# Bridging Competing Demands through Co-leadership? Potential and Limitations[1]

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**Bridging Competing Demands through Co-leadership? Potential and Limitations**


## Abstract

Collective leadership arrangements in which two people jointly occupy a shared leadership role space are often thought to enable the bridging of competing demands and sources of expertise and legitimacy in pluralistic settings where multiple institutional logics coexist. This research investigates twenty co-leadership dyads in health care organizations to examine whether, when and how co-leadership arrangements can enable the bridging of institutional logics. Empirical findings suggest that the potential for bridging through co-leadership arrangements is present, but that it may often be achieved through the assimilation of one side by the other rather than balanced integration of competing demands. We conclude that the challenge of collective leadership (and of co-leadership, in particular) may lie not only in developing smooth relations among multiple leaders and their followers, but also in maintaining and mobilizing the tensions that can make their collaboration most fruitful. We suggest that the collective leadership literature has often missed the significance of this central paradox: that collective leadership may be most needed where it is most difficult to achieve. When it seems to operate most smoothly, it is possible that it may not always be fulfilling its mission.

Many professionalized settings are traversed by competing "institutional logics" associated with the notions of professionalism and managerialism (Glynn, 2000; Reid and Karambayya, 2009; Reay and Hinings, 2009), where institutional logics are defined as, "socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their daily activity" (Thornton et al., 2012: 51). Specifically, the logic of professionalism implies the primacy of expertise based on training and professional certification as a source of authority and legitimacy, while managerialism implies the primacy of formal hierarchical position and a focus on efficiency (Thornton et al., 2012). Logics are constituted here by both cognitive elements (assumptions, values and beliefs) and practices that support them.

The tension between professional and managerial logics is ubiquitous in sectors such as health care (Reay and Hinings, 2009; Kitchener, 2002; Currie and Spyridonidis, 2016), professional service firms (e.g., law, accounting, architecture) (Empson et al., 2013; Bévort and Suddaby, 2016), and the cultural sector (e.g., theatre, orchestras, museums) (Glynn, 2000; Reid and Karambayya, 2009; Thornton, 2004). Moreover, a variety of studies have addressed ways of bridging tensions between different logics (Battilana and Dorado, 2010; Fossestol et al., 2015; Kraatz and Block, 2008; Pache and Santos, 2013; Reay and Hinings, 2009; Smets et al., 2015).

However, one possible but largely under-researched approach to managing the tensions that may arise from the coexistence of professional and managerial logics is the development of co-leadership arrangements at different organizational levels in which a professional and an individual with managerial training share a leadership role positioned at the boundary between logics. In such an arrangement, a dyad of leaders becomes jointly responsible for the achievement of shared objectives, which can, in theory, be reached by leveraging the expertise and influence of

both members in their respective areas (Gibeau et al., 2015). Such arrangements are prevalent at executive levels in the cultural sector where artistic directors support artistic expression alongside administrative directors with financial responsibilities (De Voogt, 2006; MacNeill et al., 2012; Reid and Karambayya, 2009). The model is also appearing in other domains (Alvarez and Svejenova, 2005) including health care organizations where a medical professional and an administrator work to reconcile the clinical concerns of professionals grounded in a professional logic with financial constraints and performance targets grounded in a managerial logic (Ponte, 2004; Zismer et al., 2010; Steinert et al., 2006).

Denis et al. (2012) argued that the literature on plural leadership could be viewed as composed of four streams, each holding different views of the notion of collective leadership. We focus here on one of these streams, that concerned with "pooled leadership" i.e., the idea that multiple leaders may work together to collectively serve as leaders for other organization members. "Co-leadership" (sometimes called "dual leadership") represents one form of pooled leadership, involving the sharing of leadership positions by two individuals acting as a dyad.

As mentioned above, it can be argued that such co-leadership dyads may be able to effectively mobilize and combine their members' respective sources of expertise, authority and legitimacy to bridge different logics and improve their integration within organizational decision making (Gibeau et al., 2015; Reid and Karambayya, 2009; Denis et al., 2012). Yet there has been little research into how co-leadership dyads play their boundary roles, or to what extent they are able to achieve logic integration. We therefore ask *whether and how co-leadership models can contribute to bridging different institutional logics in professional settings?*

To address this question, we carried out in-depth case studies of four Canadian health care organizations which implemented a formal co-leadership arrangement between physicians and

middle managers at the level of clinical programs (i.e., units oriented around services for particular types of patients, and reporting directly to top management in the organizational structure). We examined in particular how twenty co-leaders pairs across these four organizations positioned themselves with respect to professional and managerial logics and at the same time how they negotiated roles and responsibilities within the dyad. Based on our analysis, we identified six co-leadership configurations characterized by different ways of occupying the "shared role space" (Gronn and Hamilton, 2004) created by the collaboration between the two leaders, as well as different ways of expressing the intersection of logics. The study suggests that although most leadership dyads were able to achieve some form of "collectiveness" in the sense of establishing a modus vivendi that enabled them to collaborate successfully, they were often less successful in bridging the logics that justified the collaboration in a balanced and integrated manner. Based on these findings, we question whether such formalized co-leadership arrangements may in fact mask a form of cooptation (i.e., the assimilation or submission of one logic into the other), that does not resolve the tensions underlying institutional multiplicity.

Our contribution to the collective leadership literature is to illustrate how pooled leadership configurations can sometimes result in mutually satisfactory collaborations within a shared role space, and yet still fail in their mission to equitably balance competing demands. The challenge of pooled leadership, in particular, lies not only in developing productive relations among leaders, but also in maintaining and mobilizing the tensions that can make their collaboration most fruitful.

Our study also illustrates alignment between theory and method in collective leadership research in several ways. First, the context of health care organizations is clearly an ideal setting to study the presence of competing institutional logics. Second, the existence of a natural experiment within this setting in which co-leadership arrangements were piloted in four different

organizations allowed us to capture variety in co-leadership configurations in relation to these logics. Prolonged engagement over two years enabled us to obtain a rich picture of these configurations. Third, our conceptualization of institutional logics is clearly reflected in the methodology used to capture their manifestations in participants' discourses (Reay and Jones, 2016). Finally, we mobilized in this paper an approach to visualizing co-leadership configurations that reflects Gronn and Hamilton's (2004) notion of the "shared role space" (see also Gibeau et al., 2015; Gronn, 2009; Hodgson et al., 1965).

In the following, we review the literature on institutional logics and co-leadership arrangements, before explaining the methods and findings.

