HEC MONTRÉAL
École affiliée à l'Université de Montréal

**L'intégration de professionnels dans des rôles de gestion :
Identité, co-leadership et légitimité**

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Thèse présentée en vue de l'obtention du grade de Ph. D. en administration
(option Management)

Novembre 2016

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Cette thèse intitulée :

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Identité, co-leadership et légitimité

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RÉSUMÉ

Les organisations complexes composées de professionnels autonomes (comptabilité, droit, médecine (Brock, Powell, Powell, & Hinings, 1999) dont le travail consiste à appliquer un corps de connaissances théoriques et scientifiques presque exclusivement contrôlé à la réalisation de tâches socialement incontournables sont d'une importance sociale et économique indéniable (Leicht & Fennell, 2008). Or, selon certains auteurs, cette forme organisationnelle engendre plusieurs défis de gestion (Baker, Denis, Pomey, & MacIntosh-Murray, 2010). Par exemple, plusieurs auteurs (Ackroyd & Muzio, 2007; Von Nordenflycht, 2010) ont récemment expliqué comment le pouvoir de négociation des professionnels et leur préférence pour l'autonomie empêchent l'exercice de l'autorité et bloque les tentatives de façonner la nature et la direction de leur travail. Les auteurs insistent aussi sur la résistance des professionnels à l'exercice de la gouvernance par des non-professionnels, particulièrement lorsque l'approche de gestion privilégiée met l'emphase sur le contrôle et la surveillance. Au cœur de ces défis se trouve la différence significative entre les normes, cultures et règles des mondes professionnel et managérial qui prescrivent des interprétations différentes de la réalité organisationnelle et des manières distinctes de fonctionner en situations sociales (Thornton, 2004). Dans les mots de Friedland et Alford (1991), on se réfère à la rencontre de la logique professionnelle avec la logique managériale.

Une stratégie parfois mise de l'avant pour faire face à ces défis consiste en l'intégration de professionnels dans des rôles de gestion conçus pour faire le pont entre les deux logiques (par exemple, Braithwaite (2004) et Llewellyn (2001)). Cependant, on en sait très peu sur le processus d'implantation de tels rôles de liaison et sur les conséquences de ces nouvelles positions. Mon projet de thèse vise donc à mieux comprendre l'introduction de ces rôles en répondant à la question de recherche suivante : *quel est l'impact à travers le temps de l'intégration de professionnels dans des rôles de gestion dans les organisations professionnelles au niveau des individus, des dyades et de l'organisation?*

Au niveau individuel, l'étude explore comment l'identité des professionnels évolue à travers le temps lorsqu'ils intègrent des rôles de gestion (où la notion d'identité est définie suivant Ashforth (2001) comme la réponse à la question : qui suis-je?). Une telle transition peut en effet représenter un défi important découlant du passage du travail de professionnel autonome à une position charnière spécifiquement créée pour lier deux groupes aux logiques souvent contradictoires. L'individu se percevant antérieurement par opposition à la gestion (c'est-à-dire, un *non*-gestionnaire), doit soudainement réconcilier les différents points de vue tout en s'efforçant d'infuser un sens à cette position paradoxale (DeRue & Ashford, 2010). La question de recherche à laquelle s'attarde le premier article de cette thèse est donc : *Comment les professionnels gèrent discursivement les tensions identitaires auxquels ils font face lorsqu'ils intègrent des rôles de gestion à travers le temps?* Sur le plan théorique, les travaux sur le travail identitaire (Croft, Currie, & Lockett, 2015; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015; Pratt, Rockmann, & Kaufmann, 2006) servent de point de départ. C'est à travers une approche processuelle que je contribue, celle-ci permettant de mieux comprendre le processus de changements (ou non) de l'identité à travers le temps.

Le second article se situe au niveau de la dyade. Dans le cas qui nous intéresse, les professionnels ont intégré des rôles de *co*-leadership (plutôt que de leadership en *solo*). Ceux-ci deviennent donc conjointement responsables de la performance d'une unité dans une organisation avec un vis-à-vis administratif. Il est espéré que les co-leaders fassent le pont entre les logiques managériale et professionnelle au sein de leur organisation. Le second article de cette thèse tente donc de mettre en lumière *si et comment un modèle de co-leadership permet de faire le pont entre deux logiques institutionnelles.* Le cadre théorique de cette étude est inspiré des travaux antérieurs sur les réponses organisationnelles et individuelles à des logiques multiples (Battilana & Lee, 2014; Fossestol, Breit, Andreassen, & Klemsdal, 2015; Kellogg, 2009) ainsi que sur l'utilisation du co-leadership dans ces contextes (Court, 2004; Empson, Cleaver, & Allen, 2013; Fjellvaer, 2010; Hodgson, Levinson, & Zaleznik, 1965). Je vais cependant au-delà de ces travaux en laissant émerger différentes façons de

combiner des logiques institutionnelles dans le discours, diverses configurations de dyades ainsi que l'évolution de ces assemblages à travers le temps.

Le troisième et dernier article se trouve au niveau collectif. Effectivement, l'introduction de professionnels dans des rôles de gestion peut changer – ou non – les relations des professionnels avec la communauté managériale. Or, l'implantation de ces nouveaux rôles de gestion vise non seulement une amélioration des relations entre les deux groupes, mais également une influence plus importante des communautés médicales sur les décisions stratégiques. Le troisième article s'attarde donc à la manière dont le processus de prise de décision évolue suite à l'ajout d'un nouveau rôle de liaison. Plus précisément, celui-ci vise à répondre à la sous-question suivante : *Comment l'intégration de professionnels dans des rôles de gestion affecte (ou non) leur influence sur les processus de prise de décision stratégique à travers le temps?* Théoriquement, les écrits portant sur le travail de légitimation inspirent cette démarche (Daudigeos, 2013; Kellogg, 2009; Reay & Golden-Biddle, 2006; Reay, Goodrick, Casebeer, & Hinings, 2013; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014). Ces travaux m'assistent pour mettre en lumière les actions visant l'établissement de l'influence sur les décisions stratégiques, mais également les actions visant volontairement ou contribuant involontairement à contrer le changement et préserver le statu quo.

Les efforts de recherche dépeints plus haut ont pris la forme d'un projet de collecte de données longitudinal se déroulant sur 21 mois, soit de février 2012 à octobre 2013 au sein de quatre organisations de santé et services sociaux canadiennes sélectionnées en fonction de leurs structures organisationnelles, leurs tailles et leurs complexités. La collecte de données entreprise incluait la conduite de 167 entrevues ainsi que l'observation non participante de 102 rencontres de différentes instances décisionnelles et informationnelles. L'ensemble des documents de travail et écrits officiels distribués lors de ces rencontres, ainsi que tout autre document diffusé par les organisations, ont également été scrutés. Une codification ancrée dans les données fonde l'approche d'analyse privilégiée.

L'étude contribue aux débats dans trois champs de recherche, soit l'identité, les logiques institutionnelles et la légitimation. Aux débats touchant l'identité, une contribution découle de l'exploration du processus de transition identitaire, un aspect peu étudié dans la littérature. Quant aux littératures portant sur les logiques institutionnelles, la contribution passe par la mise en relief des différentes façons dont des dyades peuvent jouer leur rôle de liaison et diverses manières dont les membres de ces dyades combinent les logiques dans leur discours à travers le temps. Aux discussions portant sur la légitimation, la présente thèse aide à mettre en lumière les pratiques de légitimation et délégitimation à l'aide desquelles l'influence de nouveaux rôles peut être établie ou affaiblie dans la prise de décision stratégique à travers le temps.

Pour les praticiens, cette étude contribue à une meilleure compréhension des rôles de liaison et de leurs impacts réels, assistant dans l'évaluation de si et comment de tels rôles de gestion devraient être implantés. De plus, l'étude aide à clarifier comment des co-leaders peuvent jouer leur rôle pour engendrer les impacts désirés. Finalement, il pourra être utile aux praticiens souhaitant implanter de tels rôles de connaître différentes stratégies pour établir ces positions dans les organisations professionnelles, ainsi que pour bâtir la légitimité et l'influence des détenteurs du rôle.

Mots clés : organisations professionnelles, co-leadership, médecin-gestionnaire, identité, logiques institutionnelles, rôles, travail de (dé)légitimation, influence, prise de décision, recherche qualitative, recherche longitudinale, méthode d'observation, entrevues, analyse documentaire.

ABSTRACT

Complex organizations constituted of autonomous professionals (accounting, law, medicine (Brock et al., 1999)) whose work involves applying an almost exclusively controlled body of theoretical and scientific knowledge to socially important tasks are of undeniable social and economic importance (Leicht & Fennell, 2008). However, some scholars believe that this form of organization generates many management challenges (Baker et al., 2010). For instance, many authors (Ackroyd & Muzio, 2007; Von Nordenflycht, 2010) recently explained how professionals' negotiation power and preference for autonomy prevent the exercise of authority and block attempts to shape the nature or direction of their work. The authors also insist on professionals' resistance to governance by non-professionals, especially when the privileged management approach emphasizes control and surveillance. At the core of these challenges lie the significant differences between the norms, cultures and rules of the professional and managerial worlds, which prescribe interpretations of organizational reality and ways of functioning in social situations (Thornton, 2004). In Friedland and Alford (1991)'s words, we are referring to the meeting of the professional logic with the managerial logic.

One strategy proposed in the past to face these challenges is the integration of professionals in management roles designed to link the two logics (for instance Braithwaite (2004) and Llewellyn (2001)). However, we know little about the process of implementing such boundary roles and the real life consequences of these positions over time. This thesis thus aims at better understanding the introduction of such roles by answering the following research question: *What is the impact over time of the integration of professionals in management roles in professional organizations at the individual, dyadic and organizational levels?*

At the individual level, I explore how the identity of professional managers evolve over time as they take on managerial roles (where the notion of identity is defined according to Ashforth (2001) as the

answer to the question: who am I?). Entering such roles can be challenging as one moves from acting as an autonomous professional solely belonging to one group to a position specifically created to act as a bridge between two groups holding contradictory logics and intended to stimulate professionals' involvement in the management of organizations. Role holders previously perceiving themselves in opposition to the management group (that is, I am *not* a manager) are suddenly mandated to reconcile viewpoints while having to make sense for themselves of their paradoxical position (DeRue & Ashford, 2010). This research project seeks to explore *how professionals handle identity tensions in their narratives over time as they take on management roles*. Theoretically, the identity work literature (Croft et al., 2015; McGivern et al., 2015; Pratt et al., 2006) serves as departure point. My contribution stems from the process perspective taken, allowing us to better understand the evolution (or lack thereof) of identities over time.

The second level assessed is the dyad. The professionals studied integrated *co*-leadership roles (as opposed to *solo* leadership roles). Along with an administrator, they hence become jointly responsible for the performance of a unit in an organization. It is expected that the co-leaders will bridge the managerial and professional logics. The second article thus aims at uncovering i*f and how a co-leadership model bridges two institutional logics?* The theoretical foundation of this study lies mainly in previous work on organizations' and individuals' responses to multiple institutional logics (Battilana & Lee, 2014; Fossestol et al., 2015; Kellogg, 2009) as well as literature on co-leadership as a way to link logics (Court, 2004; Empson et al., 2013; Fjellvaer, 2010). Going beyond these theories, I will let the data reveal different ways of playing the role and discursively mobilize logics over time.

The third and last level is located at the collective level. Indeed, introducing management roles for professionals may change – or not – professionals' relationship with the managerial community. However, the introduction of these new bridging roles aims not only at improving the relationship between the two groups, but also at increasing professionals' influence on strategic decisions. The third article examines this understudied aspect by answering the following research question: *how*

and why does the introduction of professionals into senior management roles shape (or not) their effective participation in strategic decision processes over time? The theoretical framing relied on is derived from the literature on legitimacy work (Daudigeos, 2013; Kellogg, 2009; Reay & Golden-Biddle, 2006; ; Treviño et al., 2014). Beyond these theories, I uncover from the data the different actions voluntarily aimed at or involuntarily contributing to counter the change and preserve the status quo.

To answer the research questions, a longitudinal case-based exploratory study was performed from February 2012 to October 2013 in four Canadian healthcare organizations selected based on their structure, size and complexity. Data collection included 167 interviews as well as non-participant observation of 102 meetings of various informational and decisional committees. All documents distributed during the meetings or circulated within the organizations were also analyzed. A codification grounded in the data was the privileged approach.

The thesis contributes to three academic debates on identity theories, institutional logics and legitimacy work. The stream of research on identity will be enriched by the exploration of identity transitions as processes, a perspective few have thus far taken. Shedding light on the different ways in which dyads play their role and on the way institutional logics are combined in co-leaders' discourse over time will help further our current understanding of how institutional logics may co-exist. Finally, this thesis contributes to legitimation theories by exploring the legitimacy work practices through which the influence of the holders of the new role is established or weakened in strategic decision making over time.

To practitioners, this study brings a better understanding of boundary roles and their actual impact, assisting practitioners in evaluating if and how management roles for professionals should be implemented. Furthermore, the study helps clarify how co-leadership roles should be played to have the desired impact. Finally, different strategies to establish such roles in professional organizations as well as to build role holders' legitimacy and influence will be discussed.

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REMERCIEMENTS

La solitude a fait partie de mon parcours doctoral. J'étais seule dans ma voiture lorsque je conduisais 2h30 pour aller observer une réunion ou rencontrer un participant. Seule devant mes données à tenter de dégager de cette étude des conclusions qui pourraient faciliter la vie de mes participants. Seule devant les 39 étudiants du baccalauréat avec qui j'ai appris la recherche et l'enseignement. 39 étudiants qui ne se doutent probablement pas que j'ai appris plus d'eux qu'ils n'ont appris de moi. Seule à essayer de comprendre comment le monde fonctionne. Le monde académique, le monde de la santé, le monde médical, le monde administratif.

En écrivant ces lignes, je réalise tout ce que j'ai appris et contemple tout ce qu'il me reste à apprendre. J'ai appris que je me suis sentie seule, mais ne l'ai pas été. Le suffixe Ph. D. que je porterai dorénavant, je devrais le partager. Le partager avec Ann Langley, ma directrice de recherche, qui a su me guider dans le développement de mon potentiel de chercheur, m'offrir diverses opportunités et soutenir le rayonnement de mes travaux. Le partager avec Jean-Louis Denis, mon codirecteur de thèse, qui a su me faire bénéficier de sa profonde compréhension du réseau de la santé et de la recherche à travers ses rétroactions toujours éclairantes. Le Groupe d'étude sur la pratique de la stratégie, la Chaire de recherche du Canada sur la gestion stratégique en contexte pluraliste et le Pôle santé m'ont par ailleurs offert un accueil, des opportunités et un soutien importants. Ce doctorat n'aurait par ailleurs pas été possible sans le soutien financier du Fonds société et culture, du Conseil de recherche en sciences humaines du Canada, de la Chaire de recherche du Canada sur la gestion stratégique en contexte pluraliste ainsi que du programme de doctorat de HEC Montréal.

Le titre de docteure, je le dois aussi à mes participants, qui se sont si généreusement ouverts à moi. Je leur demandais de me faire confiance, de m'intégrer dans leur vie professionnelle et de partager avec moi leurs satisfactions, mais surtout leurs préoccupations. Ma thèse touche des aspects très intimes (l'identité d'un individu), mais aussi souvent difficiles (conflits médico-administratifs). Mes

participants m'ont donné accès à leur monde extérieur et intérieur. Ils m'ont offert des données riches et honnêtes. J'espère que cette thèse, qui témoigne des cinq dernières années de ma vie, vous sera utile.

Une partie de ce doctorat, je le dois à Nicolas Van Schendel et Véronique St-Michel, qui ont, l'un avec expérience et l'autre avec enthousiasme, contribué significativement à la réalisation de la collecte de données de ce projet de thèse. Je suis également reconnaissante envers Wendy Reid pour ses conseils judicieux et sa générosité ainsi qu'à Samia Chreim pour m'avoir aidé à voir les possibilités incroyablement intéressantes de recherche qui m'attendent après le doctorat. Je dois aussi beaucoup à Lourdes Zubieta pour m'avoir fait confiance en m'offrant l'opportunité d'une première expérience d'enseignement et pour m'avoir généreusement conseillée au cours de cette expérience si enrichissante. Ces 39 étudiants du cours de méthodes de recherche en gestion auxquels j'ai enseigné ont également contribué à ce doctorat. Leurs préoccupations, leurs erreurs, leurs frustrations, leurs apprentissages et leurs succès m'ont appris plus qu'ils ne pourraient l'imaginer. J'espère leur avoir transmis un peu de ma passion pour la recherche.

Les membres de mon comité, Linda Rouleau et Henriette Bilodeau, mon président-rapporteur ainsi que mon évaluateur externe contribuent à développer mes idées et papiers à travers leur précieuse rétroaction. Un merci tout particulier à Linda Rouleau dont le support a grandement facilité les différentes démarches que j'ai entreprises et avec qui j'ai beaucoup apprécié discuter. Un grand merci à Isabelle LeBreton-Miller pour les opportunités de développement d'articles qu'elle offre aux étudiants et pour sa générosité ainsi qu'à Alex Bitektine pour son accessibilité, son honnêteté et pour sa bonne humeur. Mes collègues du doctorat (et post doctorat) m'ont aidée à me sentir moins seule et à développer mes travaux. Un merci tout particulier à Maricela Arellano, Joëlle Basque, Gustavo Birollo, Mathieu Bouchard, Maria El Chabadi, Mariline Comeau-Vallée, Kafui Dansou, Nolywé Delannon, Karl-Émanuel Dionne, Israël Fortin, Jean-François Harvey, Saouré Kouamé, Véronique Labelle, Véronique LeGall, Josée Lortie, Hamed Motaghi, Geneviève Renaud, Mina

Rohani, Nasser Shahrasbi, Jean-François Tremblay, Thu Trang Tran, John Vongas et Leighton Wilks.

Merci à Miriam Cooper et John Trischuck pour leurs conseils et leur certitude que je possédais toutes les aptitudes pour performer dans tout ce que j'entreprends. Pour sa générosité et parce qu'il sera probablement l'un des seuls à lire chaque mot de cet ouvrage, je remercie André Lambert. Le tout nouveau titre de docteure, je le dois aussi à mes amies, dont tout particulièrement à Sandra, Doris, Martine et Anick qui ont écouté mes joies, peines, préoccupations, satisfactions et frustrations. Elles sont présentes durant mes hauts et mes bas et enrichissent ma vie, chacune à sa façon. Mes beaux-parents, Elaine et Miguel, m'inspirent pour leur part par leur ambition, leurs valeurs familiales, et leur acceptation de ma culture, ma langue et ma personnalité.

À mes parents, Nicole et Michel, l'entente stipule que je dois 10% du titre et de ses retombées pour leur aide en informatique et en français. En réalité, je décernerais à chacun d'eux un doctorat honorifique. Leur écoute, leurs conseils, leur soutien constant dans tous les domaines, leur tolérance et leur confiance en ma capacité de réussir font la différence. Mon frère, un doctorat, il n'en a pas besoin, et encore moins d'une portion du mien. Il possède une connaissance approfondie et vaste de nombreux domaines surpassant significativement celle de la majorité des individus que j'ai rencontrés dans ma vie. Et ce qu'il ne connaît pas, il l'apprendra. Dominique est un autodidacte aussi à l'aise dans des discussions philosophiques ou théoriques qu'à construire une voiture dans un garage ou à refaire l'électricité d'une maison. J'admire sa curiosité intellectuelle et son sens critique. Ma belle-sœur Maud est aussi élégante que pétillante. Elle m'apporte quant à elle par son humour et en partageant avec moi sa perspective sur différents sujets.

