood, A.G. (1974), *Accounting and Human Behavior*, Prentice Hall, Englewood Cliffs, NJ.

Jonasson, C., Kjeldsen, A.M. and Ovesen, M.S. (2018). “Dynamics of distributed leadership during a hospital merger”, *Journal of Health Organization and Management*, Vol. 32 No. 5, pp. 691–707.

Kurunmaki, L., Lapsley, I. and Melia, K. (2003), “Accountingization vs. legitimation: A comparative study of the use of accounting information in intensive care”, *Management Accounting Research*, Vol. 14 No. 2, pp. 112–139.

Llewellyn, S. (2001), “Two-way windows: Clinicians as medical managers”, *Organization Studies*, Vol. 22 No. 4, pp. 593–623.

Lounsbury, M. (2007), “A tale of two cities: Competing logics and practice variation in the professionalizing of mutual funds”, *Academy of Management Journal*, Vol. 50 No. 2, pp. 289–307.

Lounsbury, M. (2008), “Institutional rationality and practice variation: New directions in the institutional analysis of practice”, *Accounting, Organization and Society*, Vol. 33 No. 4–5, pp. 349–361.

Malmi, T. and Brown, D.A. (2008), “Management control systems as a package: Opportunities, challenges and research directions”, *Management Accounting Research*, Vol. 19 No. 4, pp. 287–300.

Meyer, C.B. (2006), “Destructive dynamics of middle management intervention in postmerger processes”, *Journal of Applied Behavioral Science*, Vol. 42 No. 4, pp. 397–419.

Mussari, R. and Ruggiero, P. (2017), “Merging for capacity and a capacity for merging: Politicians, citizens, and discourses in public administrations”, *Financial Accountability & Management*, Vol. 33 No. 1, pp. 27–47.

Nyland, K., Morland, C. and Burns, J. (2017), “The interplay of managerial and non-managerial controls, institutional work, and the coordination of laterally dependent hospital activities”, *Qualitative Research in Accounting & Management*, Vol. 14 No. 4, pp. 467–495.

Nzinga, J., McGivern, G. and English, M. (2019), “Hybrid clinical-managers in Kenyan hospitals: Navigating between professional, official and practical norms”, *Journal of Health Organization and Management*, Vol. 33 No. 2, pp. 173–187.

Olsen, T.H. and Solstad, E. (2017), “Changes in the power balance of institutional logics: Middle managers’ responses”, *Journal of Management & Organization*, Published online: 26 December 2017. doi:10.1017/jmo.2017.72, date of access; 1 October 2019.

Pettersen, I.J. and Solstad, E. (2014), “Managerialism and profession-based logic: The use of accounting information in changing hospitals”, *Financial Accountability & Management*, Vol. 30 No. 4, pp. 363–382.

Simons, R. (1995), *Levers of Control: How Managers use Innovative Control Systems to Drive Strategic Renewal*, Harvard Business School Press, Boston, MA.

Simons, R. (2000), *Performance Measurement and Control Systems for Implementing Strategies*, Prentice Hall, Upper Saddle River, NJ.

Solstad, E. and Pettersen, I.J. (2010), “The role of path dependency in a hospital merger”, *Qualitative Research in Organization and Management*, Vol. 5 No. 3, pp. 238–258.

Tomkins, C. (2001), “Interdependencies, trust and information in relationships, alliances and networks”, *Accounting, Organizations and Society*, Vol. 26 No. 2, pp. 161–191.

van der Meer-Kooistra, J. and Scapens, R.W. (2008), “The governance of lateral relations between and within organisations”, *Management Accounting Research*, Vol. 19 No. 4, pp. 365–384.

Wooldridge, B., Schmid, T., and Floyd, S. W. (2008), “The middle management perspective on strategy process: Contributions, synthesis, and future research”, *Journal of Management*, Vol. 34 No. 6, pp. 1190–1221.

Yin, R.K. (2014), *Case Study Research: Design and Methods*, Sage, Los Angeles, CA.

Table 1: Survey data: Hospital 1 and Hospital 2

	Hospital 1 (N = 125)			Hospital 2 (N = 71)		
	Agree (%)	Neither agree nor disagree (%)	Disagree (%)	Agree (%)	Neither agree nor disagree (%)	Disagree (%)
<i>I know the top clinical superior running my department.</i>	22	13	65	22	19	59
<i>My clinical top manager is dedicated to providing me with information about issues that affect my daily work.</i>	29	23	48	36	24	40
<i>I am well informed about key decisions made by the top management.</i>	25	32	43	28	30	42
<i>I believe that no hospital is favoured when decisions are taken by the top management.</i>	2	20	78	10	27	63
<i>Geographical distance poses a problem for cooperation in the hospital enterprise.</i>	75	14	11	66	25	9