## Bridging Institutional Logics through Co-leadership? Literature Review

### Responding to multiple logics and institutional complexity

In recent years, researchers have become particularly interested in how organizations respond to multiple institutional logics or to what has been called institutional complexity (Greenwood et al., 2011) or institutional pluralism (Kraatz and Block, 2008), where multiple sets of beliefs, values and practices coexist in a single organizational context. Typically, authors have suggested alternative approaches to accommodating multiplicity that involve either ignoring one logic, separating attention to different logics structurally or temporally (compartmentalization), or finding ways to integrate them by creating structures or practices that transcend the tensions (Kraatz and Block, 2008; Fossestol et al., 2015; Battilana and Dorado, 2010).

Empirical findings have revealed some quite subtle manifestations of these strategies in practice. For example, Pache and Santos (2013) found that social enterprises tended to adopt practices associated with two competing logics selectively, rather than attempt to compromise within practices (structural separation). Battilana and Dorado (2010), in contrast, found that it was

more productive for micro-finance organizations to train their own personnel in hybrid micro-finance practices rather than attempt to hire experts in banking and experts in development and get them to work together (an integrative solution). Besharov and Smith (2017) showed how a social enterprise developed structures that enabled it to switch flexibly between competing goals as its actions encountered legitimacy questions over time, producing an oscillatory dynamic (temporal separation). Finally, at the level of everyday practices, Smets et al. (2015) showed how insurance underwriters engaged smoothly in segmenting, bridging and demarcating practices as they dealt with the competing demands of commercial and community logics in their work (a combination of structural and temporal separation, as well as integration to some degree). Similarly, in a study of health care reform, Reay and Hinings (2009) showed how physicians and managers grounded in different logics accommodated their differences pragmatically in ad hoc collaborations, while nevertheless sustaining distinct beliefs and identities associated with preferred logics.

Overall, while the logics literature has considered multiple ways of bridging differences, there has been very little interaction between the institutional logics literature and the more general leadership literature. Nevertheless, scholars of professional organizations have drawn attention to one type of integrative leadership-related practice that appears *a priori* to offer potential for bridging logics. This involves placing individuals in leadership positions who embody within themselves multiple logics through their diverse training and experiences that enables them to appreciate different beliefs and practices. For example, a literature has developed on the role of "hybrid professionals," i.e., people with professional training who take on management roles, a phenomenon studied quite intensively in the health care sector (Blomgren and Waks, 2015; Llewellyn, 2001; McGivern et al., 2015). For example, Llewellyn (2001) described physician-managers as "two-way windows" combining both professional and managerial perspectives.

The degree to which such "hybrids" successfully integrate competing logics into their identities and practices has been shown to be quite variable however. Kippist and Fitzgerald (2009) for example found that medical managers may emphasize mainly professional goals, potentially undermining attention to managerial demands. McGivern et al. (2015) described two distinct kinds of identity profiles among medical managers in the UK: "incidental hybrids" who essentially adhered to professional logics, and "willing hybrids" who more strongly integrated managerial goals into their professional identities, taking on what the authors described as an "elite" position within their profession and acquiring considerable influence. Blomgren and Waks (2015) illustrated the potential influence of such "willing" medical-hybrid managers in a study of how such individuals contributed to dealing with the multiple logics embedded in quality comparison reports in Swedish health care organizations. On the other hand, the ability to acquire influence as a hybrid professional may depend on professional status. Croft et al. (2015) found, for example, that nurse-hybrid managers appeared to have limited ability to position themselves as legitimate and authoritative actors in either professional or managerial domains. Overall, while it appears that hybrid leadership roles might potentially contribute to logic bridging, this is clearly not a panacea.

This brings us to a related, though somewhat different proposal: the potential of *co-leadership* arrangements to enable the integration of multiple logics. Rather than attempting to embody multiple logics within one individual, such a proposal implies designing leadership and management structures in which two individuals representing different logics work together as a collaborative leadership team, a particular form of collective or plural leadership.

**Co-Leadership in contexts of institutional complexity**

As mentioned, co-leadership is a form of "pooled leadership" (Denis et al., 2012), involving the sharing of leadership positions by two individuals acting as a dyad. A stream of

literature has developed around the dynamics of co-leadership arrangements without necessarily considering explicitly how they bridge competing demands (Bhansing et al., 2012; MacNeill et al., 2012; Reid and Karambayya, 2015). For example, Reid and Karambayya (2009) studied executive duos in artistic organizations where artistic excellence and financial viability need to be balanced. They focused in particular on conflicts and trust, and how they were managed (see also, Reid and Karambayya, 2015). Empson et al. (2013) showed how the dyadic relationship can be a mechanism for institutional work in large international law firms traditionally adhering to a professional logic but dealing with an emerging logic of corporatized partnership. Although these studies take place in pluralistic settings, they do not consider how these logics are manifested concretely in co-leaders' beliefs, discourses and practices of collaboration.

However, there are some contributions that focus specifically on the way in which leadership roles may be shared in co-leadership arrangements, and these could offer some preliminary grounding for considering our research question. First, in their study of the education sector, Gronn and Hamilton (2004) proposed that co-leaders may be seen as a *"form of shared role space inhabited by a distributed mind"* (p. 3). In a subsequent conceptual paper, Gibeau et al. (2015) proposed different ways in which co-leaders might occupy these so-called "shared role spaces". The authors propose four configurations: distribution, dominance, duplication and disconnection. Distribution refers to dyads in which the co-leaders play roles of comparable scope covering the entire shared role of the dyad. The co-leaders' roles have a limited overlap that is sufficient for the co-leaders to remain connected. Dominance implies that one co-leader plays the biggest part of the role, while duplication exists when co-leaders have similar interests and expertise, and hence play overlapping roles. Finally, disconnection involves co-leaders playing separate roles but failing to coordinate their work. This typology is inspired by the earlier work of

Hodgson et al. (1965) on 'executive role constellations', that is, the way executive groups play their roles. Hodgson et al. (1965) discussed the specialization, differentiation and complementarity that exist between top executive roles. The specialization dimension concerns the broadness or narrowness of roles, while differentiation refers to the extent to which roles overlap. Complementarity refers to the degree to which individuals' roles cover the role of the executive team as well as whether these individuals coordinate their work. These ideas are useful to consider the way in which roles are shared across the dyad. However, they still do not specifically address the coverage and balance among different institutional logics in the context of shared roles.