Au moment de lire ses lignes, Fernando a probablement aussi obtenu son doctorat. Il le mérite. Sa persévérance, son éthique de travail, sa capacité d'analyse et de rationalisation, son habileté en argumentation m'impressionnent. Si je naviguais le monde académique instinctivement et peut être un peu naïvement avant de le rencontrer, Fernando a toujours été assez généreux pour partager avec

moi sa connaissance de cet environnement particulier tout en respectant mes décisions. Grâce à sa capacité à reconstruire les situations, Fernando m'a aidée à surmonter de nombreuses situations à court terme et à en sortir grandie à long terme. Sa confiance dans ma capacité de réussir et sa volonté de m'aider à trouver une place qui me convient professionnellement ont grandement solidifié ma propre confiance. Finalement, parce qu'il est toujours prêt à jouer, se promener, partir à l'aventure et à prêter son corps pour des séances de zoothérapie, je dois une grande partie de mon doctorat à Herr Wagner (*aka Mr. Dog*) qui a contribué significativement à apaiser mes peines et mes angoisses tout en multipliant les sourires et éclats rires autour de lui.

Bref, le titre de docteur est remis à un seul individu, mais c'est une quête qu'on ne fait pas seul. Je partage donc le titre avec eux et espère continuer à apprendre à leur côté.

CHAPITRE 1 - INTRODUCTION

L'économie du savoir a sans contredit fait couler beaucoup d'encre dans les dernières décennies. À la fois fondation et découlant de cette économie se trouvent les organisations professionnelles, des organisations dont la principale ressource réside dans une main-d'œuvre hautement qualifiée produisant des services intangibles qui prennent la forme de conseils donnés au moment opportun et adaptés aux besoins de chaque client (ou patient, dans le cas des organisations de santé) (Royston Greenwood, Li, Prakash, & Deephouse, 2005). Cette main-d'œuvre qualifiée exerce un travail professionnel impliquant l'application de connaissances théoriques et scientifiques à des tâches socialement importantes, l'autonomie dans la pratique avec évaluation uniquement par les pairs ainsi que le contrôle quasi exclusif de l'application des connaissances acquises (Abbott, 1988; Freidson, 1988; Leicht & Fennell, 2008). La préférence des professionnels pour l'autonomie, que Englel (1970) définit comme la liberté de pratiquer sa profession à sa discrétion, est souvent associée à une aversion pour la supervision et l'autorité traditionnelle (Von Nordenflycht, 2010) et pour les tentatives de modeler la direction ou l'accomplissement de leur travail (Ackroyd & Muzio, 2007).

Originellement composées et gérées par des professionnels, les organisations professionnelles de différents domaines ont par le passé (tel que les organisations de santé) ou intègrent actuellement (tel que les grandes firmes d'avocats internationales) des gestionnaires de carrière dans leurs rangs afin de faire face aux défis associés à l'étendue et de la complexité des tâches de gestion (Empson, Cleaver, & Allen, 2013). Or, tandis que les professionnels mettent l'accent sur l'expertise et les relations, les gestionnaires se concentrent sur la hiérarchie et l'utilisation efficace des ressources (Reay & Hinings, 2009; Thornton, Ocasio, & Lounsbury, 2012). Ainsi, les deux groupes fonctionnent selon des normes, cultures et règles significativement différentes. Dans les mots de Friedland et Alford (1991), on parlera de la rencontre des logiques professionnelle et bureaucratique (ou managériale). Les logiques institutionnelles se décrivent comme un ensemble de principes qui prescrivent une façon d'interpréter la réalité organisationnelle et de fonctionner en situations

sociales (Friedland & Alford, 1991; Thornton, 2004). En d'autres mots,

les logiques institutionnelles représentent des cadres de référence qui conditionnent les choix des

acteurs pour faire du sens, le vocabulaire qu'ils utilisent pour motiver l'action, et leurs sens de

soi et identité. Les principes, pratiques et symboles de chaque ordre institutionnel façonnent

différemment comment s'effectue le raisonnement et comment la rationalité est perçue et vécue.

(Thornton et al., 2012 : p. 2 : Traduction libre).

Les cas caractérisés par la présence d'au moins deux logiques comme ceux des organisations

professionnelles sont baptisés pluralisme institutionnel par Kraatz et Block (2008) ou complexité

institutionnelle par Blomgren et Waks (2015). Métaphoriquement, ces organisations jouent dans

plus d'un jeu à la fois, et sont donc sujettes à plus d'un ensemble de règles (Dunn & Jones, 2010).

Alors que certains voient dans le pluralisme une source de tensions persistantes et profondes forçant

les organisations à être « par nécessité, partiellement en guerre avec elles-mêmes » (Kerr, 1963 :

p.8), la multiplicité des logiques amène également selon d'autres un potentiel créatif important

(Battilana & Lee, 2014; Kraatz & Block, 2008).

D'un point de vue pratique, la complexité institutionnelle a des implications significatives sur la

gestion des organisations. D'abord, la prise de décision peut être compliquée par la distribution à

travers l'organisation de la connaissance requise entre différents acteurs aux intérêts dissemblables

et parfois en conflit, par les bases différentes de prise de décision ainsi que par le partage des

pouvoirs entre plusieurs groupes et acteurs (LeTourneau & W. Curry, 1997; Waldman & Cohn,

2007; Witman, Smid, Meurs, & Willems, 2011). La multiplicité des valeurs et normes dictant des

comportements distincts ainsi que l'existence de langages différents peuvent nuire à la

communication, la coordination et la compréhension des intentions des individus adhérant à une

autre logique (Bujak, 2003). Les conflits et tensions pouvant en découler peuvent pour leur part

compliquer la mobilisation des membres de telles organisations vers un objectif commun (Denis,

Gibeau, Langley, Pomey, & Van Schendel, 2012). Le défi que représente cette mobilisation est

d'autant plus grand que différentes logiques peuvent suggérer des fondations divergentes sur

lesquelles baser et accorder le leadership, rendant difficile pour un seul individu d'influencer les deux groupes à la fois (Empson, 2014; Gillies et al., 2001; Von Nordenflycht, 2010). Des stéréotypes concernant les individus adhérant à une autre logique peuvent par ailleurs être associés aux logiques, pouvant nuire à l'émergence d'un dialogue constructif et à la construction d'une relation entre les deux groupes (Hall, 2005).

Si la multiplicité des logiques présentes dans plusieurs contextes organisationnels n'est plus remise en question d'un point de vue théorique, la coexistence de logiques fait l'objet de nombreux travaux (Friedland & Alford, 1991; Kraatz & Block, 2008; Selznick, 1949). Bien que les premiers auteurs en théorie institutionnelle aient mis l'accent sur la compétition entre les différentes logiques menant à l'ascendance d'une nouvelle logique et au démantèlement de celle antérieurement dominante (Rao, Monin, & Durand, 2003; Thornton & Ocasio, 1999), les travaux plus récents témoignent plutôt de l'acceptation grandissante de l'idée d'une stabilité relative entre des logiques existant de manière durable dans une incohérence variable (Fossestol, Breit, Andreassen, & Klemsdal, 2015; Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011; Oliver, 1991; Pache & Santos, 2010a). Les efforts actuels dans le champ d'études visent donc à comprendre comment se combinent des logiques multiples apparemment difficilement réconciliables (Battilana & Lee, 2014; Lawrence, Suddaby, & Leca, 2009; Mair, Mayer, & Lutz, 2015).

Plusieurs auteurs perçoivent les systèmes de santé actuels comme particulièrement susceptibles de faire face à une telle complexité relative durable (Greenwood et al., 2011). À l'origine, les organisations de santé ont été créées pour appuyer les médecins dans leur pratique et étaient gérées par des professionnels de la médecine eux-mêmes. Des gestionnaires de carrière ont progressivement joint, puis occupé presque entièrement les rangs des administrateurs des organisations de santé (Pauly, 1980). Graduellement, le contrôle collectif sur le corps administratif dont jouissaient les professionnels de ces bureaucraties professionnelles (Mintzberg, 1980) s'est effrité. On a alors assisté à une avancée en premier plan des gestionnaires et de la technostructure (Leicht & Fennell, 1997). Alors que les médecins avaient presque disparu de ces rangs (n'étant

généralement représentés que par un individu dans l'équipe de gestion stratégique), on assiste aujourd'hui à un retour de l'implication médicale dans l'administration de la santé de nombreux systèmes (Ham, 2008).

Des efforts actuels pour cultiver une collaboration constructive entre deux groupes à logiques souvent en tension sont centrés sur l'intégration de professionnels dans des rôles de gestion au sommet de l'organisation – notamment dans des postes de gestion dans lesquels ils partagent des responsabilités de programmes ou de services cliniques avec un gestionnaire détenant une formation plus administrative – une formule de partenariat qui s'appelle la « cogestion ». Il est espéré que les détenteurs de ces rôles sauront exercer leur leadership dans les deux communautés, contribuer à faire ressortir des objectifs communs (Denis, Langley, & Sergi, 2012), et enrichir la prise de décision stratégique (Denis et al., 2013). La présente initiative de recherche explore les découlants de tels changements. Plus spécifiquement, la question de recherche générale de ce projet se décline comme suit : *quel est l'impact à travers le temps de l'intégration de professionnels dans des rôles de gestion dans les organisations professionnelles au niveau des individus, des dyades et de l'organisation?*

La présente initiative de recherche conçoit l'intégration de professionnels dans des rôles de gestion comme une réponse mise de l'avant face aux complexités des contextes pluralistes tels que les systèmes de santé. Comme en témoignent les travaux théoriques de Greenwood et al. (2011), plusieurs écrits abordent déjà les questions des complexités institutionnelles et des réponses mises de l'avant (par exemple, (Pache & Santos, 2010a; Reay & Hinings, 2005; Reay & Hinings, 2009). Or, l'incohérence relative soutenue de différentes logiques qui est créée et modelée par les réponses au pluralisme a reçu moins d'attention. Les conclusions de plusieurs auteurs soutiennent néanmoins l'importance d'aller au-delà de la complexité et des réponses mises de l'avant.

Par exemple, Van Gestel et Hillebrand (2011) ont mené un projet dans le secteur public des Pays-Bas visant à explorer la manière dont les champs pluralistes évoluent à travers le temps.

Ceux-ci remarquent que les aboutissements du processus de transformation peuvent différer des effets initialement anticipés ou désirés, et que le recours à une série de petits arrangements lors de la prise de décisions peut amener une stabilité temporaire superficielle qui pave la voie pour l'émergence de nouvelles complexités et tensions puisque les questions subjacentes persistent. Currie et Guah (2007) argumentent en ce sens que contrairement aux modèles processuels linéaires en théorie institutionnelle souvent mis de l'avant (par exemple, (Tolbert & Zucker, 1996)), leurs résultats laissent apercevoir un processus non linéaire d'interaction entre des logiques en conflit constant. Jarzabkowski, Matthiesen, et Van de Ven (2009) ont pour leur part montré que le travail institutionnel prend la forme de mouvements et contre-mouvements constants, alors que Shipilov, Greve, et Rowley (2010) parlent de diffusion de pratiques découlant d'une logique institutionnelle en multiples vagues. Dans la même lignée, Levina et Orlikowski (2009) mettent en relief la période pleine d'opportunités de reconfiguration des pouvoirs et hiérarchies produite par l'ambigüité qui découle des changements liés aux logiques.

En s'enracinant dans la perspective processuelle à travers un design de recherche longitudinal inspiré par ces conclusions, la présente recherche cherche à mieux comprendre ce qui se passe *après* que soient mises de l'avant les réponses. De nouvelles configurations de tensions entre les logiques, qu'elles soient inférieures ou supérieures, sont alors créées, laissant place à de nouvelles adaptations. Dans notre cas, ces adaptations suivent l'introduction de professionnels dans des rôles de gestion.

1.1. L'intégration de professionnels en gestion

Les nombreux écrits récents sur l'introduction de professionnels dans des rôles de gestion ou de leadership témoignent de l'intérêt actuellement suscité par le phénomène (Correia & Denis, 2016; Lega & Sartirana, 2016; Quinn & Perelli, 2016). Différents changements majeurs en cours dans les organisations de santé en Europe et en Amérique du Nord tels que le mouvement vers un professionnalisme organisé imbibé de la logique managériale (Noordegraaf, 2011) et la poussée pour un leadership professionnel pluriel qui pourrait permettre une synergie et performance accrue

(Denis & van Gestel, 2016) stimulent cet intérêt et contribuent à la pertinence de l'étude du phénomène. Rotar et al. (2016) soulignent cependant que la compréhension de l'intégration de professionnels dans la gestion est à ce stade limitée, les recherches mettant principalement l'emphase sur les aspects institutionnels, politiques, économiques et technologiques. Kirkpatrick (2016) abonde en ce sens en insistant sur le besoin d'initiatives de recherche enrichissant la connaissance sur les impacts de l'implication de professionnels dans des rôles de gestion ou hybrides.

Au sujet de l'introduction de professionnels en gestion, Baker et Denis (2011) soulignent que les stratégies purement structurelles ne semblent pas suffire. En effet, l'ajout d'un poste dans une structure organisationnelle ne représente pas une fin en soi mais prépare plutôt la scène pour la négociation par différents acteurs des attentes liées au rôle (Fitzgerald, Ferlie, & Buchanan, 2006; Graen, 1976; Graen & Scandura, 1987; Ilgen & Hollenbeck, 1991; Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1976). En raison de leur position charnière à la frontière des communautés professionnelle et managériale, les professionnels en gestion sont sujets à recevoir des demandes parfois contradictoires pouvant créer des tensions (Denis, 2016). Souvent qualifié d' « hybrides », un terme s'appliquant aux entités composées d'un mélange de différentes parties (Battilana & Lee, 2014; Kirkpatrick, 2016; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015), ceux-ci retiennent l'attention pour la nature de leur identité puisqu'ils sont en position de recombiner et d'estomper les façons de fonctionner propres aux professionnels et au management (Kirkpatrick, 2016). La manière dont les professionnels joueront leur rôle de cogestion pour lier les logiques managériale et professionnelle constitue un enjeu additionnel, tout comme la transformation des pratiques décisionnelles associée à l'intégration de ceux-ci dans des rôles de décideurs. Ces trois enjeux – l'identité, le co-leadership pour lier des logiques et l'influence sur la prise de décision – représentent trois problématiques particulières qui peuvent retenir l'attention des chercheurs en lien avec le phénomène d'intégration des médecins dans les postes de gestion. Ces enjeux sont discutés dans les prochaines pages.

1.1.1. L'intégration de professionnels en gestion comme enjeu identitaire

Les études portant spécifiquement sur l'identité des médecins en gestion catégorisent souvent ceux-ci en deux groupes : médecins ayant une identité compatible avec l'organisation et médecins dont l'identité est compatible avec la profession (Hoff, 1999), les hybrides volontaires (*willing)* qui développent une identité d'hybride de manière plus permanente et les hybrides accidentels (*incidental)* qui construisent cette identité temporairement tout en protégeant leur professionnalisme (McGivern et al., 2015) ou les investisseurs chez lesquels une identité plus managériale émerge et les réticents (*reluctants)* qui se distancient de la gestion (Forbes, Hallier, & Kelly, 2004). Spyridonidis, Hendy, et Barlow (2014) proposent quant à eux trois catégories, soit les innovateurs qui intègrent facilement une identité de gestionnaire, les sceptiques qui voient une identité managériale comme une menace et la majorité tardive qui apprivoise l'identité de gestionnaire après avoir délégué les aspects moins prestigieux de la tâche pour mettre l'emphase sur le leadership clinique.

D'autres auteurs ont suggéré que certains professionnels peuvent développer une double loyauté à l'organisation et à la profession (Champagne, Denis, & Bilodeau, 1998) ou s'adapter aux spécificités du cadre organisationnel tout en préservant une autonomie importante (Adler, Kwon, & Heckscher, 2008; Kitchener, Caronna, & Shortell, 2005; MacIntosh, Beech, & Martin, 2012; Reay & Hinings, 2009). La plupart des auteurs s'entendent tout de même pour dire que l'aspect professionnel demeurera prédominant, et ce peu importe le titre ou le temps consacré à la gestion (LeTourneau & Curry, 1997; Llewellyn, 2001; Quinn & Perelli, 2016; Witman, Smid, Meurs, & Willems, 2011). D'une analyse des narratifs de médecins-gestionnaires, Llewellyn (2001) a pour sa part fait ressortir comment ces derniers minimisent les perceptions parfois négatives associées à leur rôle en créant une division additionnelle à celle de médecine versus management, soit médecin-gestionnaire versus gestionnaire non médecin. Différemment, selon Lega et Sartirana (2016), si certains professionnels deviennent des hybrides capables d'incarner à la fois les logiques managériale et professionnelle, la majorité éprouvait de sérieuses difficultés à habiter leur rôle même après plusieurs années dans des postes de gestion.

Or, comme le soulignent Correia et Denis (2016), la façon dont les professionnels interagissent avec la logique managériale devrait être explorée davantage, plusieurs auteurs tenant pour acquise la convergence des deux logiques ou construisant une dichotomie entre les logiques. À travers son premier article, cette étude contribue à répondre à cet appel en explorant de façon plus nuancée le positionnement identitaire des professionnels entrant en gestion entre les deux logiques qu'ils sont mandatés de lier. De plus, l'article contribue en clarifiant le processus de transition identitaire à travers le temps en utilisant le concept de « travail identitaire » (c'est-à-dire la formation, réparation, maintenance, fortification ou révision de leur conception d'eux-mêmes permettant de créer un sens de cohérence et distinction (Alvesson, 2010)) discuté en détails plus loin. Aller ainsi au-delà des différentes catégorisations de l'identité des professionnels en gestion mises de l'avant dans la littérature contribue à clarifier pourquoi les professionnels évoluant parfois dans un même milieu organisationnel répondent différemment à leur rôle d'hybride et aux pressions y étant associées, un besoin soulevé par Kirkpatrick (2016).

1.1.2. L'intégration de professionnels en gestion comme enjeu de co-leadership

S'ils se positionnent individuellement par rapport aux logiques qu'ils chevauchent, les dyades de cogestionnaires se positionnent également conjointement en mobilisant à différents degrés dans leur discours les logiques et partageant l'accomplissement de leur rôle de différentes manières. En effet, cette thèse entre dans la lignée des travaux découlant des écrits de Ilgen et Hollenbeck (1991) qui conçoivent le rôle comme composé d'une partie formelle et d'une partie émergente modelée par l'individu en poste. Ainsi, suivant Neogy et Kirkpatrick (2009) et Lega et Sartirana (2016) qui soulignent que les rôles et responsabilités officielles ne représentent pas toujours les pratiques réelles des professionnels en gestion, cet ouvrage s'attardera aux pratiques réelles des membres des dyades de cogestionnaires.