Indeed, to our knowledge, only one study (an unpublished doctoral thesis) has explicitly related co-leadership arrangements with institutional logics directly, that of Fjellvaer (2010). In her study of unitary and dual leadership in 27 pluralistic settings in Norway (including newspapers, arts organizations, health care, education), dyads of co-leaders were shown to integrate logics in three possible ways or configurations that she labels: balancing-balancing; dominant-balancing and dominant-dominant. The balancing-balancing configuration involves both co-leaders adopting a balancing mode. In other words, both try to conform to the demands of multiple logics at the same time. The dominant-balancing configuration occurs when one co-leader tries to balance the demands of different logics while the other adheres solely to one logic. The dominant-dominant configuration is recognizable when the co-leaders each follow different logics without considering the other (Fjellvaer, 2010). Note, however, that while Fjellvaer's (2010) typology considers how each co-leader balances different logics, it does not explain how the two individuals achieve coordination within their shared role space. Overall, there is a clear need for further study of how co-leadership arrangements play out in a context of competing logics or demands and the degree to which they can enable bridging or integration. The focus of the current paper is therefore to

explore *whether and how co-leadership models can contribute to bridging different institutional logics in professional settings?*

## Methods

### Research context:

In studies of collective leadership, as in other domains, it is important to ensure adequate fit between the theoretical frameworks adopted and the methods used. To answer our research question, we conducted a longitudinal qualitative case-based study in four health care organizations, a setting in which professional and managerial logics naturally co-exist (Noordegraaf, 2011; Reay and Hinings, 2009). At the same time, we were particularly fortunate to have access to a natural experiment in which an association of health care organizations within the Canadian province of Quebec (*Association québécoise d'établissements de santé et de services sociaux*) brought together different stakeholders from the medical and health care management communities to discuss ways to improve the relationship between physicians and managers. The committee developed a new model of organizing intended to further medical professionals' aspirations while ensuring their collaboration in reaching organizational objectives. The implementation of formal co-leadership arrangements at the strategic level was a key feature of this model. The setting is thus a perfect fit for a study of how collective leadership arrangements might bridge competing logics. The fact that several co-leadership dyads were established simultaneously across four organizations was also ideal for examining variations amongst them. Finally, prolonged engagement with the organizations studied over two years enabled us to better appreciate the dynamics of collective leadership among the dyads studied.

The dyads of designated co-leaders were composed of a medical co-director and a "clinico-administrative" co-director. The medical co-director was a doctor assigned to a top management

role and mandated to represent the medical perspective within strategic decision making (something that was felt to be less evident previously) and at the same time to share the managerial viewpoint with fellow physicians. The clinico-administrative co-director (a position we will label simply "administrative co-director" from now on for the sake of simplicity and to avoid confusion with the medical role) possessed training and experience in both a (non-medical) clinical profession and in management. Most often, the administrative co-directors managed the directorate single-handedly before the implementation of the co-leadership structure. The new structure thus required them to adjust, giving greater space to medical concerns.

Note that the non-medical workforce of the health care units was salaried and unionized, while physicians were paid on a fee-for-service basis by an outside government agency. These practices reflect in themselves different institutional logics: managerial hierarchy is prevalent for the non-medical workers (including nurses and other professionals), while physicians possess much greater autonomy and were often described as independent entrepreneurs.

Our research team was asked to study the implementation of the model in the four organizations longitudinally over two years in order to assess its potential to bridge medical and management communities, and to bring to bear medical concerns within strategic decision making. The four health and social service centers participating in the project were selected to represent the range of organizations in the field in terms of structure, size, complexity and stage in implementing the co-leadership model. Table 1 illustrates their particular characteristics.

Within these organizations, 20 co-leadership dyads at the strategic level (reporting directly to the CEO or COO) were studied: nine at the University Health Center, four at the Regional Health Center, four at the Semi-Rural Health Center and three at the Primary Care Health Center. It is

important to note that while the University Health Center's co-leadership arrangements had been established several years prior to the study, the other organizations were newer to this form.

Differences among the four organizations that might influence the way the dyads evolved and functioned are summarized in the bottom half of Table 1. Notably, two of the organizations (University Health Center and the Semi-Rural Health Center) appeared better positioned to benefit from co-leadership arrangements. Both were characterized by better historical relations with physicians at the start of the project (based on surveys with managers and medical staff), and both had longer experience with co-leadership. In addition, the Semi-Rural Health Center had invested in training programs for the new co-leadership teams during the pilot project, whereas the other organizations had not. In contrast, the other two organizations (Regional Health Center; Primary Care Health Center) were in a less favorable position, with more recent involvement in co-leadership, and poorer physician-management relations overall. The focus of the current paper is on understanding the diverse ways in which the co-leadership dyads bridge professional and managerial logics, independently of context. However, we will consider the potential role of the context in explaining our findings in the discussion.

*Insert Table 1 here*

**Data collection**

In this paper, we take the leadership dyad as the unit of analysis and describe the data collection methods relevant to this focus. The data collected involved interviews, observations of meetings and documentary analysis with the combination of methods allowing triangulation, and contributing to establishing the trustworthiness of the study (Lincoln and Guba, 1985).

Throughout the 2-year time period, all internal and external documents likely to help gain an in-depth understanding of the four organizations studied were gathered (history, structure,

changes undertaken, strategic plans, etc.). Document analysis constituted an unobtrusive opportunity to gain a deeper understanding of the environment of the organization as well as the terminology used. Especially useful were the documents describing the roles and responsibilities of co-leaders, giving us a vision of how different actors described the configurations of the dyads.

Non-participant observation of meetings were also performed throughout the study (see Table 2), offering a nuanced understanding of the co-leaders' ways of playing their individual and shared roles in real life situations in the medical and management communities, access to the discourse of co-leaders in different contexts, and the tools to differentiate routine or situation-specific dynamics. For instance, observing training sessions aimed at defining the co-leaders' roles and shaping the dyads' configurations allowed us to hear co-leaders discuss and negotiate their vision of their joint role as a dyad and their individual roles as members. Meetings could not be electronically recorded, so hand-written field notes were used to capture these interactions.

Interviews were performed in two waves T1 and T2 in the first six months and the last six months of the study with members of the dyads. The interviews lasted 60-90 minutes each. Questions were asked relating to the participants' academic and professional history, current roles, the history of relationships between the medical and managerial communities in the organization as well as examples of successful and challenging projects they were involved in related to bridging between the two communities. These last questions, inspired by the critical incident technique, provided information about the way in which the dyads jointly played their roles. In addition to the interviews with the dyads themselves, we also interviewed other actors within the organization (including senior managers and operational level managers). These interviews (not listed in Table 2 and not cited in the current paper) provide further context for the research. The interviews were fully transcribed, for a total of 929 single-spaced pages used in this research.

*Insert Table 2 here*

**Data analysis**

Data analysis was carried out initially using open-ended coding to uncover the different co-leadership configurations and their evolution over time without referring to pre-established categories for these roles. To begin the analysis, we combined the interview and observation data and coded for ways in which co-leaders jointly played their role. More specifically, we coded for the structure of relationships (including the difference in positions and availabilities of the co-leaders as well as division of leadership tasks and decision making), the way in which the dyads functioned (the quality of the relationship, the co-leaders' understanding of their roles and the way they communicated) as well as individual characteristics (such as attitudes toward the role, and co-leaders' perceived competencies). While all materials were systematically coded, the interviews were the more dominant source in our analysis and in the findings below (see also online Appendix), with the meeting data providing corroborating evidence and contextual background.

As the study advanced, we began to see the relevance of institutional logics to understanding patterns of role sharing. Thus a second step involved coding all excerpts reflecting (either or both simultaneously) the management or professional logic in the discourse of co-leaders. Inspired by prior research on logics by Thornton et al. (2012) and Reay and Hinings (2009), we coded as "professional logic" any extract reflecting the principle of autonomy (the freedom to practice one's profession as one sees fit (Englel, 1970), the view that legitimacy (in leadership positions for instance) is based on expertise as well as the perception of resources as a source of anxiety. Differently, codes for the management logic in leaders' discourses reflect preoccupations for performance, efficient use of resources and financial control. Quotes reflecting an emphasis on hierarchies, structures and formal positions as a source of legitimacy were also

coded as “management logic.” At this stage, we noticed three ways in which these logics were juxtaposed in specific statements, and coded all excerpts as: (1) pure management or professional logic, (2) opposition of the logics and positioning in relation one logic and (3) a mix of the two logics. In doing this, we noted that a third important notion seemed to interact with the two logics: this is what we call the “mission.” We coded as “mission” any extract expressing a concern for the patient (individually) or for patients (collectively). The notion of mission emerged from the data as a possible implicit form of discursive bridging of the two logics, given the overarching legitimacy of patient concerns in both professional and managerial views.

We then developed a typology of ways in which the professional and managerial logics and/or mission references were combined in the discourse of participants. The following four types emerged: (1) *pure* when only one logic is mobilized (i.e., drawn on as a frame of reference for action), (2) *opposing and positioning* when two logics are presented as conflicting and the participant explains how they prefer one over the other, (3) *converging* when logics are presented as parallel considerations leading to the same actions or decisions, and (4) *embedding* when one logic is presented as being inserted in another or as the basis for actions and decisions within another logic. Representative extracts reflecting these four codes are provided in Appendix 1.

In the interests of further elucidating theory-method alignment in this study, it is worth commenting here on the use of interview and other verbal materials (what Fairhurst, 2007: would call small "d" discourse) to capture the emphasis on different institutional logics for each dyad. We defined logics above drawing on Thornton et al. (2012: 51) as “socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their daily activity.” Our assumption is therefore that when respondents call on ideas

associated with professional and managerial logics, they are both reflecting and at the same time "performing" in their communications with us (Cornelissen et al., 2015; Lammers and Proulx, 2015) "historical patterns of cultural symbols, material practices, assumptions and beliefs." In other words, they are drawing on what might be called big "D" discourses prevalent within their context, and instilled in them by their training and experience, but as competent actors, they use these discourses as "interpretive repertoires" (Fairhurst, 2007) to explain and give meaning to their activities, sometimes mixing them in quite subtle ways. Note that the method adopted here corresponds to what Reay and Jones (2016) labeled a "pattern inducing" approach in their methodological article on capturing institutional logics qualitatively.

The final step in our methodology involved developing a typology reflecting both the way co-leaders jointly play their roles in relation to each other and the way they combine institutional logics in their discourse. To develop this typology, we evaluated the preponderance of logics, for each dyad, taking into account both the number and tenor of the extracts coded as above. We crossed this information with that concerning roles played by each leader within the dyad. This typology is explained below in the findings section.

To ensure the trustworthiness of the study, throughout our data collection and analysis process, we followed Lincoln and Guba (1985)'s guidelines. Iterative questioning was used to capture data not supporting emerging patterns, frequent debriefing sessions with members of the research team were organized, thick descriptions were exchanged among members of the team, and member checks with participants were conducted midway through the study, and at the end. Triangulation, early familiarity with the culture of participating organizations as well as the use of these different tactics contribute to the trustworthiness of the study.

## Findings

We propose six configurations reflecting the way dyads jointly play their leadership roles and the way co-leaders combine logics in their discourse: these are displayed in Figure 1, and successively labeled dyad of one, professional consulting, boundary duo, management duo, management unit and mission unit. Below, we illustrate these configurations using an example of a typical dyad. Note that in Figure 1, while the horizontal dimension represents an increasing degree of overlap in shared role spaces, roughly reflecting the degree of collaboration occurring between the two actors, the vertical dimension reflects the relative weight of professional vs. managerial logics in the discourse of the two protagonists. We describe the six configurations starting at the top left of Figure 1 (low collaboration and managerial logic dominance) and moving gradually towards the bottom right (high collaboration and balanced integration of logics). Additional data supporting the six configurations is provided in Appendix 2.

*Insert Figure 1 here*

### The dyad of one

The first configuration, the dyad of one shown in the top left of Figure 1, represents two dyads in which one co-leader, specifically the administrative co-director, accomplished the bulk of the work. Typically, the medical co-director more or less actively but always unsuccessfully attempted to become more involved. These efforts of the medical co-director emphasized the professional logic and usually involved trying to access budgets, representing colleagues and having a say in the allocation of resources. For instance, the medical director associated with our proto-typical case explained how she viewed the health center as a provider of resources for which she needed to fight, *"The health center must provide the infrastructure, the resources. My role is to obtain what we need to practice and teach. (…) They tell us to mind our own business"* (Medical

director 18-PC, T1[2]). This statement reflects the role of representation specific to the professional logic and a view of resources as a source of anxiety. The statement also reveals the medical director's efforts to get involved as well as the failure of these attempts.

In this particular dyad, the administrative co-director, who single-handedly managed the directorate before the implementation of the co-leadership model, continued to independently carry out her work and was seen by the medical director as leaving no space for the medical director within the dyad. The following statement by the medical director expresses this idea:

> *She made all financial decisions and never consulted us. We have been fighting for years to see the numbers. We have needs, can we talk about it? No – they decide.* (Medical director 18-PC, T1)

These two statements by the medical director are instances of the mobilization of a single logic. In this case, the statements reflect 'pure professionalism' as they draw on the professional ideas of representation and fighting for resources that the organization should provide. From the viewpoint of the administrative co-director, the medical director's attempts to get involved reflected her desire to further physicians' interests. The administrative co-director believed that clarifying the roles of the dyad and of the co-leaders would be helpful, *"It is about helping the organization achieve its goals and looking beyond your own practice. (…) Currently, it seems that doctors get into co-leadership positions to obtain more without giving much. But it should be win-win. I have said it many times: let's define the role of medical directors, debate it, present it, agree on what it is"* (Administrative co-director 18-PC, T1).