Bien que la question sera discutée en détail dans le second article, notons que la notion de « co-leadership » a été retenue pour l'étude des dyades de cogestionnaires. Celle-ci implique

l'accomplissement conjoint par deux individus d'un rôle de leadership (Gibeau, Reid, & Langley, 2015), lui-même définit comme le processus d'amener un autre à prendre action vers un objectif spécifique (Locke, 2003). Différemment, la cogestion peut être définie comme l'exécution conjointe par deux individus d'un rôle de gestion, celui-ci étant à son tour défini comme des activités de planification, organisation, commande, coordination et contrôle (Fayol, 1949). La notion de co-leadership a été préconisée pour étudier les efforts de liaison des dyades puisque les pratiques de cogestion observées reflétaient en fait des pratiques de leadership visant à influencer les médecins et administrateurs.

Peu d'auteurs se sont à ce jour penchés sur les dyades liant des logiques institutionnelles. Kirkpatrick, Dent, et Jespersen (2011) comptent parmi ces quelques auteurs et soulignent que le processus de négociation de la division des rôles entre les membres de ces dyades peut être particulièrement chargé en raison des enjeux sous-jacents liés à la négociation du positionnement relatif des professions. Quelques auteurs ont proposé des typologies reflétant différentes manières de diviser des rôles dans des dyades ou groupes de leaders (Gibeau, Reid, & Langley, 2015; Hodgson, Levinson, & Zaleznik, 1965), alors que d'autres ont mis de l'avant trois modes d'intégration de logiques divergentes dans des dyades de co-leaders (Fjellvaer, 2010). Or, on en sait encore très peu sur la manière dont des dyades peuvent conjointement accomplir leur rôle de liaison entre différentes logiques, un sujet qui sera abordé dans le second article de cette thèse. L'importance de cette investigation réside dans le potentiel du modèle de contribuer à lier des logiques divergentes, un enjeu qui suscite beaucoup d'intérêt chez les auteurs intéressés par la pluralité institutionnelle (Battilana & Lee, 2014; Greenwood et al., 2011; Pache & Santos, 2010a; Reay & Hinings, 2009).

1.1.3. L'intégration de professionnels en gestion comme enjeu de transformation organisationnelle des pratiques décisionnelles

Outre l'objectif de lier des logiques institutionnelles divergentes au sein de leurs dyades, l'intégration des professionnels en gestion est vue comme un moyen de bâtir l'influence des

professionnels sur la prise de décision managériale (Lingard et al., 2008; Mohr & Batalden, 2002). La question de l'influence est d'autant plus importante que plusieurs auteurs identifient la possibilité d'influencer la prise de décision comme l'une des raisons principales qui motivent les professionnels à accepter des rôles de gestion (Denis, Gibeau, et al., 2012; Fitzgerald, 1994; Gibeau, Langley, Denis, Pomey, & Van Schendel, 2014; Ireri, Walshe, Benson, & Mwanthi, 2011; Snell, Briscoe, & Dickson, 2011).

Or, de nombreux auteurs estiment que l'influence des professionnels en gestion est souvent en fait relativement limitée, ceux-ci n'ayant pas accès aux instances de prise de décision, ne participant pas lorsqu'ils sont inclus ou n'ayant que peu d'influence dans plusieurs cas. De leur étude des médecins en gestion dans différents systèmes de santé européens, Neogy et Kirkpatrick (2009) soulignent en ce sens que ceux-ci demeurent souvent exclus de la prise de décision malgré leur rôle formel ou peuvent avoir peu d'influence sur la stratégie malgré leur présence dans l'équipe de gestion stratégique. Dans cette lignée, Thomas et Hewitt (2011) notent l'importance de l'accès à la prise de décision d'un nombre suffisant de médecins-gestionnaires pour influencer la décision, tandis que Burns, Andersen, et Shortell (1989) soulignent qu'inclure des médecins dans la prise de décision n'est pas nécessairement synonyme de participation.

Les travaux récents convergent pour argumenter que l'exercice de l'influence par les professionnels en gestion nécessite un ensemble diversifié de conditions allant au-delà des approches purement structurelles traditionnellement mises de l'avant (Denis, Gibeau, et al., 2012; Denis, Van Gestel, & Lepage, 2016). Si la nature de cette combinaison de conditions demeure toujours à clarifier, certains auteurs ont exploré différents leviers et enjeux du processus d'intégration. Dans les organisations de santé, Ham (2008) identifie, au-delà d'arrangements financiers contribuant à l'alignement des intérêts, la culture organisationnelle d'engagement, de valorisation du leadership et de responsabilité des professionnels comme leviers pour l'intégration des professionnels en gestion. Berry (2004) insiste quant à lui sur l'importance de la sélection des co-leaders lorsqu'un modèle de gestion en tandem est préconisé (et plus particulièrement du profil et des relations du cogestionnaire

issu du monde administratif), tandis que Baker (2008) discute de l'utilisation des systèmes d'information ou de reconnaissance pour renforcer le leadership professionnel. Allant au-delà de l'approche structurelle, le troisième article de cette thèse contribue à la littérature sur l'intégration des professionnels en gestion en montrant comment est modelée l'influence sur la prise de décision stratégique associée à de tels rôles. Comme le suggèrent Denis et al. (2016), les professionnels en gestion ne sont pas dépeints comme des victimes de changements organisationnels mais plutôt comme des acteurs à part entière. Leur impact sur l'influence est donc pris en compte.

En somme, la littérature portant sur l'introduction de nouveaux rôles de gestion pour professionnels montre que les attentes des deux groupes à lier peuvent diverger et provoquer des tensions qui engendreront des adaptations variables de l'identité du professionnel tiraillé entre le monde administratif et celui de la gestion, dans la façon des co-leaders de se positionner entre les deux logiques qu'ils sont mandatés de lier et au niveau organisationnel dans l'influence dont jouiront les professionnels en gestion sur la prise de décision. Les trois sous-questions de recherche de cette thèse découlent de ces trois débats présents dans la littérature. Les prochaines lignes survolent ces sous-questions et la littérature y touchant.

1.2.   Trois sous-questions de recherche

La question générale de recherche sera étudiée à travers trois sous-questions de recherche explorant trois interfaces auxquelles se rencontrent les différentes logiques étudiées, soit l'individu, la dyade et l'organisation. Notons que ces différentes interfaces constituent des niveaux auxquels des logiques peuvent se rencontrer et ne sont pas vues comme hermétiques, mais plutôt en interaction constante. La figure 1.1. illustre ces différents niveaux étudiés dans les trois articles constituant cette thèse. Il s'agit ainsi du squelette de la structure de cet ouvrage.
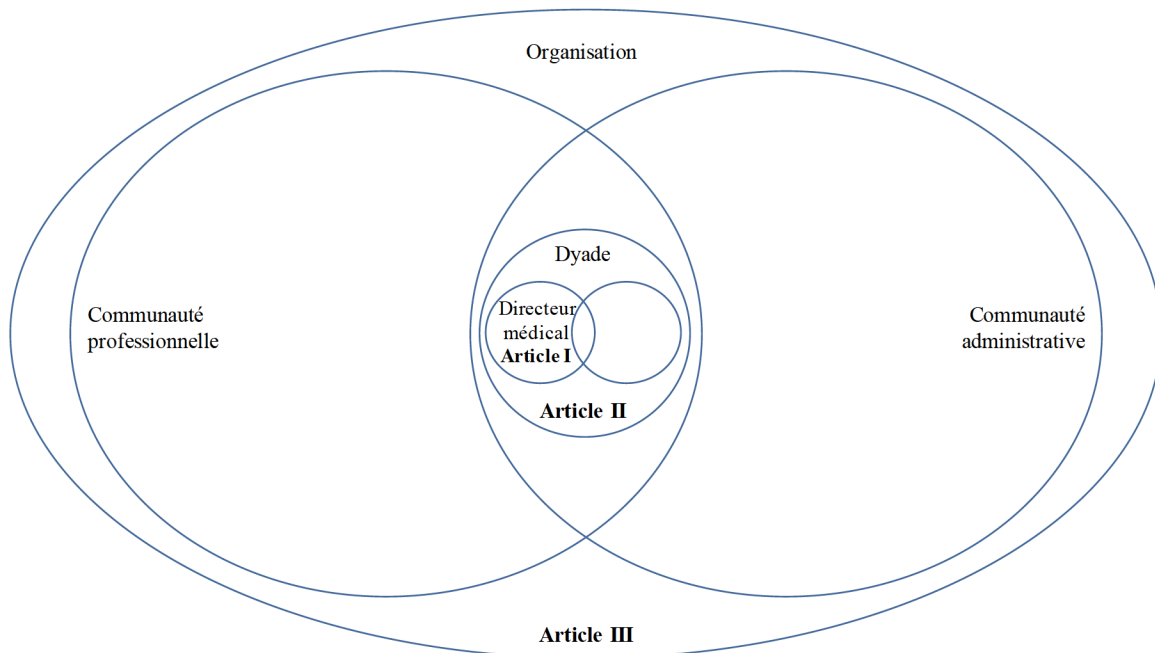
Figure 1.1. Structuration des écrits et configuration des trois articles par *niveaux*

Les prochaines sections donnent un rapide aperçu de la littérature scientifique existante contribuant à nos efforts pour répondre aux sous-questions de recherche et justifiant la pertinence de celles-ci. Ces trois littératures seront ensuite examinées de manière plus approfondie dans les articles de cette thèse. Tout d'abord, le tableau 1.1. situe les fondements et visées des trois articles.

	Niveau	Question de recherche	Fondement théorique
Article I	L'individu	Comment l'identité des professionnels évolue-t-elle à travers le temps lorsqu'ils intègrent des rôles de gestion?	Théories identitaires
Article II	La dyade	Si et comment un modèle de co-leadership permet de faire le pont entre deux logiques institutionnelles?	Travaux sur les réponses à la complexité institutionnelle
Article III	L'organisation	Comment et pourquoi l'intégration de professionnels dans des rôles de gestion affecte (ou non) leur influence sur la prise de décision stratégique à travers le temps?	Théories de la légitimité

Tableau 1.1. Structuration des écrits et configuration des trois articles par *niveaux*

1.2.1. L'individu

Au niveau microscopique, la rencontre de logiques institutionnelles est abordée dans la littérature portant sur l'identité individuelle. Lorsque des logiques cohabitent relativement harmonieusement, les écrits parlent de la fragmentation de l'identité (Alvesson, Ashcraft, & Thomas, 2008) ou d'identités multiples (Gotsi, Andriopoulos, Lewis, & Ingram, 2010; Robertson & Swan, 2003). Lorsqu'ils entrent dans des rôles de gestion, les professionnels sont en effet sujets à des pressions divergentes provenant de différents acteurs adhérant à des logiques distinctes. Ces pressions pour se conformer aux logiques peuvent donner naissance à des tensions (Denis, 2016). La collision de logiques plus difficilement compatibles est pour sa part abordée comme un conflit identitaire, soit les tensions découlant de la possession d'identités en confrontation telles que celle de mère avec celle de femme de carrière traitée par Russo et Van Hooft (2011) ou de médecin avec celle de gestionnaire à laquelle se sont intéressés Quinn et Perelli (2016). Le travail identitaire, défini comme la formation, réparation, maintenance, fortification ou révision par les individus de leur conception d'eux-mêmes permettant de créer un sens de cohérence et distinction (Alvesson, 2010), constitue la réponse des individus aux tensions pouvant émerger des conflits identitaires. Dans la lignée de recherche portant sur le travail identitaire, certains auteurs s'attardent à la construction de l'identité (Beech, MacIntosh, & McInnes, 2008), l'établissement de la centralité des identités (Johnson, Morgeson, Ilgen, Meyer, & Lloyd, 2006), le jeu identitaire (Ibarra & Petriglieri, 2010), les identités temporaires (Ibarra, 1999) et le travail identitaire correctif (Lutgen-Sandvik, 2008).

Or, la vision statique de l'identité proposée dans ces écrits ne permet pas de comprendre comment l'identité des professionnels entrant dans des rôles de gestion évolue à travers le temps. Ces études explorent par ailleurs l'identité de professionnels entrant dans des rôles de gestion en *solo* plutôt que de *co*gestion. Ainsi, si ces écrits fournissent une fondation pour aborder la rencontre de logiques au niveau individuel, des clarifications additionnelles seraient nécessaires pour mieux comprendre le processus de changement identitaire survenant à travers le temps lors de l'entrée dans des rôles de *co*gestion. La première interface de rencontre de logiques traitée dans cette thèse

prend donc place à l'intérieur du détenteur du rôle où l'ambigüité et les conflits de rôles dérivant du chevauchement de deux logiques peuvent demander des ajustements identitaires afin de préserver ou redéfinir la réponse à la question *qui suis-je?* La première sous-question de recherche à laquelle s'attardera le premier article de cette thèse est donc : *comment les professionnels gèrent-ils discursivement les tensions identitaires auxquelles ils font face lorsqu'ils intègrent des rôles de gestion à travers le temps?*

1.2.2. **La dyade**

Au-delà des individus, les logiques institutionnelles peuvent entrer en contact à l'intérieur de dyades occupant des positions charnières. Les différentes manières dont cette rencontre des logiques se réalise – c'est-à-dire les façons dont les dyades jouent leur rôle de liaison - n'ont toutefois pas été examinées malgré leur potentiel d'enrichir notre compréhension de la pluralité institutionnelle. Si elles se situent au niveau individuel, les théories des rôles suggèrent tout de même que les membres des dyades peuvent, conjointement, jouer leurs rôles de liaison et incarner les logiques de diverses façons déterminées à travers un processus continu et cyclique d'ajustements découlant de chaque interaction jusqu'à ce que les attentes exprimées et comportements adoptés convergent (Ashforth, 2001; Beyer & Hannah, 2002; Graen, 1976; Graen & Scandura, 1987; Ilgen & Hollenbeck, 1991).

À ce jour, l'utilisation d'un modèle de co-leadership pour faire le pont entre deux logiques institutionnelles n'a pas été explorée directement. Sans s'attarder aux dyades de co-leaders, la littérature portant sur les réponses organisationnelles à la complexité organisationnelle discute plusieurs modèles relativement similaires qui dépeignent par ailleurs la manière dont les organisations peuvent choisir de faire face à la complexité, allant de l'ignorance d'une logique à l'hybridité en passant par la compartimentalisation (Battilana & Lee, 2014; Fossestol et al., 2015; Kraatz & Block, 2008; Oliver, 1991; Pache & Santos, 2010b). Du côté des études sur le co-leadership, la question des logiques institutionnelles est rarement abordée explicitement. Néanmoins, quelques études explorent différents aspects du co-leadership lorsque celui-ci est utilisé pour lier des logiques

différentes. Les dyades dans les domaines des arts (Reid & Karambayya, 2009), de l'éducation (Court, 2004; Gronn & Hamilton, 2004) et du droit (Empson et al., 2013) ont particulièrement retenu l'attention.

Si ces travaux offrent une base pour explorer les dynamiques au sein des dyades chargées de faire le pont entre deux communautés aux logiques divergentes, une meilleure compréhension des configurations de dyades reflétant les combinaisons de logiques dans le discours des co-leaders et la manière dont ceux-ci se coordonnent (ou non) pour jouer leur rôle permettrait une meilleure compréhension des retombées de l'implantation d'un modèle de co-leadership comme réponse à la complexité institutionnelle. Ainsi, le second article de cette thèse tentera de répondre à la sous-question suivante : *Si et comment un modèle de co-leadership permet de faire le pont entre deux logiques institutionnelles?* Comme le soulignent Kraatz et Block (2008), comprendre le positionnement des acteurs situés à la frontière de multiples logiques est important puisque celui-ci façonnera la manière dont l'organisation évoluera par la suite.

Les deux premiers articles répondent à un appel de Powell et Colyvas (2008) pour des recherches au niveau microscopique qui fonderaient ensuite une meilleure compréhension des dynamiques macroscopiques. Selon les propos tenus par les auteurs dans un écrit théorique, les forces institutionnelles façonnent les intérêts et désirs des individus, qui à leur tour dictent leurs comportements. Ceux-ci contribueront ensuite à la persistance ou au maintien des institutions, ces dernières étant reproduites (ou non) à travers les activités quotidiennes des individus :

> Les membres des organisations engagent dans des pratiques quotidiennes, découvrent des aspects intrigants ou des anomalies dans leur travail, problématisent ces questions et développent des réponses en les théorisant. Ensuite, les participants attribuent un sens à ces théories et, ce faisant, développent et reproduisent des compréhensions tenues pour acquises (Powell & Colyvas, 2008 : p. 277 : traduction libre).

Entre autres, Powell et Colyvas (2008) encouragent explicitement de nouveaux efforts pour explorer comment les individus se positionnent dans leur contexte institutionnel. Du même coup, comme le demandaient Dunn et Jones (2010), nos articles iront au-delà de la supposition souvent tenue pour acquise de la profession comme un ensemble homogène (Thomas & Hewitt, 2011). Selon les auteurs, les environnements institutionnels sont plutôt fragmentés, composés de demandes conflictuelles, de logiques multiples et de sous-groupes aux intérêts divergents qui peuvent nuire, voire empêcher l'entente ou le consensus. De telles différences au sein de la profession sont souvent minimisées, mais Abbott (1988) les soulignaient déjà.

1.2.3. **L'organisation**

À un niveau plus macroscopique, c'est à l'influence des professionnels en gestion et à la place de différentes logiques dans la prise de décision que s'attardent certains auteurs. Dans un article exposant les résultats d'une étude empirique du système de santé albertain entre 1994 et 2008, Reay et Hinings (2009) expliquent que des groupes à logiques en compétition peuvent coexister et éventuellement développer une collaboration en délimitant la logique à laquelle appartiennent différentes décisions et en consultant de manière informelle mais routinière les membres de l'organisation adhérant à chaque logique dans la prise de décision. Llewellyn (2001) argumente pour sa part que les professionnels en rôle de gestion se trouvent dans un espace charnière qui peut leur permettre de questionner de l'intérieur et dans leur langage le droit exclusif des administrateurs de contrôler la prise de décision stratégique. Selon l'auteur, les idées de ces professionnels en gestion commencent alors à prendre davantage d'espace dans la prise de décision, renforçant ainsi leur position.