While arguing for the need for bridging ("win-win"), the administrative co-director's discourse reflects her emphasis on formal mandates and hierarchical structures, a point of view

[2] Note that interviewees are identified by their formal role, the number of the dyad, the code of the organization (U=University Health Centre; R=Regional Health Centre; SR=Semi-Rural Health Centre; PC=Primary Care Health Centre) and by the interview wave (T1=Time 1; T2=Time 2)

more typical of the management logic. The medical director differently does not see her formal organizational role as guiding her behavior, and did not ascribe much value to this role, "*My role as medical director is pure fiction. Legally, they [administrators] had to put a name in the box in the organizational chart. We [physicians] did not want that role."* (Medical director 18-PC, T2)

To summarize, this configuration brought together individuals who strongly reflected distinct professional and managerial logics. However, because of the lack of any form of collaboration between the two co-leaders, there was no bridging or integration of logics – indeed, we have labeled this configuration in Figure 1 as characterized by "disconnection." Moreover, because the individual who represented the managerial logic appropriated almost unilaterally the shared role space, the professional logic appeared marginalized and the managerial logic remained dominant. This did not mean, however, that the professional logic disappeared entirely. Rather it remained as a pocket of resistance, with the two logics clearly constructed as oppositional.

**Professional Consulting**

The second configuration (bottom left box of Figure 1) shares some similarities with the first, in that it is the administrative co-director who accomplishes the biggest portion of the dyads' work. However, the medical director in this configuration was more involved, providing expertise or leveraging his or her influence on specific issues when invited, *"I contribute when needed. There is no mobilizing project that could make me put in extra effort. It has been about routine work. (…) But when I am asked to contribute, I always respond."* (Medical director 20-PC, T1).

This consulting role reflects the influence of the professional logic on the medical director, as it allows him to represent his colleagues, *"I do not see myself as an administrator, but as a representative of physicians in the administrative community."* (Medical director 20-PC, T1). Nevertheless, the medical director's discourse also reflects to some degree the managerial logic

when he states that his formal managerial role guarantees that his point of view will be taken into consideration. For example, in the following excerpt, the medical director explained how having a formal role in the organizational structure (management logic) ensured that he would be able to play his representation role (professional logic) embedding the professional logic within the context of a managerial logic, something that he saw as useful, "*The advantage of the role is to have a defined path to work and defend ideas. More certainty that we are going to be consulted for issues affecting us" (Medical director 20-PC, T1).*

While he saw his role as providing him with some influence with managers, the medical director did not, however, believe that such influence is granted to him on the basis of his role as a professional: *"I am medical director of a directorate where all the members are autonomous professionals who have theoretical obligations but whom I cannot even sanction. I ask for everybody's collaboration but I do not have power over them" (Medical director 20-PC, T2).* In this statement, the medical director highlights the autonomy characterizing his profession and the professional logic, as well as the typically professional view that leadership and influence do not derive from formal position.

The discourse of the administrative co-director on the other hand largely reflected the managerial logic. While appreciating the ability to consult with a professional counterpart, she believed that better defining the responsibilities associated with different co-leadership roles would allow the co-directors to develop the new model further, "*We have to work on the definition of everyone's roles and responsibilities. How can I contribute, what competencies need to be developed? (…) Can we define it more" (Administrative co-director 20-PC, T1).*

In summary, like the dyad of one, the professional consulting configuration brings together individuals who largely reflect distinct professional and managerial logics in their discourse (see

Figure 1). In addition, the managerially-oriented partner occupies a predominant role in the shared role space. The difference between the two configurations lies, however, in the way in which professional and managerial concerns are jointly considered. In professional consulting, the medical co-director's opinion on issues can be integrated into decisions and he or she shows some recognition of the legitimate needs of management, embedding the professional logic within a managerial logic of recognized formal roles. Thus both professional and managerial logics are maintained as separate and to some degree mutually legitimized, although the managerial role is dominant in the shared role space. This is a fairly common configuration (six out of twenty dyads).

**Boundary Duo**

The third configuration (middle bottom in Figure 1), the boundary duo, reflects the two dyads in which both co-leaders possessed roughly the same influence within the shared role space, and were able to function collaboratively. In this configuration, work was typically *distributed* based on expertise, but some issues were jointly addressed. The 'boundary' element of this type reflects the idea that the members of these dyads are located at the boundary between different logics as one co-leader drew predominantly on one logic while the other seemed to play the role of what the literature has called a "hybrid," mobilizing both logics in his/her discourse. Hybrids are individuals who have internalized the imperatives of both logics (Blomgren and Waks, 2015; McGivern et al., 2015). Mirroring this, the co-leaders typically divided their work based on the logic they predominantly adhered to. Hence, an administrative director would perform management tasks and adhere to the management logic, while a medical director would predominantly act on issues concerning the professional community and conform to both logics. Although the co-leaders mostly played their respective roles independently, the two members of the dyad coordinated their actions:

> *When decisions cost millions of dollars or when it comes to the strategic management of our directorate, it is the two of us. One thing is clear between us: we try to respect our respective expertise." If there is a problem with doctors, I do not intervene directly. Especially if it is related to quality. [My co-leader] will take care of that, but I am informed. Same thing if an administrator in our directorate is more difficult or if we have problems with an employee. We are both informed but we respect each other's expertise (Administrative co-director 1-U, T1).*

Consistently with the management logic, the administrative co-director insisted on the dyad's efforts to clarify roles and responsibilities, *"We had to sit down and say, 'I am going to be responsible for this.' We established rules for our dyad."* (Administrative co-director 1-U, T1)

When discussing his role in strategic management, the medical director's discourse reflected both logics. In the following quote in which he contrasted the professional logic characterized by autonomy with what he believed is the right way to play this role which involved respecting formal mandates, the medical director positioned himself within the management logic, "*The administration pays me to be a medical director. I cannot take that money and act like an autonomous professional. I am a hospital manager. (…) The decisions made in those meetings, I have to support them even if I do not agree with them."* (Medical director 1-U, T2)

However, the professional logic also appeared central as we observed during a strategic management committee meeting involving all medical and administrative co-directors when the medical director represented physicians in attempting to gain resources for the acquisition of expensive specialized equipment:

> *For physicians, it is clear that "we do not have a choice. We must acquire the [equipment]. Otherwise, we are shooting ourselves in the foot." [Medical director 1] goes further, saying that if the project of acquiring the [specialized equipment] was to be abandoned, physicians' participation in management would be greatly compromised and might decline. (Notes taken during a strategic management meeting-U – February 12, 2013)*

In summary, the boundary duo has some similarities to the two previous configurations in that both logics are clearly represented. However, it differs from the two previous configurations in that the shared role space is occupied in a relatively equal manner by the two individuals who

coordinate through a form of "distributed" co-leadership – dividing up key roles so that each operates in their area of personal expertise, though at times collaborating at points of overlap. This configuration also differs from the previous two in the degree to which the medical co-leader has personally integrated both logics into his or her discourse. In this configuration that involved much greater personal investment of time for the physician than the previous two, the medical co-leader could be described as a true "hybrid." Hybridity is however not generally something we saw for the administrative leaders although there were occasional references to mission. Of all the configurations we are proposing, the boundary duo is the closest to the ideal proposed by Hodgson et al. (1965) in which co-leaders' roles are specialized, differentiated and complementary.