Dans le cas qui nous concerne, l'implantation de nouveaux rôles œuvrant en cogestion chargés d'agir comme agents de liaison et gestionnaires vise entre autres une influence plus importante des communautés professionnelles sur les décisions stratégiques. L'étude de la troisième interface s'attardera donc à la manière dont le processus de prise de décision évolue suite à l'ajout d'un nouveau rôle de liaison. Ainsi, la sous-question de recherche du troisième article vise à répondre à

la question : *comment et pourquoi l'intégration de professionnels dans des rôles de gestion façonne (ou non) leur influence sur les processus de prise de décision stratégique à travers le temps?*

L'étude des pratiques de légitimation permettra de répondre à cette question en offrant un cadre pour examiner comment l'influence sur la prise de décision est légitimée (ou non). Actuellement, la littérature sur la légitimation portant sur l'introduction d'occupations, rôles ou pratiques demeure limitée et fragmentée. On y discute les stratégies discursives de légitimation (Goodrick & Reay, 2010; Vaara & Tienari, 2008), les pratiques et actions visant la légitimation (Daudigeos, 2013; Reay & Golden-Biddle, 2006; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014) ainsi que le discours et les actions de différents acteurs (Kellogg, 2009; Reay, Goodrick, Casebeer, & Hinings, 2013). Par exemple, Rondeau et Bareil (2010) estiment que légitimer un changement demande des efforts pour établir un dialogue soutenu ainsi que d'assister les agents de changement faisant face aux déséquilibres causés par des transformations dans les rôles et responsabilités, rapports de pouvoirs et relations tout en protégeant leur intégrité. Ces études se limitent cependant généralement à l'identification de stratégies de légitimation et assignent des positions statiques et polarisées aux acteurs (pour et contre). Les stratégies de délégitimation ainsi que la fluidité potentielle des positions des acteurs à travers le temps demeurent cependant presque inexplorées. Si l'exploration des stratégies de (dé)légitimation ne se limitera pas aux professionnels en gestion eux-mêmes - un facteur de différenciation de l'étude réalisée - notons que l'identification des pratiques de ces derniers permettra de répondre à l'appel de Correia et Denis (2016) pour des efforts qui permettraient de mieux comprendre le rôle des professionnels dans la définition du changement au cœur duquel ils se trouvent, un aspect peu exploré à ce jour.

Pour répondre à la question de recherche générale et aux trois sous-questions, une étude longitudinale qualitative est réalisée. La prochaine section explique la méthodologie préconisée, discute de l'aspect éthique relié à la recherche auprès de sujets humains et expose le contexte de la recherche. Des détails sur les changements structurels étudiés sont ensuite donnés afin de paver la voie pour les trois articles qui suivront.

CHAPITRE 2 - MÉTHODOLOGIE

2.1. Le contexte de la recherche

C'est dans le cadre des efforts concertés de différents acteurs (établissements, associations et fédérations professionnels) du réseau de la santé pour améliorer les relations médico-administratives au Québec que le présent projet de thèse a vu le jour. Après avoir réalisé un diagnostic de l'état de ces relations, ceux-ci ont proposé à l'ensemble des établissements de santé et services sociaux de la province de participer à des projets pilotes visant la réconciliation les impératifs organisationnels et professionnels au sein du système de santé en favorisant une participation active de la profession médicale (Baker, Denis, Pomey, & Macintosh-Murray, 2010; Ham & Dickinson, 2008). Dans le cadre de ces projets pilotes, les établissements devaient procéder à l'implantation d'un certain nombre de pistes de partenariat médico-administratif et permettre un suivi rapproché des impacts et enjeux associés aux changements apportés. Les pistes de partenariat médico-administratif proposées incluaient :

1) La cogestion médico-administrative des programmes ou services cliniques impliquant la création de rôles de gestion au niveau stratégique pour des professionnels de la médecine qui partageraient la responsabilité de gérer un programme ou service clinique en collaboration rapprochée avec un administrateur;

2) La création d'un comité de coordination pour l'ensemble des programmes ou services cliniques sur lequel siègeraient les tandems en cogestion pour collaborer dans l'accomplissement de différents projets touchant plusieurs programmes ou services cliniques;

3) La participation des co-leaders médicaux de programmes cliniques au comité de direction de l'établissement;

4) Le renforcement des liens entre le comité d'administration et le conseil des médecins, dentistes et pharmaciens (CMDP) de l'établissement;

5) La création au sein du comité d'administration d'un comité qui traiterait des affaires cliniques de l'établissement;

6) La création d'une cellule de réflexion et d'orientation stratégique qui comprendrait le directeur général, le président du comité d'administration, le président du CMDP et le directeur des services professionnels.

Durant le processus d'implantation de ces pistes, les établissements s'engageaient à permettre à une équipe de recherche de réaliser un suivi rapproché des impacts et enjeux découlant des changements mis en branle. Derrière cette recherche se cachait la volonté de différents acteurs du réseau de la santé d'étudier la pertinence de différentes pistes d'amélioration des relations médico-administratives d'un point de vue managérial (identification des éléments facilitateurs, conditions de succès, difficultés rencontrées) et d'utiliser l'opportunité pour développer les connaissances scientifiques entourant la problématique. C'est donc dès 2010 que l'idée d'un projet de recherche scientifique s'est d'abord dessinée dans ce contexte du changement. Le présent projet de thèse fait partie de ces efforts de développement des connaissances scientifiques réalisés dans le contexte de l'implantation de ces pistes.

2.2. Le design de la recherche

Les efforts de recherche dépeints plus haut prennent la forme d'un projet de cueillette de données longitudinal se déroulant sur 21 mois, soit de février 2012 à octobre 2013. Une telle étude de cas longitudinale et en profondeur a été jugée adéquate dans l'étude d'une perspective processuelle de l'identité, du co-leadership et de la prise de décision impliquant de multiples logiques (Van Gestel & Hillebrand, 2011). Aux tous débuts de la démarche de projets pilotes, l'ensemble des organisations du champ d'activité ont été invitées à soumettre leur candidature pour participer au projet, soit 95 organisations. Parmi les neuf organisations ayant exprimé leur intérêt, quatre organisations ont été sélectionnées en fonction de leurs structures organisationnelles, tailles et complexités et ont ouvert leurs portes au chercheur. Ensemble, ces organisations peignent un portrait représentatif des organisations présentes dans leur champ d'activité, la santé. Le tableau 2.1. expose les caractéristiques des organisations à l'étude.

	Centre de santé universitaire (Site U)	Centre de santé régional (Site R)	Centre de santé semi-rural (Site SR)	Centre de santé de première ligne (Site PC)
Installations à vocation de courte durée	2 majeurs	2 majeurs	Un petit hôpital	Aucun
Installations à vocation de longue durée	4	8	3	8
Centres locaux de services communautaires	5	7	3	7
Nombre d'employés	5500-6000	5000-5500	100-1500	3000-3500
Nombre de médecins actifs	600-650	450-500	50-100	200 - 250
Enseignement et recherche	Central	Présent	Présence minimale	En développement

Tableau 2.1. Caractéristiques des sites

La collecte de données entreprise parallèlement dans ces quatre organisations se divise en deux phases. Les informations précises relatives à la collecte de données sont présentées dans le tableau 2.2. Avant de détailler la démarche, notons que deux chercheurs (dont l'auteur de cette thèse) ont assuré la collecte des données, couvrant deux sites chacun. Ceux-ci ont développé les outils de cueillette conjointement, ont pris soin de coordonner les démarches dans différents centres et ont échangé sur leurs données et résultats à différents moments. La présente thèse porte sur le matériel recueilli par les deux chercheurs dans les quatre sites.

La première phase visait à bien comprendre les organisations (structure, acteurs clefs, relations, culture, historique, etc.) et incluait la conduite d'entrevues avec approximativement 25 acteurs clefs dans chacune des quatre organisations identifiées par l'examen de document, lors de l'observation et par la méthode boule de neige. Des efforts ont été mis de l'avant pour s'assurer de rencontrer un nombre similaire de professionnels et d'administrateurs dans chaque organisation. Le guide d'entretien bâti pour guider les entretiens de la phase 1 est exposé en annexe 3. Au-delà d'un portrait de chaque organisation, ces rencontres individuelles avaient pour but de connaître le parcours des participants, d'obtenir une vision claire de l'implication et des perceptions des participants en ce qui a trait aux relations entre les mondes professionnel et managérial, ainsi que de mieux comprendre les efforts déployés pour améliorer ces liens.

Site	Entrevues		Observations	Analyse documentaire
	Phase 1 (T1)	**Phase 2 (T2)**		
Universitaire	27	22	• Comité de direction • Bureau stratégique • Comités opérationnels	• Descriptions de tâches • Organigrammes • Descriptions des mandats des instances de consultation et de gouvernance
Régional	11[1]	19	• Comité de direction • Conseil des médecins, dentistes et pharmaciens • Table des chefs de départements médicaux • Rencontres de consultation stratégique	• Descriptions de tâches • Organigrammes • Présentations et documents sur la planification de l'implantation du modèle • Descriptions des mandats des instances de consultation et de gouvernance
Semi-rural	27	18	• Comité de direction et comité de direction clinique • Comité d'implantation de la cogestion • Conseil des médecins, dentistes et pharmaciens • Table des chefs de départements médicaux • Rencontres de consultation stratégique • Sessions de formation en cogestion • Comités opérationnels	• Descriptions de tâches • Organigrammes • Exercices de réflexion sur le modèle • Présentations et documents informatifs sur le modèle • Rapports de l'évolution de l'implantation du modèle
Première ligne	25	18	• Comité de direction • Comité de direction clinique • Conseil des médecins, dentistes et pharmaciens • Comités opérationnels • Comité sur l'enseignement médical • Table des chefs de départements médicaux	• Descriptions de tâches • Organigrammes • Descriptions des mandats des instances de consultation et de gouvernance

Tableau 2.2. Portrait de la collecte de données réalisée

[1] Le Centre régional a effectué les changements structurels à l'été 2013, juste avant la deuxième phase de collecte de données. Des entrevues, observations et une analyse documentaire ont néanmoins été réalisées afin de comprendre la situation, les enjeux retardant l'implantation et les positions de différents acteurs.

Parallèlement aux entrevues de phase un, différentes instances décisionnelles et informationnelles (comités) ont été observées au sein des quatre organisations. L'identification des instances les plus pertinentes s'est principalement faite à l'aide de différents documents officiels exposant les mandats et activités des comités. Le souci d'observer des instances professionnelles, administratives et dans lesquelles les deux communautés étaient impliquées a également guidé les décisions. L'ensemble des documents de travail et écrits officiels distribué lors de ces rencontres, ainsi que tout autre document diffusé à l'intérieur ou extérieur des organisations ont été scrutés. Y étaient visibles les perceptions des différents participants des relations entre les deux communautés, des efforts de rapprochement ainsi que de l'implication individuelle dans les changements.

L'observation et l'analyse documentaire se sont toutes deux poursuivies tout au long de l'étude. La phase deux a impliqué des rencontres individuelles avec les acteurs clefs des organisations rencontrées en entrevue en phase un (voir le guide d'entretien des phases 1 et 2 en annexe 3 et 4). Cette étape de la recherche a contribué à comprendre le processus de transformation organisationnelle ainsi que l'évolution des perceptions. Si la collecte de données générale se décline ainsi, les spécificités de l'analyse réalisées dans le but de répondre aux trois sous-questions de recherche seront expliquées dans la section méthodologique de chacun des articles constituant cette thèse, accompagnées d'un traitement des questions de validité et fidélité.

Dans les pages qui suivront, les citations mobilisées seront identifiées en étant suivies par des parenthèses dans lesquelles seront identifiés le titre du participant, son numéro lorsqu'il s'agit d'un co-leader, l'organisation dans laquelle il œuvre ainsi que la phase de collecte de données durant laquelle l'extrait a été collecté (par exemple, T1 pour identifier la première phase). Les abréviations suivantes sont utilisées pour identifier les organisations :

- Centre de santé et services sociaux universitaire : U
- Centre de santé et services sociaux régional : R
- Centre de santé et services sociaux semi-rural : SR
- Centre de santé et services sociaux de première ligne (ou *Primary care) :* PC

Ainsi, *(Medical Director 4 –U, T1)* indique que la citation identifiée a été collectée durant la première phase de collecte de données et identifie le directeur médical numéro 4 du centre de santé et services sociaux universitaire.

2.3. L'éthique de la recherche

Dans l'optique de réaliser un travail de recherche répondant aux standards éthiques, le projet de thèse ainsi que le projet plus vaste duquel il fait partie ont obtenu l'approbation du comité d'éthique de la recherche de HEC Montréal ainsi que l'autorisation éthique des sites participants. Des copies de l'avis de conformité émis par le comité d'éthique de la recherche de HEC Montréal ainsi que des formulaires associés à cette demande sont présentés en annexe 6. Les documents associés aux approbations des organisations participantes sont conservés par l'équipe de recherche, mais n'apparaissent pas dans le présent document puisqu'ils risqueraient de permettre l'identification des participants.

Lors de la collecte en elle-même, des formulaires de consentement exposant le but, le design, les contributions attendues et les considérations éthiques liées à la recherche ont dû être signés par chaque participant lors de la première introduction des chercheurs pour l'observation des rencontres ainsi qu'au début de chaque entretien. Dans chacun de ces formulaires, le participant devait se positionner quant à son ouverture à la participation ainsi qu'au niveau de confidentialité souhaitée. Malgré cette signature, les participants possédaient la liberté de se retirer de l'étude sans justification à n'importe quel moment. Les participants pouvaient également consulter les données collectées auprès d'eux ou demander à ce que certaines interventions spécifiques soient retirées des données.

Les données collectées lors des entrevues et observations ont été conservées par l'équipe de recherche dans un site sécurisé accessible à l'aide d'un nom d'utilisateur et mot de passe. Chaque membre de cette équipe a dû signer un engagement de confidentialité au commencement du projet et s'engager à protéger les données et participants, tel qu'exigé par la politique en matière d'éthique

des trois conseils (*Énoncé politique des trois Conseils : Éthique de la recherche avec des êtres humains*, 2010). Si les quatre sites, organismes initiateurs du projet et les participants à l'étude ont pu avoir accès aux résultats des efforts de recherche, seuls les membres de l'équipe de recherche détenaient l'autorisation d'accéder aux données.

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2.4. Les quatre organisations : précisions sur les modèles adoptés et leur implantation

Avant d'expliquer les modèles mis en place dans les quatre organisations participantes, il convient de présenter les acteurs clefs d'une structure traditionnelle. Notons d'abord que si différentes orientations et réformes au niveau provincial imposent ou proposent certains modèles d'organisations aux établissements de santé, un certain espace d'ajustement aux réalités locales permet aux établissements de modeler leur structure. Les organisations de santé possèdent donc des structures qui diffèrent les unes des autres à des degrés variables. Je fournis conséquemment dans les prochains paragraphes une explication générale d'une structure traditionnelle, sans toutefois peindre un portrait exhaustif des nuances des structures organisationnelles des établissements de santé.

Tout au long de l'étude, la structure organisationnelle par programme-clientèle était en place dans les sites participants. Celle-ci répartissait les gestionnaires à l'intérieur de deux types de direction (programmes-clientèles et soutien) ayant des fonctions différentes (voir la figure 2.1.). Les

directions programmes-clientèles (telles que la direction de la santé physique ou du soutien à l'autonomie des personnes âgées) ont été formées de manière à créer des continuums de soins et services pour répondre aux besoins de clientèles regroupées en groupes homogènes. Traditionnellement, un directeur clinico-administratif de programme-clientèle se charge de la gestion des opérations pour répondre à ces besoins tout en mettant en application les orientations de l'établissement au sein de leurs équipes. Deux types de direction de soutien sont présents dans les organisations de santé : administratives et cliniques. Les premières (incluant par exemple les directions des ressources humaines, financières ou matérielles) appuient les directions programmes-clientèles dans leurs efforts pour appliquer les orientations prises par l'établissement à travers la gestion de leurs ressources et champs d'expertise respectifs. Le rôle de ces dernières demeure inchangé dans le cadre des projets pilotes à l'étude. Les directions de soutien cliniques telles que la direction des soins infirmiers mettent l'emphase sur le développement des pratiques professionnelles ainsi que les processus d'amélioration de la qualité et de la sécurité. Également dans un rôle de soutien clinique défini par la loi sur les services de santé et services sociaux, les directions des services professionnels (DSP) coordonnent l'activité professionnelle en dirigeant, coordonnant et surveillant les activités des chefs de départements cliniques. Les directeurs des services professionnels sont des médecins de formation dont les responsabilités concernent tout particulièrement le corps médical de l'établissement dans lequel ils œuvrent.

Parallèlement à la structure par programme-clientèle existe une structure propre à la communauté médicale des établissements de santé : le conseil des médecins, dentistes et pharmaciens (CMDP). Le CMDP comprend tous les médecins, dentistes et pharmaciens d'un établissement qui élisent un exécutif se rapportant au conseil d'administration responsable d'assurer la qualité de l'acte médical en collaboration avec le directeur des services professionnels et à travers le travail des chefs de départements médicaux. Selon la loi sur les services de santé et services sociaux, les chefs de départements cliniques sont des médecins qui ont entre autres l'obligation d'assurer la coordination des activités professionnelles, la gestion des ressources ainsi que la qualité de la pratique médicale au sein du département.
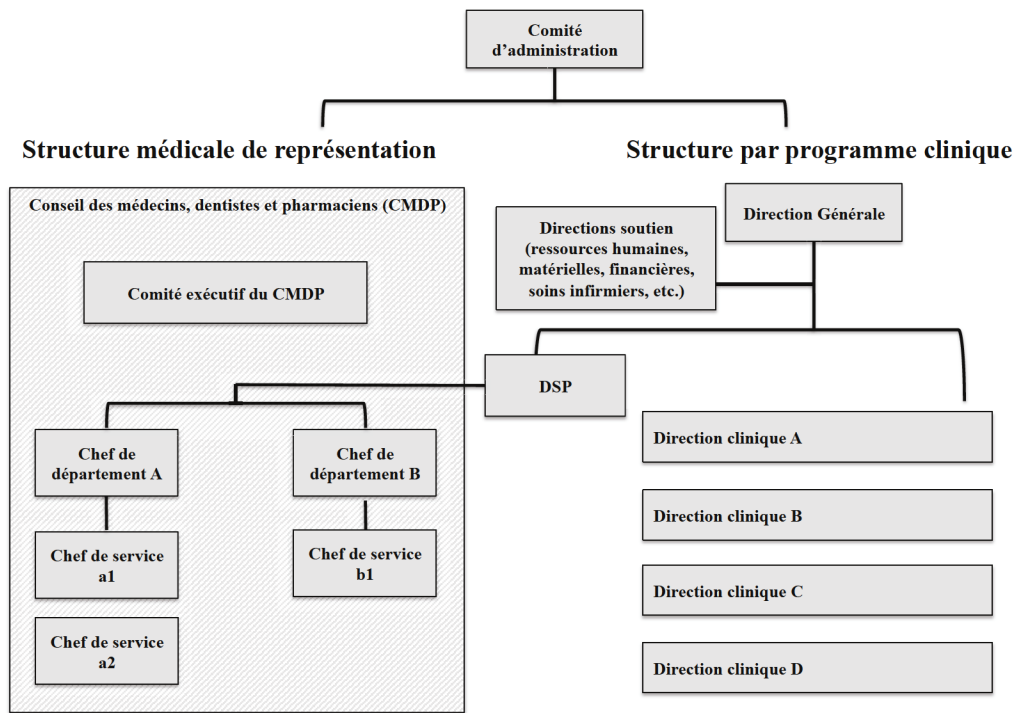
Figure 2.1. Organigramme par programme traditionnel simplifié

Tel que mentionné précédemment, les projets pilotes impliquaient la mise en place d'un modèle de cogestion dans lequel un médecin a été invité à prendre un rôle de cogestionnaire en collaboration avec un administrateur. À la base de cette initiative se trouve une volonté d'intégrer la perspective médicale dans la prise de décision stratégique des établissements de santé ainsi que de construire et faciliter les liens entre les communautés médicales et managériales. Puisque chaque organisation évolue dans un contexte différent et a un profil particulier, le modèle adapté diffère légèrement d'une organisation à l'autre. Les spécificités du modèle préconisé dans les quatre sites pilotes sont donc expliquées dans les lignes qui suivent. Notons tout de même que dans tous les cas, les rôles des directions de soutien administratif sont demeurés inchangés.

2.4.1. Site U : Centre de santé universitaire

Parmi les quatre sites participants, le centre de santé universitaire a constitué dès le début le site repère, étant le plus avancé dans l'implantation et l'expérimentation de la cogestion. Effectivement, le site U possédait une structure de cogestion depuis plusieurs années lors du commencement du projet de recherche. Cette structure était caractérisée par le regroupement de 11 programmes-clientèles sous un tandem de codirecteurs formé de la direction des soins infirmiers et la direction des services professionnels qui formait un seul directorat : la direction des services cliniques. C'est d'ailleurs ce dernier tandem qui agissait à titre de champion du modèle de cogestion et exemplifiait le tandem idéal aux yeux des membres de l'organisation. Dix de ces 11 programmes-clientèles étaient gérés par des tandems composés d'un chef médical et d'un chef clinico-administratif œuvrant en cogestion. Notons également deux particularités du site U. Tout d'abord, contrairement aux trois autres sites, les co-leaders médicaux du centre de santé universitaire cumulaient les rôles de chef de département universitaire, chef de département médical et chef de programme clinique. Ensuite, soulignons que certains chefs de départements médicaux n'ont pas été jumelés à un chef clinico-administratif pour gérer un programme-clientèle, mais demeuraient seuls à la tête de leurs départements. Ceux-ci n'ont ainsi pas eu à travailler dans un mode de cogestion. La figure 2.2. fournit une illustration simplifiée de l'organigramme du site U.
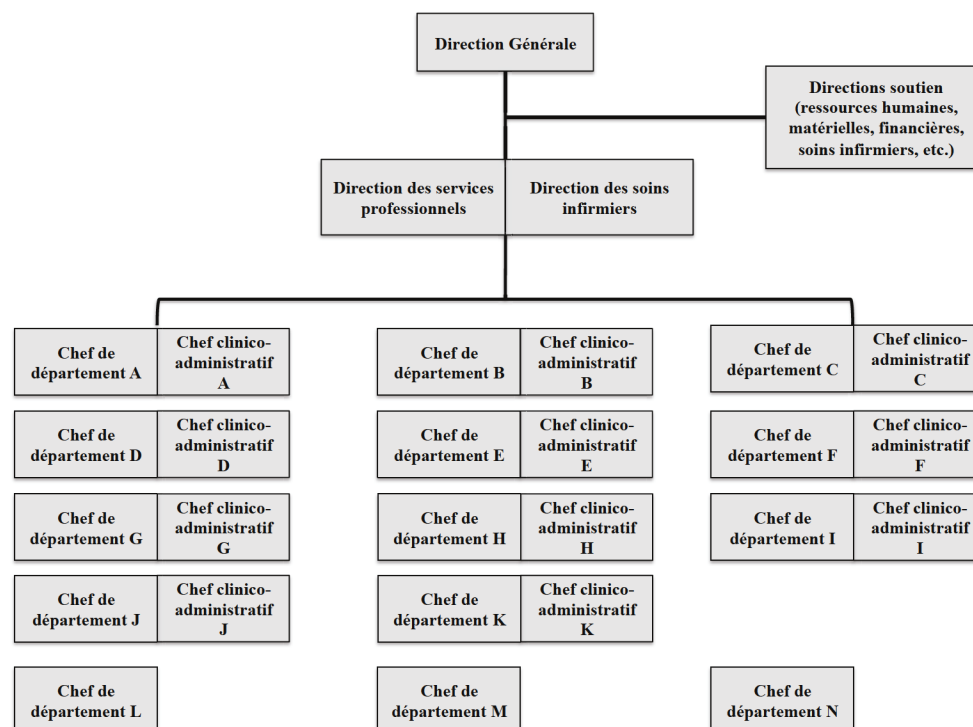
Figure 2.2. Organigramme simplifié du centre de santé universitaire (site U)

Durant la collecte de données, le tandem de directeurs siégeait au comité de direction de l'établissement aux côtés de certains chefs de départements et des directions administratives. Le tandem DSI-DSP présidait également une table composée de l'ensemble des tandems de programmes-clientèles (chefs de départements et clinico-administratifs). Au terme de l'étude, ce comité décisionnel s'attardant aux questions cliniques préoccupant l'organisation était devenu d'une importance telle qu'il provoqua un questionnement de la pertinence du comité de direction. Notons finalement que d'importants efforts d'encadrement et de formation ont été déployés au centre de santé universitaire pour faciliter la réalisation du rôle et consolider leur implantation.

2.4.2. Site R : Centre de santé régional

Le centre de santé régional a choisi de greffer quatre directeurs médicaux à ses quatre directeurs cliniques ayant une formation administrative, comme l'illustre la figure 2.3. ci-dessous. La présence de ces co-leaders médicaux au comité de direction a été requise dès l'entrée en fonction de ces derniers. Contrairement aux trois autres sites participants, le centre de santé régional a dû retarder à

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l'été 2013 l'introduction de ces nouveaux rôles pour des raisons principalement financières. À la fin du projet de recherche, les besoins de soutien et de formation des directeurs médicaux et des tandems étaient explorés, mais aucune action concrète n'avait à ce stade été entreprise. Au site R, la directrice générale adjointe a initié et mené le projet de changement structurel. S'il n'était originellement pas convaincu de la pertinence de la nouvelle structure, le DSP a adhéré au projet avant l'introduction des nouveaux rôles pour ensuite jouer un rôle important. Aux côtés de la directrice générale adjointe, le DSP a effectivement pris les rênes du projet. Dans les derniers mois de la collecte de données, des discussions étaient en cours pour créer un tandem qui superviserait les quatre tandems cliniques composés de la directrice générale adjointe et du DSP. Dans l'implantation du changement structurel, on pouvait d'ailleurs constater des efforts des deux acteurs pour se présenter comme un tandem ayant la charge du projet.
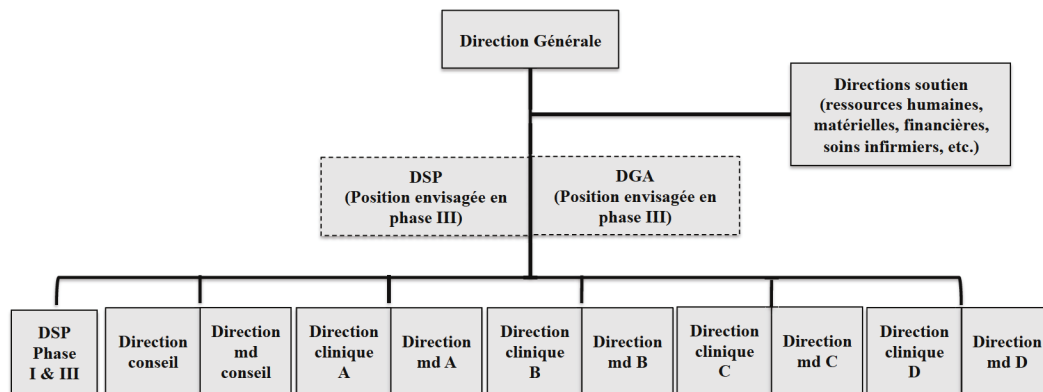
Figure 2.3. Organigramme simplifié du centre de santé régional (site R)

2.4.3. Site SR : Centre de santé semi-rural

Tout comme le centre de santé universitaire, le centre semi-rural avait déjà entrepris la mise en place de la cogestion et des nouveaux rôles de co-leaders médicaux au moment du lancement de l'étude. La directrice des services professionnels, accompagnée par le directeur des ressources humaines, menait le projet. Le modèle préconisé incluait l'ajout d'un directeur médical de programme clinique au côté de chaque directeur programme-clientèle (quatre au total) ainsi que le développement de la cogestion entre les chefs d'unités et chefs de départements médicaux. Bien que

cette étude se concentre sur le niveau stratégique, la figure 2.4. illustre l'organigramme de cogestion dans l'ensemble du site S.
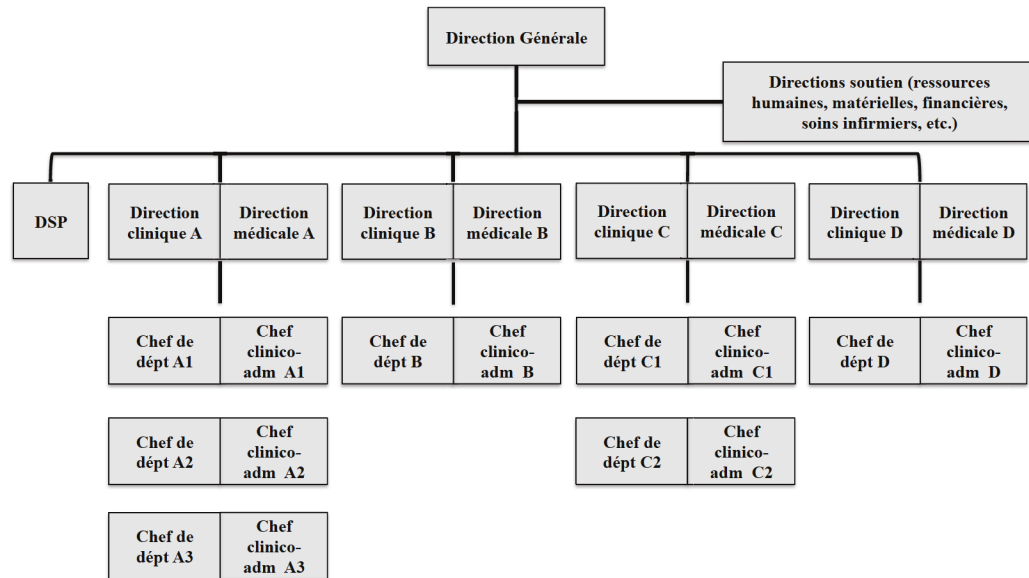
Figure 2.4. Organigramme simplifié du centre de santé semi-rural (site SR)

Entre février 2012 et octobre 2013, des changements importants dans la structure de comité ont été réalisés. À l'hiver 2012 existait effectivement un seul comité de direction composé des directeurs administratifs et clinico-administratifs de l'établissement, mais n'incluant pas les nouveaux directeurs médicaux de programmes cliniques. Un comité de direction clinique alternant avec le comité de direction a été ajouté pour inclure les directeurs médicaux dans les discussions stratégiques. Tandis que le comité de direction gardait une constitution inchangée, le comité de direction clinique comprenait l'ensemble des tandems directeurs (directeurs médicaux et clinico-administratifs) ainsi que le directeur général et la directrice des services professionnels. En 2013, aux comités de direction et comités de directions cliniques s'est ajouté un comité de direction conjoint sur lequel siégeaient à la fois les directeurs administratifs, clinico-administratifs et médicaux. Notons par ailleurs que lors du déroulement de l'étude, des efforts importants ont été mis en branle pour développer les tandems aux deux niveaux (*coaching*, codéveloppement, formations, etc.) et pour assurer la pérennité de la nouvelle structure.

2.4.4. Site PC : Centre de santé de première ligne

La structure de cogestion implantée au centre de santé de première ligne est la plus complexe des quatre sites de l'étude. Celle-ci impliquait la cogestion médicale de deux des quatre directions cliniques ainsi que de six des huit chefs clinico-administratifs, coordonnateurs et directeurs adjoints situés à l'intérieur des directions cliniques. Trois de ces six cadres intermédiaires travaillaient en collaboration avec un vis-à-vis médical dans un tandem, alors que les trois autres devaient s'arrimer avec deux vis-à-vis médicaux associés à différents départements ou groupes de médecins. Bien que la présente étude s'attarde aux rôles de directeurs médicaux, les niveaux stratégiques et tactiques sont illustrés en figure 2.5. afin de faciliter la compréhension du lecteur des dynamiques abordées.
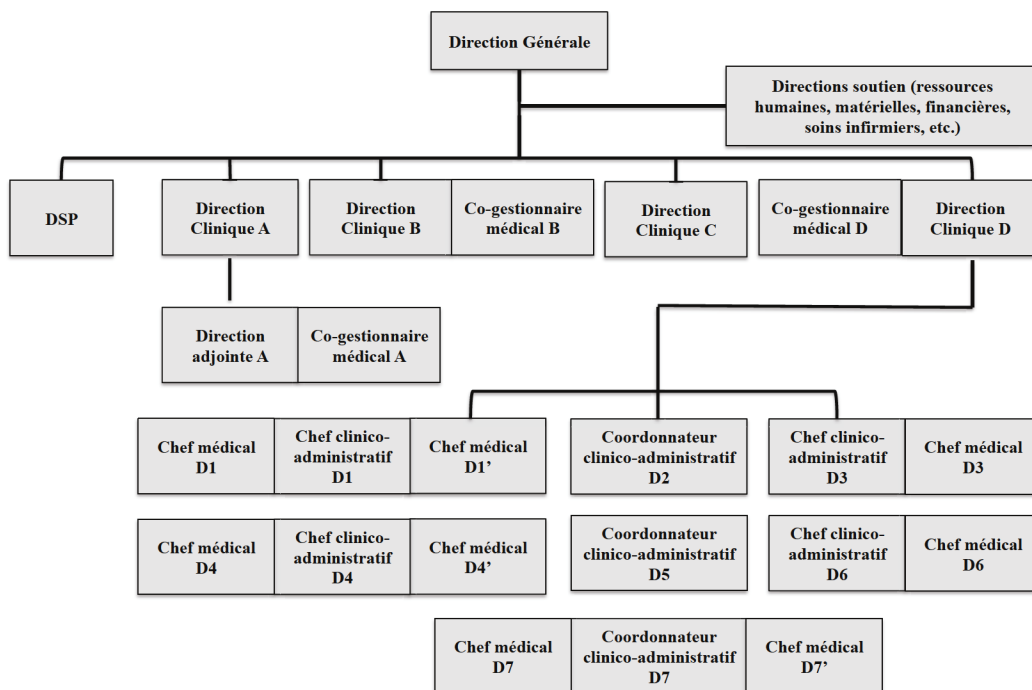
Figure 2.5. Organigramme simplifié du centre de santé de première ligne (site PC)

Au moment de l'étude, les médecins co-leaders n'étaient pas invités au comité de direction, et les efforts d'encadrement ou de formation entourant les nouveaux rôles étaient discrets et dispersés. Au sein du centre de santé et services sociaux PC, le DSP était le chargé de projet pour l'implantation du modèle préconisé.

CHAPITRE 3

ARTICLE I: The Identity Work of Professionals Entering Management Roles: A Process Perspective

Abstract

In professional service organizations, tensions may arise from the coexistence of professional and managerial logics. The introduction of professionals into management roles is seen as a potential avenue to bridge these different logics and align professional and managerial interests toward a common goal. However, professionals entering management roles may be subject to pressures from administrators to adhere to the managerial logic, and from fellow professionals to stay true to the professional logic. Professionals in management roles need to navigate attempts at regulating their identity in different ways. This research project seeks to explore how professionals handle identity tensions in their narratives over time as they take on management roles. To answer this research question, I analyzed the narratives of 20 professionals who recently became managers within healthcare organizations. The findings suggest that professionals entering management roles perform five kinds of identity work: constructing continuity, distancing from management, reinventing management, positioning above the crowd and defining the relationship with the co-leader. I suggest that the patterns of identity work described here can be understood as means to transcend conflicting pressures of identity regulation by assigning unique and distinctive value to the new role.

Keywords: Identity Work, Identity Transitions, Professionals, Medical Managers, Process.

3.1. Introduction

Professionals belong to a world in which autonomy is central, and where organizational constraints are not at the top of their agenda (Witman et al., 2011). Indeed, professionals often do not see themselves as accountable to the organization in which they are practicing for their use of resources and work performance, but rather mainly to their individual clients or patients, and to their fellow professionals (Salter, 2001). Differently, in the managerial world, organizational accountability is central. Improvement in outcomes is thought to be achieved through better managerial practices, better work organization, and better coordination and control mechanisms (Ferlie & Pettigrew, 1996). Thus, when practicing professionals become managers, they may experience a certain tension or mismatch. Navigating the transition from the professional world to a management role can be difficult as individuals find themselves confronted with pressures to change their thinking and behavior, potentially challenging their "identity:" i.e., their sense of coherence and distinctiveness in answering the question "who am I?" (Brown, 2014).

As Ashforth (2001) suggests, such role transitions are likely to be particularly disconcerting when they imply a "role reversal," i.e., when individuals have previously defined themselves in terms of the negation of what they now appear destined to become. Thus, for professionals who may have previously defined themselves as *not* being managers, (focusing on the incompatibility between professionalism and management), the move may raise very difficult identity tensions. These are likely to be amplified, for example, when fellow members of the profession and senior managers exercise contradictory pressures on the new role holder to represent their interests, and behave according to their occupations' respective norms and values.

While several researchers have investigated managerial identity narratives (Clarke, Brown, & Hailey, 2009; Thomas & Davies, 2005; Watson, 2009), or have focused on identity issues associated with role transition (Ashforth, 2001; Croft et al., 2015; Pratt et al., 2006), we still have a limited understanding of how individuals facing identity pressures from multiple sources handle these identity tensions as they move into and adapt to new roles over time. The temporal dimension

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seems important because transitions are not just a momentary phenomenon: pressures from others may shift, decline or even intensify, and identity tensions may be experienced differently as time goes by. My research attempts to address this puzzle by exploring how professionals handle identity tensions in their narratives over time as they take on management roles.

Specifically, I conducted a longitudinal qualitative study exploring the experience of 20 physicians entering top management roles in four healthcare organizations. I draw from the literature on "identity work" - defined by Sveningsson and Alvesson (2003) as the continuous formation, revision and strengthening of one's identity - to unpack the professionals' discursive identity work strategies. I find that professionals entering management roles perform five kinds of identity work that appear in the data according to a common pattern during the professional's tenure: "constructing continuity," "distancing from management," "reinventing management," "positioning above the crowd" and "defining the relationship with the co-leader." I suggest that the patterns of identity work described here can be understood as means to transcend conflicting pressures of identity regulation by assigning unique and distinctive value to the new role.

This article proceeds as follows. First, I explore the literature on the identities of hybrids – that is, entities composed of disparate parts (Kirkpatrick, 2016) - such as these individuals combining management and clinical roles and therefore having to achieve divergent sets of objectives. The literature review continues with an explanation of the literature on identity work to deal with tensions and of studies on the process of identity work. I then explain the methods. In the following section, I present the findings in four stages, focusing first on the types of pressures experienced by professionals entering management roles (i.e., forms of "identity regulation"), and second on the five identity work strategies uncovered. I then present detailed narratives of three specific professionals to illustrate typical processes of identity work at different stages of their involvement in management, before describing overall patterns of identity change and identity work across all twenty participants. To conclude, I discuss the contributions of the paper and situate the findings with respect to the existing literature.