**Management Duo**

Like the boundary duo, the management duo (middle top in Figure 1) is composed of two members coordinating their work but mostly working independently. However, unlike the previous configuration, and somewhat surprisingly, both members of the four management duos – even the doctors, primarily emphasize the management logic in their discourse and hardly at all the professional logic. Although the references to the mission (i.e., patients) vary significantly from one dyad to the next, when this was used, it was predominantly embedded in the management logic within the co-leaders' narratives. Here, both members of our proto-typical management duo described the way they coordinated their work as complementary and oriented around operations:

> *When there are specific issues, I discuss it with him, but we do not decide the number of nurses we need together. Or the number of attendants we need to move the patients. (Administrative co-director 6-U, T2)*

> *In the day-to-day, if there is an emergency and I need to ask the physicians to release patients or transfer patients, [my co-leader] calls me. I do my part of the work, she does her part of the work with the administrators. (Medical director 6-U, T2)*

In both quotes, the mission is embedded in the management logic as the co-leaders explain how patients are part of their decision making process when managing resources. The management

logic was also mobilized independently in the co-leaders' narratives. For instance, the administrative co-director expressed the centrality of budgets in decision making, "*Physician representatives weren't interested in knowing whether what they were asking for was worth one million dollars. -They do not even know the price of things."-(Administrative co-director 6-U, T1)*

In the medical director's discourse, the management logic was 'pure' when he explained efforts made to establish his dyad in the hierarchy by preventing physicians from bypassing him:

> *If they [physicians] want to develop a project, they start by talking to the [co-leaders] instead of going straight to top management. (…) [If they go to top management,] they face a closed door and are told, 'No, go talk to the co-leaders.' (Medical director 6-U, T2)*

In summary, the management duo is a dyad in which the two members emphasize the management logic when accomplishing their work independently but in a coordinated way the tasks associated with their role. Although the management logic is predominant in the co-directors' discourse, the mission sometimes seems to be embedded within it as a context for decision making. The overall picture however, is that in contrast to previous configurations, the professional logic seems relatively absent from the discourse of either protagonist, even though their roles are different and constructed so as to be complementary.

**Management Unit**

The last two configurations (labeled as "units" – the management unit, and the mission unit) differ from the previous two (labeled as "duos" – the boundary duo and the mission duo) particularly in terms of how roles are divided within the shared role space. For example, while the "management duo" involves distributed roles, the "management unit" (see the top right of Figure 1) is composed of two members who see themselves as almost inter-changeable – able to substitute for each other despite their different backgrounds, and in this case both guided by the management logic. This configuration was observed in four dyads. As an administrative co-director and his medical co-director respectively put it, their dyad functioned in an integrated way:

> *We do not say, 'you manage this project, I manage this project.' Some projects are managed together, others mainly by one of us. But information circulates, no matter what the project is. (Administrative co-director 4-U, T1)*
>
> *We work in an integrated way, that is, at this point, whether I am present or not, or whether she is present or not at a meeting, our mutual trust is so high that it barely makes a difference. (Medical director 4-U, T1)*

The medical director's emphasis on the managerial logic was especially clear when he explained his vision for the organization, emphasizing budgets, human resources management and performance indicators, "*I want to prove… I want proofs that it [co-leadership] works. I want to become the highest performing health center financially, in terms of human resources, but also in terms of care indicators." (Medical director 4-U, T1)*

The administrative director's perspective appears in his analysis of one key organizational decision, the purchase of expensive specialized equipment. The quote reflects 'pure' references to the managerial logic by emphasizing financial considerations and human resource management, "*That equipment that we wanted to acquire, we [administrators] wanted the physicians to analyze it the same way [as managers] …with the same constraints in relation to financial and human resources." (Administrative co-director 4-U, T2)*

In summary, the management unit is a configuration in which both members of a dyad see themselves as interchangeable (expressed as a large overlap in the shared role space In Figure 1) and yet they emphasize almost exclusively the management logic. While one of the members has medical training and in that sense could be expected to act as a carrier of medical values, the co-leadership dyad's discourse has become almost exclusively managerial, suppressing the professional logic, even as the fluidity and collaborative nature of the relationship between the medical and administrative co-leader has become more intense.

**Mission Unit**

Two additional dyads in our sample were, like the management unit, acting in an integrated way with almost interchangeable roles. However, contrary to the previous configuration, the members of these dyads primarily emphasized the mission in their discourse, although the management logic also appears. For example, the medical director of one of these dyads described their joint role as accomplishing strategic management work as a unit: *"The medical director is part of the team. Decisions are made together. (…) If there is an opportunity to develop services, if the minister makes requests affecting my directorate directly or indirectly – then we reflect together and really share." (Medical director 5-U, T1)*

The administrative co-director referred to the mission frequently. In the following excerpt, the mission is embedded in the management logic as the director explained how serving the patient justifies breaking silos in the organizational structure, "*Clients at the emergency room are not other directorate's clients, they are our clients. How can we offer better services to these clients? It's not, 'It's your patient, it's my patient'. It is OUR patient who happens to be at the emergency room" (Administrative co-director 5-U, T2).*

The administrative co-director also mobilized the management logic, which appears in the following quotes in which she insisted on the need to agree on roles and responsibilities, "*Beyond giving a title to a doctor, we have to make sure that he understands what is associated with it. The package deal. (…) When they accept the title, they have to accept what comes with it." (Administrative co-director 5-U, T1)*

The medical director also emphasized the management logic. His discourse repeatedly expressed his concern for roles, structures and hierarchies, "*We went from a vertical structure in silos to a matrix structure forcing the medical chiefs to interact with the administrative chiefs."*

*(Medical director 5-U, T2).* Beside the management logic, the mission seems to guide the medical director's discourse. For example, he explained how his role as medical director involves not only responsibilities toward patients but also toward the organization. He therefore framed the mission and management logic as converging:

> *I am the employee of an hospital, not an autonomous professional. When I was a medical student in the 60s, I was taught that I was accountable to god and my patient. It has changed a lot since then. I have a responsibility toward the population, a responsibility toward the patient, yes, but also a responsibility toward the health center. Yes, I represent my patients and their needs in the health center, but at the same time I have a responsibility toward my health center which has the same mission as I have, which is to offer quality services. (Medical director 5-U, T2)*

In sum, within the "mission unit" configuration, synergy is created by shared values (i.e., the emphasis on the mission) which seems to transcend both professional and managerial logics. The co-leaders act in synchrony (with high overlap in the shared role space – See Figure 1), focusing mainly on meeting patients' needs. Beside the mission, the management logic remains present in the co-leaders' discourse, but mission and managerial discourses are either embedded or converging within the co-leaders' narratives.