3.2. Literature Review: Hybrids' Identity and Identity Work

How individuals define themselves and perform identity work to maintain a sense of coherence and distinctiveness has long intrigued scholars. Times of transition, such as moving into a new role, have received considerable attention because they constitute situations in which tensions are prevalent, triggering self-doubt and an examination of the self (Brown, 2015). Some scholars focused on describing the identity of hybrids such as professionals entering management roles. The next paragraphs explore their conclusions. Studies on identity work to deal with tensions will then be exposed, with an emphasis put on those taking a process perspective in the third part of the review.

3.2.1. The Identity of Hybrids

The identity of hybrids received significant attention in recent years. Many authors propose typologies putting hybrids in two or three groups, one of which reflects a more managerial identity while the other reflects a predominantly professional identity. These scholars discuss organization- or profession- compatible identities (Hoff, 1999), willing hybrids possessing a permanent identity and incidental hybrids who construct a temporary identity while protecting their professionalism (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015), investors who construct a managerial identity and reluctants who distance themselves from management (Forbes, Hallier, & Kelly, 2004) or innovators who develop an identity as managers early, sceptics who see management as a threat and the late majority who may slowly develop a management identity emphasizing clinical leadership (Spyridonidis, Hendy, & Barlow, 2014). Others argue that physician hybrids may attempt to overcome the typical dichotomy of management versus medicine by creating an additional distinction: medical manager versus non-medical manager (Llewellyn, 2001).

Beside these typologies, the potential of hybrids to be loyal to both their organization and their profession has been highlighted (Champagne, Denis, & Bilodeau, 1998), although the likely dominance of the professional aspect despite a possible adaptation to organizational constraints has

been widely agreed upon (Adler, Kwon, & Heckscher, 2008; Kitchener, Caronna, & Shortell, 2005; LeTourneau & Curry, 1997; Llewellyn, 2001; MacIntosh, Beech, & Martin, 2012; Quinn & Perelli, 2016; Reay & Hinings, 2009; Valette & Burellier, 2014). Although it offers an understanding of the identities of professionals in management roles, the literature on hybrids' identities provides a static portrait and do not help understand how the tensions caused by the identity regulation the professionals entering management roles are subject to. The literature on identity work to deal with tensions provides a foundation to gain this understanding.

3.2.2. Identity Work to Deal with Tensions

The very notion of "identity work" generally implies efforts by individuals to construct a sense of self in the face of challenges or tensions (Brown, 2014; Giddens, 1991; Lutgen-Sandvik, 2008). These tensions may derive from alternative discourses in the environment (such as the professional and managerial discourse in McGivern et al. (2015)), or from pressures from managers or others attempting to impose or induce particular constructions of identity on others. In the literature, these pressures, and notably those imposed by managers on employees through various means (such as clarifying values, establishing rules for doing things or developing and assigning social categories) have been labeled "identity regulation" (Alvesson & Willmott, 2002). Following Alvesson and Willmott (2002) as well as Schultz, Maguire, Langley, and Tsoukas (2012) and Wieland (2010), I define "identity regulation" here as more or less intentional efforts aimed at influencing how individuals construct and reconstruct their identity. I see as identity regulation any formal or informal work done at the individuals, group or organizational level to shape the identity of an individual. I note that forms of identity regulation may be directed not only from managers, but also from other sources, such as other professionals in this case. Hence, this work would be done by professionals or managers, individually or as a group, to push the professionals entering management roles to conform to their logic.

Studies of the identity work professionals perform to deal with tensions such as those created by contradictory identity regulation reveal that individuals can incorporate antagonistic discourses to

alleviate tensions (Ashcraft, 2005; Clarke, Brown, & Hailey, 2009), use threats to their work identities as resources to create their preferred selves (Brown & Coupland, 2015), or work to dissociate from, associate with, reframe or reconcile various aspects of identity regulation (Croft, Currie, & Lockett, 2015; Koveshnikov, Vaara, & Ehrnrooth, 2016; McGivern et al., 2015; Watson, 2009). For example, individuals may segregate themselves from what is creating discomfort, and even portray these differences as privileges (Thomas & Davies, 2005), construct themselves as consistently in pursuit of an identity aspired to (Thornborrow & Brown, 2009) or project unwanted aspects of the self into others to construct the desired self (Petriglieri & Stein, 2012). Individuals may also experiment with, select, discard or modify attitudes and behaviors they observe in role models depending on their feelings of authenticity or inauthenticity (Ibarra, 1999). Alternatively, professional hybrids have been found to glorify and demonize aspects of their profession or management, use organizational processes to establish their control over professionalism and position themselves collectively as an elite within their profession (McGivern et al., 2015), redefine their professional identity and shift between nested identities (Spyridonidis et al., 2014).

The studies on the identity work to deal with tensions provide an interesting basis for exploring the work of physicians entering management roles. However, these studies do not take a process perspective, and have not therefore captured the evolution of new professional managers' identities and identity work over time as we plan to do in this paper. There are however a few studies that do offer some insight into identity work processes over time, within a somewhat different context. We review these studies next.

3.2.3. The Process of Identity Work

Although the body of literature on identity work is considerable and some studies are longitudinal, few studies touched on the issue of the temporal ordering of identity work strategies. These studies show that roles and identities co-evolve over time (Järventie-Thesleff & Tienari, 2015) or argue that self-narrations and dramaturgical performances allowing self-verifications in face-to-face encounters constitute two processually co-dependent and mutually reinforcing identity work

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stratagems (Down & Reveley, 2009). In a study of the identity work of medical residents as they became qualified doctors, Pratt, Rockmann, and Kaufmann (2006) documented three identity customization strategies they believe may be temporally ordered. Identity splinting, the temporary use of a prior identity as a splint to protect a fragile identity, may be mainly used in early stages when individuals transitioning to new roles are unsure of their tasks and identities. Then, major misalignments between the work done and the professional identity may trigger identity patching, the construction of oneself as "more complete" than others. Identity enrichment, which involves a deepening understanding of the scope of their responsibilities associated with their role, may be a later stage in the transition process.

Kreiner, Hollensbe, and Sheep (2006) also offer some insight into the processes of identity work. The authors documented three types of strategies used by priests to alleviate the tensions associated with their occupation: differentiation, integration and neutral or dual-function strategies. The authors found that of their 50 participants, 21 were moving over time toward more differentiation from the role while 29 increasingly used integration strategies. The authors also noted that individuals' preference for differentiation or integration could change with situational factors and evolution in identity work. Individuals' perception of a healthy balance between differentiation and integration might also evolve over time.

From the existing literature on identity work, we learned that when facing identity regulation, individuals can dissociate from, modify or associate with components of the regulation imposed on them, and can incorporate antagonistic discourses to create narratives of their identity. Individuals can also construct complementarity between competing discourses in different ways, and can perform identity work by constructing a narrative of change or of continuity. However, despite Pratt et al. (2006) and Kreiner et al. (2006)'s initial exploration of the temporal ordering of identity work strategies, we know little about how professionals handle identity tensions in their narratives *over time* as they take on management roles. Using a process perspective, I seek to develop our understanding of the evolution of identity work by uncovering how professionals' identity work

strategies change over time, and how individuals construct and reconstruct the evolution of their identities within their life story narratives as time goes by. I also examine how individuals use different identity work strategies at different stages of their involvement in management (arriving in a management role, in the middle of their tenure or exiting the management role). My study also reaches beyond those of Pratt et al. (2006) and Kreiner et al. (2006) work by uncovering the different strategies used to navigate identity regulation coming from multiple sources over time. The design of the study was guided by these objectives.

3.3. Methodology

An exploratory qualitative case-based study with the individual as the units of analysis was designed to answer the research question. For research in areas in which substantial theory exists such as identity, such a design is particularly appropriate for capturing individuals' subjective experiences as well as complementing and extending theory by developing a process model (Graebner, Martin, & Roundy, 2012). I analyzed the identity work of 20 physician-managers working in four Health and Social Services Centres (HSSC) located in Quebec.

3.3.1. Context

The first organization is a University Health Centre composed of two major short-term care facilities, four long-term care facilities and five community centres. At the time of the data collection, the University Health Centre had 5500 to 6000 employees and 600 to 650 physicians, and medical teaching and research were central parts of the centre's activities. The second organization, the Regional HSSC, included three major hospitals, four long-term care facilities and three community centres. About 5000 employees and 500 physicians worked in the organization during the study. Teaching and research were part of the centre's activities. The third organization was the Semi-Rural HSSC. It was composed of one small hospital, three long-term care facilities and three community centres. 1000 to 1500 employees were employed by the Semi-Rural HSSC and 50 to 100 physicians practiced in the organization. Minimal medical teaching and research activities were performed in the organization. The fourth organization, the Primary Care HSSC was

composed of eight long-term care facilities and seven community centres. Teaching and research activities were increasingly central to the organization. 3000-3500 employees and 200-250 physicians worked for the Primary Care Centre. Taken together, the four organizations represent the different establishments composing the healthcare system in Quebec.

At the time of this study, the four HSSCs were participating in a wider project on the implementation of a new model of organizing intended to improve the collaboration between physicians and managers in healthcare organizations. The project, initiated by the *Association québécoise d'établissements de santé et de services sociaux* (AQESSS), required the four organizations to implement co-management at the strategic level, involving the introduction of medical directors into the organization's structure and their participation in strategic meetings. Our research team was asked to study the implementation of the model in the four organizations over approximately two years in order to evaluate the model's potential to improve decision making and the relationships between the medical and management communities. As we were collecting data, the interest of exploring the identity work of the physicians entering these newly created top management roles became increasingly clear.

The professionals in question entered what was called "medical director" roles. Medical directors are usually former medical representatives (that is, chiefs of medical departments) recruited by their organization to help achieve organizational goals by leveraging their influence in the medical community. These medical directors also worked in a co-management arrangement, i.e. they were named jointly responsible, along with an administrative/clinical director possessing a training and experience in both a (non-medical) clinical profession and in management, to operate a clinical directorate or program of care. In what follows, I will refer to the administrative/clinical co-director as the "clinical co-director". This context is especially interesting as all previous work on identity work during transitions to management roles involve *solo* management roles. In this case, the context of *co-management* brings an additional contextual factor in the close relationship with an

administrator. As we will see later, although one of the strategies uncovered appears to specifically apply to this particular context, most findings appear generalizable to other transitions.

The medical directors were also expected to work in collaboration and under the supervision of the director of professional services, a physician-manager responsible by law for coordinating the clinical activities in the organization by managing, coordinating and supervising the activities of the chiefs of medical departments. Each organization had one director of professional services. Before the arrival of the medical directors, the directors of professional services were the only members of the top management team possessing medical training and experience. Chiefs of medical departments were physicians responsible for coordinating the activities of doctors, for managing resources and for the quality of services in their medical department. Like the directors of professional services, the role of the chiefs of medical departments is defined in the law.

3.3.2. Data Collection

For the purpose of this study, ten medical directors were interviewed twice, while the other ten were interviewed once as they entered the management role after the completion of the first phase of interviews or left before the second round of interviews. Inspired by Thomas and Davies (2005), I see the interview setting as an empirical event in itself rather than a tool to collect data on topics beyond the interview. I am hence focusing on analyzing the identity work performed during the interviews themselves. During the interviews, questions were asked relating to the participants' academic and professional history, currently held roles, the history of relationships between the medical and managerial communities in the organization as well as examples of successful and challenging projects physician-managers were involved in to bridge the two communities. These last questions inspired by the critical incident technique were followed by an ending open question in which participants were invited to share whatever thoughts or experiences they considered relevant for the researcher to know.

As part of the wider research project on medical professionals entering managerial roles, 102 meetings in which the physician-managers played a key role were observed over 21 months (from February 2012 to October 2013), a thorough document analysis was performed, and 137 additional interviews with the physician-managers' close collaborators were conducted. These additional interviews, documents and observations provided us with the perspective of 90[2] close collaborators of the participants, thereby giving a rich context and perspective to the interviews emphasized in this research. Our continued presence in the organization allowed us to see the participants interacting with other individuals in their day-to-day lives, and to gain an in-depth understanding of the context in which the participants evolved. Two researchers were involved in the data collection. The author of this article was responsible for collecting all data at the Semi-Rural HSSC and the Regional HSSC. A second researcher was responsible for data collection at the University and Primary Care HSSCs.

The profiles of the participants differed significantly. Of the 20 medical directors, nine occupied a management role at the University Health Centre, four at the Regional HSSC, four at the Semi-Rural HSSC and three at the Primary Care HSSC. Ten of the medical directors were trained as general practitioners, while ten were specialists. Seven participants were entering their management roles when we met them (up to one year in that role), seven others were interviewed in the middle of their mandates (approximately one to four years into that role) while six others were about to exit the role during the project (four years or more. Participants explicitly announcing their departure were also included in this category).

3.3.3. Data Analysis

A narrative approach guided my analysis of the interviews. More concretely, I was interested in exploring how, during interviews, individuals presented themselves and constructed their identity.

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[2] Some collaborators were interviewed once while others were interviewed twice, for a total of 137 additional interviews.

The analysis was also inspired by the grounded theory methods as proposed by Gioia, Corley, and Hamilton (2013), while drawing on sensitizing concepts from the literature.

My initial efforts were aimed at uncovering the strategies of identity work used by the participants. I first coded all the data on five medical directors selected for the richness of the data we collected about them. This richness resulted mainly from their particularly strong reflexivity in interviews. This first stage of coding was guided by sensitizing concepts (Charmaz, 2006; Stebbins, 2001; Strauss, 1987) I extracted from the literature, that is, association with and dissociation from aspects of a regulation. Sensitizing concepts are background ideas I uncovered from the literature review offering insight that could potentially guide us to answer the research question. During the first stage of coding, these concepts represent stating points to help tackle the data in a more enlightened way by drawing attention to important elements while remaining flexible (Charmaz, 2003). I also coded all extracts reflecting the medical directors' identity, as well as excerpts in which the medical directors talk explicitly about changes in their answer to the question "who am I?". Special attention was devoted to go beyond the sensitizing concepts to allow new themes to emerge from the data and to keep the first order themes close to the data. Going back and forth from the data to the emerging model, I then grouped the first order themes into second order themes. I then coded the data on the 15 other medical directors according to these second order themes. I paid particular attention to excerpts that reflected identity work but could not fit into the second order themes. I was hence able to use this opportunity to refine the second order themes, which I then grouped into aggregate dimensions. The data structure I developed is presented in figure 3.1. The first and second order themes as well as the aggregate dimensions will be explored in the results section of the paper in which the aggregate dimensions are referred to as identity work "strategies" and the second order themes as "forms".

1st Order Concepts	2nd Order Themes	Aggregate Dimensions

- Medicine and management are interrelated
- Management as a natural extension of medical work
- Benefits of management involvement are both medical and managerial simultaneously
- Involvement in medicine and management as both aimed toward a same overarching value(s)
- Same values, patients, population are the cornerstone of medical and management work

→ Portraying management and medicine as embedded or interrelated

- Bringing the perspective of the front line workers to senior managers
- Contributing the point of view of all professionals to management debates
- Translating the perspective of the patient to top managers
- Sharing the medical perspective as the main contribution in management

→ Valorizing the medical perspective as contribution to management

→ Constructing Continuity

- Portraying oneself as experienced in management or medical management
- Insisting of past successes in management roles
- Explaining managers' desire for one to remain involved in management

→ Presenting oneself as an experienced medical-manager

- Presenting oneself as a junior manager
- Insisting on the novelty of the medical director role
- Not knowing how to influence
- Sharing discomfort with acting and being seen as a manager

→ Insisting on inexperience in management

- Joking about past failed attempts at change by managers
- Explaining at length the mistakes of managers in the past
- Enumerating and recounting numerous top-down interventions
- Assigning to managers the responsibility to 'do what I say'
- Positioning oneself as a supervisor of managers' work
- Representing managers as preys: muzzled and hunted
- Describing administrators as powerless and unable to make decisions
- Expressing pity for managers

→ Portraying managers negatively

→ Distancing from Management

- Dissociating from operational management
- Distancing from strategic management
- Detaching from management in the organization while associating with management *elsewhere*

→ Dissociating from aspects of management

- Illustrating one's efforts to consult employees when making decisions
- Exemplifying one's creative management style: using constraints to create opportunities
- Explaining one's bottom up management style

→ Explaining one's management style: the right way

→ Reinventing Management

- Valorizing one's involvement in shaping and implementing a new organizational model
- Insisting on one's autonomy, giving the power to speak freely and act to make needed changes
- Portraying oneself as a decision maker, making big and uneasy decisions
- Systematically exposing the benefits of one's management activities
- Insisting on one's capacity to have a significant impact in a context of budget cuts in which administrators feel powerless

→ Emphasizing Influence

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Figure 3.1. Data Structure

The second step of the analysis aimed at developing a model of the evolution of the identity work over time. I first organized all the codes on the different identity work strategies chronologically for every medical director, and compared the order in which the strategies were used by the different participants. I simultaneously organized chronologically the excerpts in which medical directors give answers to the question "who am I?", and tried to discover whether these answers evolve over time across participants. Then, I coded for instances in which individuals constructed an evolution of their identities within their narratives of their life stories, and compared this constructed

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evolution across the 20 medical directors. Finally, I grouped the medical directors into three categories: those arriving in a management role, in the middle or exiting the management role. Patterns of identity work strategies and processes within the three groups were searched for, and patterns between the groups were compared.

3.3.4. Trustworthiness

My strategies to ensure the trustworthiness of the study were inspired by Lincoln and Guba (1985)'s guidelines for establishing trustworthiness. Following the author's recommendations, different actions were taken to ensure credibility, dependability, confirmability as well as transferability. First, credibility parallels the notion of internal validity and refers to the extent to which a study measures or tests what is actually intended. Credibility was ensured by exploring data not supporting emerging patterns (that is, negative case analysis). To establish the credibility of the study, iterative questioning was used to investigate inconsistencies in data, frequent debriefing sessions with members of the research team were organized, thick descriptions were presented to other members of the team, and member checks with participants were done at strategic moments. Moreover, early familiarity with the culture of participating organizations solidified credibility, along with the use of different tactics to ensure honesty suggested by Lincoln and Guba (1985) (that is, giving participants the opportunity to withdraw, encourage being frank, demonstrating there is no right answer, emphasizing the independence of the researcher). Second, according to Lincoln and Guba (1985), dependability addresses the issue of reliability, that is, whether similar results would be obtained if the same project with the same methods and participants in the same context were to be repeated. The close relationship between credibility and dependability makes demonstrating the former simultaneously support the latter. To ensure dependability specifically, a detailed explanation of the research design and operational data gathering was provided to allow replication of the study. Third, confirmability parallels the notion of objectivity. It constitutes a preoccupation to ensure that the researcher did not influence the findings to a high degree. The findings are expected to be the "result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher." (Lincoln & Guba, 1985). Triangulation,

reflexivity, detailed methodological explanations and transparency about the limits of the study contribute to its confirmability. Finally, transferability mirrors the notion of external validity and concerns the degree to which the results can be applicable to other contexts. Transferability was sought by exposing a relatively thick description of the context and phenomenon investigated.

My presentation of the findings will be divided into four sub-sections. In the first section, I describe the identity regulation the medical directors are subject to in each of the four organizations. This explanation of the pressures exerted by the professionals and managers demonstrates the existence of identity regulation from multiple sources and shows how their nature and degree vary from one organization to the other, providing important contextual information to understand the identity work central to this study. The second section explains the generic strategies participants used to respond to this regulation when constructing their identity during interviews: constructing continuity, distancing oneself from management, reinventing management, positioning oneself above the crowd and defining the relationship with the co-leader. Then, in the third section, I examine how these strategies manifest themselves in the narratives of three participants having entered management roles between five years and one month before the beginning of the data collection. These stories are aimed at better understanding the evolution of the medical directors' identities and identity work strategies over time. In the fourth sub-section, I compare the patterns illustrated in the three cases explored at length to the findings extracted from the data on the 17 additional medical directors. This comparison documents the patterns of use of the different strategies over time in contexts characterized by different identity regulation. Finally, I contrast the patterns uncovered with the existing literature on identity work in the discussion.

3.4.   The Context for Identity Work: Patterns of Identity Regulation

Medical professionals and managers attempted to regulate the identity of the medical directors in different ways. I see identity regulation efforts (intentional or not, formal or informal) done at the individuals, group or organizational level to influence how individuals construct and reconstruct their identities (Alvesson and Willmott, 2002; Langley et al., 2012; Weiland, 1010). My objective is

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to study the medical directors' response to identity regulation, as opposed to the attempts at regulating identities. Nonetheless, I am going to quickly paint a portrait of the pressures exerted on them by both groups in the four organizations. This portrait illustrates that medical directors are subject to identity regulation from multiple sources (professionals and managers), and shows the difference in nature and intensity of this regulation from one organization to the next. This section also demonstrates that the medical directors are subject to pressures, often likely to produce tensions and stimulate a response.

3.4.1.   The University Health Centre

At the University Health Centre, the implementation of the co-leadership model and introduction of professionals in management roles had been done a few years before the beginning of the research project. Compared with the participants from the other two sites, fellow medical professionals' identity regulation attempts did not appear as prominently in medical directors' narratives. Nonetheless, a medical director recalled having been accused of passing into the enemy camp by his colleagues, "I have been accused of changing sides and of being an administrator." [Medical Director 4-U, T2][3] Administrators regulated the medical directors' identity through informal and more formal tactics. The following citations illustrate some administrators' attempts to shape the medical directors' identity through their day-to-day interactions:

> When there are important problems or contestation, the medical directors' first reflex is to protect their department. It's their first reflex. We are trying to get them to change that reflex. We are accompanying them to help them understand how they can take a stance and make their colleagues from their department accept it. [Director of professional services-U, T2]

> Before, my perception was that depending on whom he was talking to, my medical co-manager changed his discourse. When he talks to physicians, he could say, "The organization is not giving us what we need." (…) He still sometimes tells me, "It's unacceptable not to give them more resources." Then I have to explain again why we are unable to give them the

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[3] The quotes were translated from French by the author.

resources they want. I have to explain again that we are part of a bigger organization where there are established ways of allocating resources. Then he remembers the administrative constraints, and he understands. Especially when he meets with fellow physicians: he easily goes back to defending his department instead of advising and explaining. [Clinical co-director 7-U, T2]

The development of a decision making tool is an example of more formal regulation attempts by administrators. The tool was developed to guide decision making by inviting the co-leaders to consider four criteria: the efficiency of processes (including the coherence of the decision with the strategic objectives of the organization), the adequate use of resources (such as comparing available resources to the human, financial, technological and material costs of the different options), the engagement of individuals toward practices (requiring to evaluate, for instance, the human resource development requirements) as well as the relevance to patient care (involving an examination of what a decision would entail in terms of access to health services of different patient groups). The requirement to use the decision making tool could be seen as an effort to regulate identities by inviting medical co-leaders to broaden their analysis of the different options beyond medical considerations to include managerial constraints. Beyond adding criteria to the medical co-leaders' decisions, the tool shaped the weighting of different criteria [Document *Analysis and Decision Making Tool*-U, T2].

3.4.2. The Regional HSSC

Having entered their management roles only a few weeks before I met them, the medical directors working at the Regional HSSC appeared subject to more intense identity regulation. Medical professionals mainly exercised more informal pressures to regulate the identity of the medical directors. During a meeting with the top management team, three medical directors discussed the pressures they were subject to:

Medical Director 13: I am not a union representative, I am not there to defend physicians, to defend my colleagues in cardiology. I have been told, "in that case, you change your lab coat

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for a suit vest." For all physicians, no matter the function, there is a perceived threat. Those who talked to me directly about it said, "Stay a doctor", "Keep working for the patient" or "Money is not the only thing to consider."

Medical Director 11: Ever since I became medical director, the physicians in my department look at me askance, they avoid me. It's tough. In meetings, I don't exist. They don't call me Dr. they call me Mrs. I have been told to mind my own business when I said something.

Medical Director 12: If you are a physician paid by the organization to do something, the perception is that you have been bought.

Medical Director 13: People think we will have to do things in return. [Notes taken during observations-R-T2]

A medical manager explained facing such pressures during our interview:

There are many types of physicians. Some physicians don't understand the role of medical director and don't want to. He is the perfectly autonomous physician. He fulfills his obligations as physician and stops there. And there is the physician who thinks I could be an ally, but asks that I stay an ally. I have been told, "Stay a doctor." It's difficult, because the mandate of the medical director is to align with the organization's mission. So I am permanently experiencing a conflict between being a doctor and working for the HSSC. Staying a doctor means not linking care solely to what the hospital can offer. A budget will not determine the offer of services. If I do that, then I am not a physician anymore. That is what physicians are afraid of. [Medical director 13-R, T2]

Administrators' attempts to regulate medical directors' identity was done mainly through administrators' interventions during special meetings organized to reflect on the implementation of the co-management model and the roles of medical directors. Administrators also attempted to

regulate the identity of the medical directors during coaching sessions in which the deputy CEO and director of professional services attempted to clarify their expectations and shape the medical directors' or dyads' approaches:

> We are adjusting, we are learning. Physicians are not managers. They need to learn to manage. They need to learn what it means to take the political context into consideration when making a decision. It's part of the job. We also have to work with one medical director in particular who used to be a chief of medical department. It is difficult for her to change her thinking, to change the way she defends projects or tackle issues. Before it was defending her department, but now she has to position herself higher, to consider all the services offered to the population served in her clinical program, including the services offered in the community by non-profit organizations. It's much wider. [Deputy CEO-R, T2]

3.4.3. The Semi-Rural HSSC

The medical directors at the Semi-Rural HSSC, like the ones working at the Regional HSSC, were subject to important pressures from both fellow physicians and administrators. During an interview, a physician explained how she (and the other members of her medical department) refuses to collaborate with a medical director who they see as taking management's side without considering theirs:

> All I see is collusion – a fusion with administration. All [the medical director] says mirrors what her clinical co-director says. She doesn't try to know our point of view. She just accepts everything administrators say. She is withdrawn and manipulated by administrators. (…) She positions herself 100% on their side. She is supposed to be a co-leader, but she is just a manager. It's a big problem for us. She should resign. At this point, we are not interested in collaborating with her. [Physician A-SR, T1]

Another physician explained trying to send a similar message to the medical director because he felt that the role holder was not sufficiently working to defend the interests of physicians:

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If a colleague was medical director… It might be okay, depending on his attitude. If he really

tries to fight for me. If he is there to defend my interests. But the current medical director, she

doesn't listen to my point of view, she doesn't listen to my arguments. It left me cold. She is

in a co-management role, but she transmits administrators' message, not really the message

of all the other physicians practicing in the organization. (…) The medical director, I am a

physician like her, and she should represent me but she doesn't even listen to me. She

probably didn't want to do anything bad, but we easily conclude, "You are not part of our

group." [Physician B-SR, T1]

When I interviewed him, a medical director explained experiencing fellow medical professionals'

pressures and being ostracized for not conforming to these regulation attempts:

I am still struggling to be a physician and medical director. I meet the physicians working in

the directorate outside meetings, and I am struggling to find the adequate distance. It's

delicate because at one point I felt solicited to … between doctors, we are going to stick

together and support each other. A few weeks later when the administrative response to their

demand wasn't exactly satisfying… [Medical director 14-SR, T2]

The challenge in this role is to accept that there is a price to pay. I am starting to get used to

it. The advantage is that I entered the role as soon as I joined the organization. I had no

friends. I don't make friends, but at least I didn't lose any. I think medical directors need to

accept that they are at a higher risk of isolation. It's delusion to want to explain all the time

that "Yes, we want to defend the interests of doctors. Yes, we are involved in making

decisions, but no, we don't purposefully make decisions they are dissatisfied with." (…) I am

really busy right now and I have young children. But one day I might want to have a social

life. This summer, all the physicians were invited to the annual BBQ of the

department…except me. [Medical director 14-SR, T2]

Formal ways of regulating identities were especially developed at the Semi-Rural centre. For instance, various workshops were offered to physicians at different stages in the process of entering in management roles (physicians considering the role, first six months after entering the role, etc.) were created, and began with explanations of the type of contribution they would be expected to make as medical co-leaders and of the main responsibilities they would have [Document *Workshop for Physicians in Management Roles*-SR, T2]. The organization also set up a committee responsible for the implementation of the co-management model and the defining of the new roles. Through different exercises, the two medical directors who were members of the committee were socialized and senior management's expectations were explained to them. For instance, different simulations were done in which the medical directors were asked to react to real life situations. Senior managers and their hired consultants observed the medical director's reactions and coached them as to how they would be expected to respond. Different strategies were used by the medical directors to conform to or reject these pressures.

3.4.4. The Primary Care HSSC

At the Primary Care HSSC, medical directors appeared to be under infrequent yet strong pressures by their professional colleagues. Indeed, the organization is composed of a relatively small number of physicians working in numerous geographically dispersed locations. Hence, on a day-to-day basis, the medical directors are relatively isolated from fellow medical professionals. If they do not seem to be regulated on a day-to-day basis, the medical directors are subject to strong pressures when, for instance, dissatisfied physicians threatened to resign. Because the organization is facing a shortage of medical professionals, threats to resign are taken seriously and appear to shape the medical directors' behaviors:

> All members are autonomous professionals having theoretical obligations and whom I can't even sanction unless something very serious happens. I ask for everyone's collaboration, I ask for good faith, but I don't have real power. In this context of shortage, we are even less in a position of strength to impose things to people and constrain them. When you know they can just turn around and resign… you don't hit the table really hard. (Medical director 19-FL, T2)

Administrators did not appear to be expending much effort to regulate the medical directors' identities at the Primary Care HSSC. Most medical directors worked in different locations than administrators, and hence have few contacts with them. Furthermore, as we will see later, no formal efforts have been made to clarify expectations or role descriptions.

In this section, I highlighted the varying sources, nature and intensity of the identity regulation medical directors are subject to. At the University Health Centre, medical directors were subject to weak regulation from the medical side but intense formal and informal regulation from the management side. At the Regional HSSC, the medical directors appeared to be subject to more intense pressures. Fellow medical professionals exercised mostly informal regulation attempts while administrators tried to regulate during meeting and training sessions. Medical directors from the Semi-Rural HSSC were also subject to important pressures from both the medical and management side. On the medical side, ostracism appeared to be the strategy to pressure the medical director while on the management side, various workshops, committees and coaching sessions provided opportunities to regulate the new directors. At the Primary Care HSSC, fellow medical professionals exercised strong but infrequent pressures while managers made little regulation efforts. After I explore the identity work strategies and their evolution over time, I am going to compare and contrast the patterns of identity work performed by medical directors subject to different levels of identity regulation.

3.5. Identity Work Strategies

In this section, I will be explaining the five identity work strategies I uncovered, giving examples extracted from the data on the three medical directors whose narratives we will explore in details in the next section. Before explaining the strategies in details, note that table 3.1. located in this chapter's appendix 1 shows quotes reflecting the five strategies of identity work extracted from the interviews we conducted with the 17 additional medical directors from the four organizations.

3.5.1. Constructing Continuity

The first identity work strategy uncovered, constructing continuity, is defined as efforts to establish the consistency and continuity of one's activities before and after entering the management role. Thereby, participants appeared to attempt to make the narrative of their careers coherent over time, and to respond to fellow physicians' pressures to conform to the professional logic. This response highlights the consistency between medicine and management as well as how management activities can be coherent with the professional logic.

The first identity work strategy, constructing continuity, emerged from the data in three forms. First, participants portrayed management and medicine as interrelated or embedded in one another. I define this form as medical directors' efforts to portray management as a natural extension of medical work, or to explain that their involvement in medicine and management were both aimed toward a same overarching value(s). One medical director's metaphor of the nesting doll illustrates this form, "I am a Russian doll. I am a physician in the heart, with the chief of medical department on top, and the medical director on top. (…) There is something inside, then something on top, and something else on top. That's the way I feel." (Medical Director 17-SR, T1)

A second form of identity work used by participants to construct continuity is valorizing the medical perspective as the contribution to management, which is defined as individuals' work to demonstrate that their medical knowledge, experience and point of view constitute their most valuable input in management. In one instance, a medical director explains how, over her entire career as a medical practitioner, she invested significant efforts to understand the experience of patients: what it means to be sick, and what it means to be a hospital patient. She then went on to explain how sharing this understanding is her central and most important contribution as medical director, "I always put a lot of efforts to understand the experience of my patients, so I see my role as bringing this perspective to management meetings, because no one talks about the patients there." (Medical Director 10-R, T2) In other instances, medical directors insisted on how contributing the point of view of all professionals to management debates was their central

contribution, or described their efforts to bring the perspective of the front line workers to senior managers. Some medical directors' emphasis on representing their colleagues constituted another example of construction of continuity by valorizing the medical perspective as a central contribution to management.

The third manner in which participants crafted continuity in their narratives was by presenting themselves as experienced medical managers. This form is defined as participants' portrayal of themselves as experienced in management or medical management, as well as participants' efforts to assert their past successes in management roles. For instance, when telling the story of his career, a participant recalled how, approximately ten years earlier, she collaborated with an experienced physician manager to build an action plan to prevent the closing of her medical department. The participant's story was hence one in which she had been involved in management for a long time, "I was lucky enough to meet a physician manager who helped me make needed changes in my medical department. We spent the summer together working on an action plan. That was Administration 101 for me." (Medical Director 12 - FL, T2)

3.5.2. Distancing Oneself from Management

The second identity work strategy I found, distancing oneself from management, is defined as individuals' efforts to show that they were not connected with or supporters of specific elements they associate with management. Distancing oneself from management does not involve building a positive image of oneself but constructing a negative portray of administrators and aspects of management. By using this strategy, participants appeared to respond to the identity regulation from fellow professionals by conforming to their pressures to remain loyal to medicine and not change side. This strategy included insisting on inexperience in management, portraying managers negatively as well as dissociating from aspects of management.

Insisting on inexperience in management can be defined as individuals' efforts to demonstrate their lack of experience, expertise, skills or competencies in management. In one instance of insisting on

inexperience in management, a medical director recalled what he saw as a turning point in his involvement in management, a moment at which he went from seeing himself as relatively useless to perceiving himself as able to make small contributions from time to time:

> [When I contributed to solving an important problem we were facing], I think my co-director realized I could be useful, that I was not an ornament. That the CEO had not told him, "Here, we are going to put an ornament by your side, dust is going to accumulate but once in a while ask him what he thinks." No no no. I wasn't an ornament anymore. I had moved and shaken things up. (Medical Director 17-SR, T1)

This form of distancing oneself from management was also derived from participants' efforts to present themselves as junior managers or emphasize the novelty of their role.

Distancing oneself from management also appeared in the participants' narratives as negative portrayals of administrators. Portraying managers negatively can be defined as individuals' efforts to highlight the weaknesses, failures and negative characteristics of administrators. This form regroups statements in which the medical directors explained past management mistakes at length, ridiculed administrators' blunders, described managers as powerless and unable to make decisions, and represented them as preys: muzzled and hunted. One medical director's description of a management meeting he attended reflects this strategy:

> Honestly, I pitied them. I was in a meeting – and we had meetings after meetings after meetings – and they were tired, discouraged, saying, "the ministry is going to come get us." They were trying to make a decision, but they were unable to, because they are not the ones who should be making these decisions. The decisions should be fragmented and delegated. (Medical Director 10-R, T2)

Finally, participants dissociated from specific facets of management to distance themselves. I define dissociating from aspects of management as individuals' efforts to detach themselves from facets of administrative work they do not value or identify with. A medical director, for instance, insisted on

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the discomfort he felt playing a strategic management role when he saw his personality as more coherent with the operational level, "I am an operations guy. I would like to do the operational work, but I also don't want to do other people's job for them. There is a disconnection, because I am in a strategic role, but I am an operations guy. I like to find solutions to achieve objectives." (Medical Director 16-SR, T1) Another medical director distanced himself from operational management, while a third one detached from management in the organization while associating with management *elsewhere.*

3.5.3. Reinventing Management

The third identity work strategy I uncovered, reinventing management, is defined as participants' attempts to present their management style as different: a new and reinvented management. It represents the counterpart of constructing continuity, in which medical directors construct change by creating a discontinuity in the way management is done. Reinventing management appeared to allow the medical directors to respond to both parties' regulation attempts. Indeed, by portraying themselves as reinventing management, medical directors attempted to reconcile the pressures by explaining how they collaborated with managers to change work organization or collaboration mechanisms while performing these management tasks in a way that respected the professional logic.

Reinventing management takes two forms: explaining one's management style: the right way, and emphasizing influence. *Explaining one's management style: the right way* is defined as individuals' work to demonstrate that their management style differed from traditional management. This form appeared in the participants' narratives through their descriptions of their bottom-up, consultative and creative management style. One medical director for instance insisted on her dedication to listen to front line workers, "We are going to decide on the orientations, but at least we listen to the professionals first. And we are going to find many of the solutions at the bottom of the organization." (Medical Director 17-SR, T1)

Reinventing management was also done through participants' efforts to emphasize their influence. Emphasizing influence is defined as individuals' work to demonstrate their capacity to have a significant impact and shape their organization through their management activities. This form of identity work was done, for instance, by valorizing the involvement in shaping and implementing a new organizational structure. The following quote demonstrates a participant's attempt to portray himself as a definer of the new organizational model, "I have been working with my clinical co-director since 2007. But in the past two years, in the co-management implementation committee, we have been working hard to identify the roles and responsibilities of everyone." (Medical Director 16-SR, T1) Other instances of work to emphasize influence include insisting on one's autonomy giving the power to speak freely and act to make needed changes, portraying oneself as a decision maker responsible to make big and uneasy decisions, systematically exposing the benefits of one's management activities, as well as insisting on one's capacity to have a significant impact in a context of budget cuts in which administrators feel powerless.