## Discussion

In this study, we investigated *whether and how co-leadership models enable the bridging of different institutional logics.* Our starting point was the intuitive idea that while it might be difficult for individual leaders to become successful hybrids embodying different logics within the same person (Croft et al., 2015; Kippist and Fitzgerald, 2009; McGivern et al., 2015), the inclusion of two individuals within the same role space, each reflecting different logics through their background and experience, and diverse sources of authority and legitimacy might result in more balanced or integrated treatment of institutional demands (Fjellvaer, 2010; Gibeau et al., 2015).

Our findings suggest that while this is not impossible, it is by no means easy to achieve. Emerging configurations found in our study sometimes result in the separation of logics without strong integration (the dyad of one; professional consulting), or the submission of one logic to the other and/or the cooptation of one co-leader (notably in the management duo and the management unit). Hence, the tensions between the logics present at the organizational level appear to be mirrored within the dyads created over half the time. Indeed, based on our findings, we suggest that co-leadership creates paradoxical demands. On the one hand, as Reid and Karambayya (2009; Reid and Karambayya, 2015) point out there is a need for strong collaboration and trust to achieve a fully functioning leadership dyad. On the other hand, trust and collaboration may be harder to create when individuals adhere to conflicting institutional logics. Thus integration or effective coordination is often associated with suppression of one logic.

Nonetheless, there are some configurations that offer more potential for balance. For example, boundary duos in which at least one co-leader adopts a "willing hybrid" role (McGivern et al., 2015) can retain some emphasis on the professional logic within the dyad. Co-leadership may also help bridge logics when both co-leaders suppress their original logics to focus on a third overarching principle. In this study, the mission units demonstrated this type of bridging.

Fjellvaer's (2010) previous doctoral research on co-leadership configurations identified three kinds of configurations that she called balancing-balancing, dominant-balancing and dominant-dominant where the notion of balancing implies a hybrid role for one leader, while dominant implies a leader's focus on one logic. This typology focuses essentially on the combination of perspectives for the two individuals. Our typology reaches beyond this by showing that individual patterns of mobilization of logics does not automatically translate at the dyad level. Indeed, our results suggest that dyads in which both co-leaders follow *different* dominant logics

experience disintegration, leading to one co-leader's withdrawal from the role. We saw this in the "dyad of one" where the professional partner largely abdicated their position. As a result, only one logic may end up characterizing these dominant-dominant dyads' work. Likewise, when both co-leaders emphasize the *same* logic, only one logic is represented in these dyads. In dominant-balancing dyads, one logic ultimately appears to become dominant at the dyadic level if the other is seldom represented. The only balancing-balancing configuration in this study was the mission unit in which both co-leaders appeared to be balancing the management logic with the mission. The professional logic, however, was only marginal. In other words, our results suggest that regardless of whether individual co-leaders balance different logics or adhere to different logics, at the level of the dyad, one logic is likely to dominate.

Other typologies identified in the past suggest four configurations: distribution, dominance, duplication and disconnection (Gibeau et al., 2015). Our boundary duos reflect these authors' 'distribution' configuration, and seem to be closest to an 'ideal' form of co-leadership. However, the configuration appears infrequent and fragile. Furthermore, co-leaders in boundary duos may divide their roles based on expertise, each co-leader focusing on issues related to their original profession. As a result of this division, the bridging activities of the members of the duos individually may be somewhat limited by the configuration. The dyad of one and professional consulting constitute to different degrees 'dominance' configurations. In these dyads, one logic is predominant because a secondary logic is pushed aside, but the co-leader supposed to personify this logic remains embedded within it. We are hence witnessing patterns of submission of the secondary logic. The dyad of one as well as some professional consulting duos may also be seen as a 'disconnection' configuration since the members have little interaction, if any at all.

The management duo, management unit and mission unit are incarnations of 'duplication' configurations. Although Gibeau et al. (2015) highlight the potential for rivalry in these configurations caused by the lack of differentiation, our results suggest that these configurations may permit the greatest synergy between co-leaders. Our study also suggests that the coopted co-leader in management duos and units might encounter difficulties in playing their roles. Professionals may indeed be reticent to accept the leadership of a co-leader who has been coopted into the management logic. As a result, the co-leader's capacity to personify the professional logic or exercise influence may be limited. The mission unit's specific interest lies in the subordination by both co-leaders of their original logic, and their mobilization toward an overarching principle expressed in this case by the 'mission.' This conclusion is consistent with Dass (1995)'s observation that overarching objectives allow dyads to function effectively. This subordination of the original logic does not mean that the individual is not embedded in either the professional or management logic, but that he or she mitigates it when playing his/her co-leadership role.

In sum, the potential for co-leadership to help bridge institutional logics seems to be determined by the combination of the patterns of mobilization of logics by co-leaders and the practices of collaboration between dyad members. The co-leadership model is clearly not universally associated with bridging. It can contribute to this, but as we saw, it can also contribute to separating logics or reinforcing dominance.

Before concluding, it is important to draw attention to some boundary conditions and limitations of our study, and to identify opportunities for further research. First, as we noted in the methods section, our dyads were created within different organizational contexts, and had been operating for variable lengths of time when we interviewed them. Despite this variation, we noted few systematic contextual elements that might explain the prevalence of different configurations

in each of the sites. One observation however is that the weakest form of collaboration (the "dyad of one") was only observed at the Primary Care Health Center. This could be partly explained by the fact that this organization's top management team invested least effort in making the co-leadership structure work. Training sessions were planned but canceled, and many managers complained about half-hearted implementation efforts. Another explanation might be related to the Primary Care focus where physicians were simply less involved in management. However, other than this, multiple configurations were present in all sites with no obvious systematic trends.

It is noteworthy moreover that despite the fact that ten dyads were interviewed at two points in time, our data showed little evolution in co-leaders' adherence to a particular logics or changes in their working arrangements. Configurations tended to be remarkably stable, suggesting that initial moves in establishing a modus vivendi are critical.

One might also ask whether the range of possible configurations we identified is exhaustive. For example, we found no configurations in our study where managerial logics were fully subordinated to professional logics within co-leadership dyads. This is no doubt an artefact of our particular context in which people with medical training were essentially being added to a pre-existing managerial position. However, we would expect greater symmetry or even a reverse pattern in other settings. For example, in arts organizations, artistic directors often have significant power, and the evidence suggests that managers might often play lesser roles in such dyads (Alvarez and Svejenova, 2005; De Voogt, 2006; Reid and Karambayya, 2009). It would be valuable to conduct research in other sectors to examine the transferability of our findings.

Finally, in this paper, we focused on exploring the bridging potential of the co-leadership model. However, other outcomes such as team cohesiveness, organizational commitment, identification and the clinical or financial performance of dyads could also be assessed, providing

additional insight by revealing whether specific configurations (including unitary rather than co-leadership) offer greater potential for organizational level benefits. This would however likely require a different quantitative methodology involving the assessment of a larger number of dyads than we were able to include in the current study.

## Conclusion

Overall, the study contributes to the literatures on co-leadership and on responses to organizational complexity by exploring how the former may contribute to the latter. In this paper, we explained six configurations of co-leadership: dyad of one, professional consulting, boundary duo, management duo, management unit and mission unit. The study shows that co-leadership arrangements may contribute to bridging institutional logics when at least one co-leader adheres to both logics, when a dominant co-leader sporadically exploits the expertise and influence of his or her counterpart who embodies a different logic or when co-leaders move away from their original logic to focus on an overarching principle. The study also reveals that the balance between different logics is not easy to establish, the tensions present at the organizational level being mirrored within the dyad. Separation, submission or cooptation of one logic often result.

More generally, this suggests that mutually satisfying collaborations among members of a leadership collective may not be sufficient to equitably balance competing demands. The challenge of collective leadership (and of pooled leadership, in particular) lies not only in developing smooth relations among multiple leaders and followers, but also in maintaining and mobilizing the tensions that can make their collaboration most fruitful. We suggest that the collective leadership literature has often missed the significance of this central paradox: that collective leadership may be most needed where it is most difficult to achieve. Moreover when it seems to operate most smoothly, it

is possible that it may not always be fulfilling its mission to integrate diverse perspectives. Future research could focus more deeply on this tension.

In methodological terms, our study contributes by showing how the positions of different individuals in a dyad around competing logics can be captured and related empirically to particular forms of collective leadership, bringing together concepts that have not usually been operationalized in combination. The methodology that we developed for operationalizing the imbrication of different logics within members' discourse and for understanding their positioning within shared role spaces offers potential for other studies of plural leadership.

For practitioners, our findings suggest that implementing a co-leadership model may help bridge institutional logics if the dyads play their joint role as boundary duos. In this case, at least one of the co-leaders in each dyad should understand and have internalized the demands of both logics, that is be a hybrid (Blomgren and Waks, 2015). Although this might not permit the same intensity and stability of bridging activities, the professional consulting configuration may constitute another interesting strategy. The configuration does allow bridging when important issues come up, but may also represent the most interesting arrangement for professionals. Professional consulting indeed offers the potential of exploiting the specialized expertise and influence of professionals while requiring of them to perform a role of manageable scope. The demands on their time and the investment in developing management skills are indeed more limited. Finally, cultivating mobilization toward an overarching principle in the dyad is conducive to bridging. Management duos and units, differently, can be exploited to coopt members of a different logic. Yet the danger of this may be that the coopted logic re-emerges as resistance in a different, more conflictual and less controllable form. To the extent that organizations are

embedded in contexts that impose conflicting demands that are equally insistent (as may occur in professionalized settings), cooptation is unlikely to be a longer term solution.

In summary, the study suggests that co-leadership arrangements are not a panacea. While in theory, they offer potential to improve the integration of professional and managerial objectives in the organization of professionalized settings such as health care, and the arts, in practice, the complexity of these arrangements mitigates this potential. More research is needed to examine ways in which the benefits of such arrangements might be further encouraged and developed.

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## Table 1: The Four Pilot Sites

| | University Health Center | Regional Health Center | Semi-Rural Health Center | Primary Care Health Center |
|---|---|---|---|---|
| **STRUCTURAL CONTEXT** | | | | |
| Short Term Care Facilities | 2 major | 3 hospitals | 1 small hospital | No hospital |
| Long-Term Care Facilities | 4 | 4 | 3 | 8 |
| Community Centers | 5 | 3 | 3 | 7 |
| Number of Employees | 5500-6000 | 5000-5500 | 1000-1500 | 3000-3500 |
| Number of Physicians | 600-650 | 450-500 | 50-100 | 200 - 250 |
| Teaching & Research | Central | Present | Minimal | Developing |
| **PILOT PROJECT CONTEXT** | | | | |
| Number of dyads | 9 | 4 | 4 | 3 |
| Renewal during research | 1 | - | 1 | - |
| Tenure at end of research (range) | 6 months-5 years | 3 months | 1-3 years | 2 years |
| Training during research | No | No | Yes | Canceled |
| Historic physician relations | Good | Poor | Good | Average |

## Table 2: Summary of Interview and Observation Data Collected

| | Interviews with dyad members | | Meetings Observed (Number over 2 years) |
|---|---|---|---|
| | Time 1 | Time 2 | |
| **University Health Center** | 16 | 12[3] | - Executive Committee (10)<br>- Strategic Office (4)<br>- Department Head Committee (1) |
| **Regional Health Center** | -[4] | 8 | - Executive Committee (4)<br>- Council of Physician, Dentists and Pharmacists (2)<br>- Department Head Committee (8)<br>- Strategic Consultation Meetings (4) |
| **Semi-Rural Health Center** | 6[5] | 6 | - Executive Committee (9)<br>- Clinical Executive Committee (5)<br>- Co-leadership Project Management Committee (8)<br>- Council of Physician, Dentists and Pharmacists (5)<br>- Department Head Committee (5)<br>- Strategic Consultation Meetings (6)<br>- Co-leadership Training Sessions (1) |
| **Primary care Health Center** | 6 | 6 | - Clinical Executive Committee (2)<br>- Department Head Committee (1)<br>- Professional Delegation Committee (2) |
| **Total** | 28 | 32 | - 77 meetings across the three phases |

[3] Four dyads were interviewed only once at the University Health Center. Three of these dyads were only interviewed at Time 1 while the other one was only interviewed at Time 2. Changes in dyad members explain this discrepancy.

[4] The Regional Health Center had not implemented the co-leadership model at Time 1. The model was implemented a few months before the second wave of interviews Time 2.

[5] At the Semi-Rural Health Center, one dyad was only interviewed at Time 1 while another was only interviewed during Time 2. Once again, changes in dyad members explain this discrepancy.

**Figure 1: Six Configurations of Co-leadership**