3.5.4. Positioning Oneself Above the Crowd

The fourth identity work strategy I found is the positioning of oneself above the crowd. It is defined as individuals' efforts to differentiate from concerns, limitations and tensions of fellow professionals, either by themselves or in relation to administrators. Contrary to *distancing oneself from management* which is about building a negative image of management, positioning oneself above the crowd emphasizes positivity and involves work to portray oneself as better than others at something, as more enlightened or advanced. I define *representing oneself as an enhanced physician*, the first form, as individuals' efforts to demonstrate that their understanding, competencies or influence are superior to that of fellow medical professionals. In one instance, a participant portrayed herself as having an understanding and influence that others didn't have, thereby presenting herself as an enhanced physician:

> Ever since I got more involved in management, I realized that we, doctors, come to meetings, complain and go home. We keep saying, "It is administration's fault. Administration's fault." (…) My success leading the development of a new service motivated me to get involved

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more in management. I became more critical. I got more interested. I thought, "Instead of complaining in my head, maybe I can do something good." It was the second wind that made me accept becoming chief of a medical department. I know I have succeeded in the past. It is going to allow me to shape how I am working. To stop complaining. (Medical Director 17-SR, T1)

The form also appeared in the data in participants' efforts to describe themselves as professionals doing more than their colleagues, or when one interviewee explained how he was the one infusing meaning in his cynical colleagues' meaningless work. By portraying themselves as enhanced physicians, medical directors responded to managers' pressures by emphasizing their understanding of managerial considerations and highlighting their efforts to exercise influence in light of this understanding. Positioning oneself as an enhanced physician can also be conceived as the counterpart of distancing oneself from management, as through this form of identity work, medical directors differentiate themselves from fellow medical professionals.

Medical directors also performed identity work in their narratives by presenting themselves as above the fight between physicians and managers. This second way to position oneself above the crowd can be defined as individuals' efforts to detach themselves from the tensions between the two groups, often assigning themselves the role of bridge or change agent contributing to appeasing or reducing the tensions. The following citation illustrates how a medical director described both parties as wrong, and herself as being the agent mandated to correct misguided perceptions and act as bridge:

> I think it is a misunderstanding, especially ever since I have been spending more time with managers. They have so much goodwill, they work hard for things to go well. I think managers have all sorts of constraints and that the distrust is misguided. It is because we think differently, we have different constraints. We both want the same thing, but we don't understand each other. It creates distrust. Managers think physicians always want to block their projects, are only interested in their own interests, things like that. Physicians think

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managers are disconnected from reality and make decisions without consulting them. They

are both wrong, so I think my role is to bridge the two cultures. (Medical Director 10-R, T2)

I also include in this category participants' efforts to portray themselves as outside the tensions between professionals and managers, and as the ones mixing the separated communities. A medical director's work to belittle parties' apprehensions and to question whether these funny concerns are even worth his/her attention also inspired this form. Positioning themselves above the fight, medical directors respond to identity regulation by both conforming to and resisting regulating efforts by both parties. Indeed, using this strategy implies that medical directors are distancing themselves from both parties, thus conforming to both parties' pressures not to adhere to the other group's logic while simultaneously resisting each party's wish for them to adhere more fully to their own logic.

3.5.5. Defining the Relationship with the Co-Manager

The fifth and final identity work strategy involves defining the relationship with the co-leader. I define this strategy as work to, in narratives, shape others' perception of the distance between the medical director and his/her clinical co-director and of the degree of unity or alignment within the dyad they form. By positioning themselves closer or further from their co-leaders, medical directors respond to the identity tensions they are experiencing in different ways. The data reveal that medical directors can describe themselves as either ally, adjunct or distant from their co-leader.

I define allying with the co-manager as individuals' discursive work to demonstrate the oneness of the dyad they are part of. This identity work strategy took many forms in participants' narratives. Some medical directors insisted on the unity of the dyad, referred to their dyad as a couple or portrayed both roles in the dyad as embedded and in symbiosis, while others expressed strong feelings of closeness or affinity with the other member of the dyad. In the following quote, a medical director explained how his dyad functions as a unit in working toward common objectives:

I am not here to defend doctors or patients, nor [my co-director] to defend the organization. That's the way I see it. We are not there to reconcile. Reconciling implies that we disagree. I

don't see it that way. I think we set a goal and determine what we are going to do to achieve it. I don't compromise on my ideas, and [my co-director] doesn't either. We don't reconcile. We try to do the best we can with what we have. (Medical Director 7-U, T1)

When allying with the other member of the dyad, participants appeared to conform to managers' pressures to adhere more closely to the managerial logic as well as attempt to reduce the tension that results from their isolated position, belonging completely to neither the management nor the professional group. In other cases, allying with the co-manager is used to follow the professional logic. In these cases, medical directors collaborate with their co-director to reinvent co-management.

Some participants portrayed themselves as adjuncts to their co-leader. I define this form of identity work as efforts to present oneself as an auxiliary of the clinical co-director within the dyad, a subordinate or appendix. By defining their relationship with their co-manager this way, medical directors attempted to find a balance between the pressures of the medical and management groups, by simultaneously positioning themselves close to the managerial logic, but by keeping a safe distance from them as expected by the professionals. In the following excerpt, a medical director explained that his role is to support his co-director in the medical community, but that the co-director does most of the work of managing the dyad's directorate:

> In our dyad, you have two directors: administrative and medical. The administrative co-director is working full time to…he was doing fine without me before. It is a big directorate. (…) He manages the budgets, the administrators, the teams. I think he needs my help with the physicians. But he does most of the work. He manages the whole directorate, and that is a lot of work. (Medical Director 16-SR, T2)

This way of defining the relationship with the co-manager can also involve presenting oneself as an apprentice to the co-leader, illustrating one's role as a minor one in the dyad or representing oneself as the medical head of the co-leader.

The third way medical directors defined their relationship with their co-manager is by detaching from the co-leader. I define detaching from the co-manager as identity work involving efforts to separate oneself from the clinical co-director, highlight the divide within the dyad or establish the nonexistence of any dyad. This response to identity regulation and tensions represents an effort to conform to the professional logic by distancing from management. For instance, during our interview, one medical director dissociated from her co-manager by explaining that she (the clinical co-leader) was not well perceived by many physicians, "I would dare to mention that with some people, especially in the medical community, there is a build-up of frustration with [my co-director]." (Medical Director 17-SR, T2) Detaching from the co-manager includes such statements as describing the co-leaders' actions as something completely separated from oneself, recalling the dyad members' actions as independent and individual actions, explaining one's attempt to leave the dyad or insisting on the co-leader's habit to rely on someone else – a third party outside the dyad – for every issue related to the medical community.

The five identity work strategies I uncovered were used in different ways and at different moments by the participants. In the next section, I illustrate these forms of identity work over time through the story of three medical directors at different stages of their involvement in management. The objective of the next section is hence to explore how professionals' identity work strategies change over time, how the participants' narratives about their identities changed over the course of the 21 months of data collection, how individuals construct an evolution of their identities within the narratives of their life stories as well as how individuals use the different identity work strategies at different stages of their involvement in management (arriving, in the middle or exiting the management role). In the following section, I compare the narratives of the three medical directors with the stories of the 17 additional participants to uncover patterns of identity work over time and at different stages of integrating a management role. This analysis is followed by a discussion connecting my findings with existing models.

3.6. The Narratives of Three Professionals in Management Roles

To uncover how professionals handle identity tensions in their narratives over time as they take on management roles, I traced the identity work of Dr. Graham, Dr. Clark and Dr. Jensen as they position themselves in their narratives. Figure 3.2 illustrates the number of years each medical director had been in their strategic role during the research project which spanned from 2011 to 2013. I use Dr. Graham's narratives as an illustration of the identity work of physicians entering management roles and expending significant efforts to construct continuity. Dr. Clark's narratives reflects the story of medical directors with a marked career trajectory toward management. The medical director emphasizes reinventing management, their position above the fight between doctors and managers as well as increasingly allying with the co-leader. Dr. Jensen's narratives illustrate the story of medical directors in the process of exiting the role and working to detach themselves from their role and organization. In the next pages, I trace the evolution of their identity work.
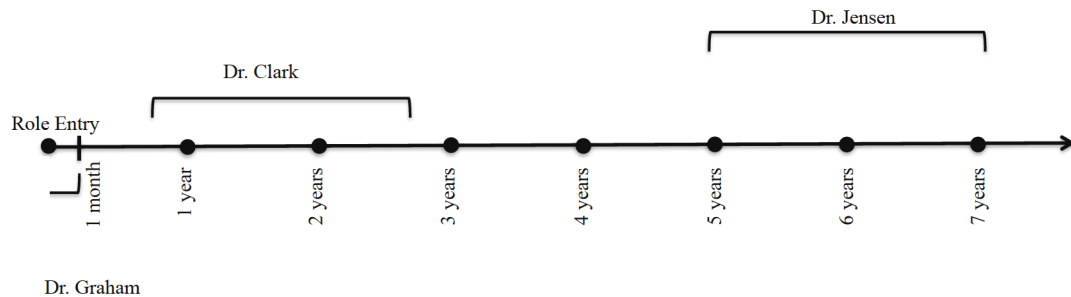
Figure 3.2. Time Spent in Medical Director Role Covered by the Project

3.6.1. Dr. Graham

I met Dr. Graham only once, four weeks after she became medical director in a Regional HSSC. Her story therefore illustrates the evolution of the identities and identity work of professionals arriving in a management role. Dr. Graham's narrative starts with her clinical work, which she describes as being rooted in interprofessional collaboration:

> I have been a physician for 30 years, and my work has always always always been done in interprofessional teams. I am very close to other professionals: nursing a lot, physiotherapists, attendants, all of them. I think my role as medical director is to integrate the clinical

perspective in decision making. Not just the perspective of physicians, but of all the professionals (Medical director 10-R, T2).

Beside crafting continuity in her life story by presenting both clinical and management work as interprofessional collaboration, Dr. Graham highlighted consistency and coherence by detailing the management tasks she performed as part of different roles she occupied as physician, "I coordinated the internship program for medical residents. I built the program. I even won a prize for organizing the internships." (Medical director 10-R, T2)

Despite the management activities she performed as physician, Dr. Graham recalled distancing herself from management by explaining how, until she entered the role of medical director, she had a negative perception of management, "Before, I saw management negatively. I was happy not to be doing that." (Medical director 10-R, T2) Dr. Graham also distanced herself by criticizing specific aspects of management, including the control of professional practice, top-down management, centralized management, the numerous and long administrative meetings, ignoring patients' needs during meetings, the endless discussions administrators have on topics they do not understand, their inability to make decisions (which according to her they should not make but delegate to knowledgeable professionals) as well as their unrealistic responsibilities.

However, Dr. Graham shed a positive light on her own management style, which she described as bottom-up and consultative:

> We would have an opportunity to do things a little differently, so I explored that with [my co-director]. Actually there were a lot, a lot of benefits that could result from working differently. So we are trying to explain that, we are trying to bring the professionals to see that. We want to make the change very consultative. [My co-director and I] don't want to impose a vision. We want to build a vision with the front line workers, so people adhere to the vision and are part of that vision. (Medical director 10-R, T2)

Dr. Graham appeared to associate with her clinical co-director, who she saw as creative. Through her description of this creativity, Dr. Graham was performing identity work by reinventing management, allying with her co-director and distancing from other administrators' management style:

> [My co-director] is very optimistic, and she takes problems and constraints to create opportunities, creativity and new ways of thinking. (…) I too have always tried to do that. You don't say, "I can't do this because I have no money." You say, "Here is what I can do." For instance, when I was organizing the internships, most physicians were not interested in participating. I took the few interested physicians, and I moved forward. We did what we could. After a while I had developed a repertory of activities the interns could do if, for example, a patient did not show up to his appointment. The intern could meet with the pharmacist, discuss with nurses, etc. Instead of saying, "nothing works, we can't have interns we don't have enough resources", I tried to use constraints to generate creativity. [My co-director] does that too, but on a larger scale and with budgets. (Medical director 10-R, T2)

When recalling a recent incident in which her role as medical director was questioned publicly in the medical community by a consultant during a presentation, Dr. Graham positioned herself as above the fight by questioning the credibility of the physicians who doubt the relevancy of her role as medical director, belittling their concerns, discrediting their issues and doubting their understanding of the consultant's message. In the quotes below, Dr. Graham explained that such criticisms of the role are not even worth her attention:

> I was told very negative things that surprised me – really surprised me. A physician who went to the presentation said, "We have to be very careful because the role is illegal and the chiefs of medical departments should be playing that role." It was very negative. I don't know if she misunderstood what the consultant was saying. (…) I don't know. These are rumours, because I wasn't there. I just suffered it… I don't know if she misinterpreted what the consultant was saying… (Medical director 10-R, T2)

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A [consultant] came and scared everyone. (…) He warned everyone that our loyalty had changed. That did not make much sense to me. I don't know… What I do know is that I am loyal to my profession and to the population. Anyway, it is all taxpayers' money, whether it comes from the organization here, it doesn't change my loyalty and it doesn't change my ethical values. I thought the arguments were funny. (Medical director 10-R, T2)

The last quote also suggests Dr. Graham's attempt to craft continuity by putting her values at the centre of all her actions, over time and across roles. Although she recognized having been involved in the tensions between physicians and managers in the past, Dr. Graham portrayed herself as above the fight between physicians and managers, external to the tensions experienced, "Part of my role is to bridge the two cultures: the management and medical cultures. I started doing that already. Many physicians distrust managers. I was even guilty of it myself." (Medical director 10-R, T2) Instead, she explained her role as staying calm, continuing to act according to her priority values (collaboration, profession and patients) and sending the same message to both groups despite what she perceived as irrelevant antagonism, "I do that with managers and with physicians. I try to stay calm, stay positive, stay optimistic, and to repeat a simple and clear message: we need to humanize patient care. Ad nauseam." (Medical director 10-R, T2) Dr. Graham also positioned herself above the crowd when explaining how, despite the context of budget cuts, her salary was a good investment for the organization:

I think my management work is a good use of my time and of the financial resources of the organization. Honestly, during a meeting in which we were trying to reduce costs, I felt uncomfortable. They just hired me. Do I add value? I think I do. I think I contribute. I think I am worth what they are paying me. I think in the short term we are going to see the benefits. (…) I think if physicians don't get involved in management a little bit more, if there is no one to bridge the medical and administrative worlds, the organization can only fail. It can only be inefficient. It will remain two big groups functioning separately instead of collaborating. (Medical director 10-R, T2)

In sum, Dr. Graham appears to be entering a trajectory toward management and away from the profession. The first part of Dr. Graham's story contains efforts to construct continuity over time by insisting on the centrality of interprofessional collaboration, her values and her involvement in management. She simultaneously distances herself from traditional management by criticizing their style and practices, while allying with her co-director and reinventing management through her personal style: creative, consultative and bottom-up. The latter strategies are reflected in the evolution of Dr. Graham's narratives from dissociating from *all* administrators to dissociating from all administrators *but one*, the creative co-director. Indeed, Dr. Graham appears to construct the dyad as a unit, using "we" extensively when commenting on her work as medical director. Dr. Graham moves on to emphasize her influence in the role and represent herself as above the fight between physicians and managers, mandated to bridge the divide. At the same time, the medical director constructs a separation between her and the physicians who were rejecting her role and paints a portrait of herself as change maker. Dr. Graham's story is a typical example of a physician arriving into a management role who clearly feels the need to justify herself. The significant identity regulation the medical directors were subject to when entering their roles at the Regional HSSC from both the medical and management side could generate their need to defend their career choices and new role.

3.6.2. Dr. Clark

Dr. Clark joined the top management team of a Semi-Rural HSSC as medical director in 2011, approximately seven months before I first met him. His story hence represents the identity construction of physicians in the middle of their mandate as medical director. When telling us the story of his professional path, Dr. Clark first recalled difficult reorganizations he had been through as physician, thereby distancing himself from what he saw as traditional management:

> When I got here in 1998, we had a way of working in the department. Administration came and destroyed everything. They hired a consultant, and they told us, "Now, this is how you are going to be working." This new way of working wasn't working well. There was a lot of frustration. Then they reorganized again. Again, it was top-down. There were many nonsense

changes implemented. I experienced three reorganizations, and thirteen years later, it is obvious that none of them worked. (Medical director 17-SR, T1)

Dr. Clark then described his first experience in management as the leader of a project in which he developed new medical services, "I succeeded in my first project. It became a concrete change to our services, so it solidified my experience [of management]. I saw, I experienced this materialization so I got hooked." (Medical director 17-SR, T1) Thereby, Dr. Clark constructed continuity in his narrative by showing how he possessed management experience much wider and longer than his involvement as medical director. Dr. Clark also crafted continuity by explaining why he accepted to occupy a management role. He mainly insisted that his strong association with medicine was the base of his involvement in management activities, and recalled how his administrative work is always oriented toward helping more patients and offering better services:

> I thought, "I have another power. If I want to touch more patients, the only way to do it is to elevate myself." Direct touch is one-on-one. Managing projects, I can touch many patients, even if it is not me physically touching them. So I started from my desire to practice medicine, and it led me to management. (Medical director 17-SR, T1)

Throughout the data collection period, Dr. Clark was simultaneously a chief of medical department and medical director. In both of these roles, Dr. Clark worked in co-management arrangements. As chief of medical department, Dr. Clark was a member of an operational-level dyad. His co-leader, Mary, was the head nurse of the department. As medical director, Dr. Clark was a member of a strategic-level dyad with his clinical co-director. In the first phase of interviews, Dr. Clark defined his relationship with both co-leaders by respectively describing his operational and strategic dyads as follows:

> [My operational co-manager and I] merged together. We were not starting at the same place, not coming from the same place. I had the history of the organization in my blood, but [my operational co-leader, Mary,] was new here. Because my role was not solid and her role was not crystalized, we made space for each other in our respective roles. So to me the roles are

embedded. I can't believe anyone could play that role without a co-leader. The medical department was just created when I became chief, so the role of chief did not exist before. Right from the start, it was a co-management role. (Medical director 17-SR, T1)

[My co-director at the strategic level] has been firmly established in his role for a long time without, without…without me. Without a medical co-director. (…) The strategic dyad is composed of two roles. One is well defined and held by an experienced person. The other role, I just arrived, and I am in a new and ambiguous role, and I have no experience. I do it naively, with the only tools that I have as a doctor. So I put a lot of concrete in my co-director's work, but he helps me be more strategic. (Medical director 17-SR, T1)

Through this description, Dr. Clark appeared to craft continuity by explaining the embeddedness of medicine and operational management, ally with his operational co-leader, detach from his strategic co-director and distance from strategic management. Dr. Clark also seemed to construct continuity by insisting on and valorizing his medical contribution to management, "I bring [my co-director] what he did not have: an understanding of the practice of medicine. I take my knowledge and experience on the front lines and bring it to my co-director." (Medical director 17-SR, T1)

When asked to describe his role as medical director, Dr. Clark insisted on his inexperience, thereby distancing from management:

I am a junior manager. Junior - junior. I did not go to school in management, so I use what I can, what I have. This is why we absolutely need a lot of help from management. (Medical director 17-SR, T1)

I am a physician who is learning to become a manager. I need to learn communication, leadership, all that. I was scared to lead my first meetings. I believe in co-management, but I don't have the words to pass the flame. I stutter, I stammer, I wonder how I am going to be able to pass that message. (Medical director 17-SR, T1)

While distancing himself, Dr. Clark was simultaneously rooting himself in the management world when expressing that he is a manager, but nuancing this position by insisting on his inexperience. In the quotes above, Dr. Clark almost appeared to be apologizing for not being a good manager. Dr. Clark also appeared to attempt to distance himself from management by insisting on his inexperience in management when he recalled incidents in the medical community. The medical director indeed reported experiencing significant tensions when he attempted to influence, or perceived he should be exercising some influence. The following quotes expressed these tensions respectively during an annual meeting of the medical community, and within a medical department of his directorate:

> At the meeting in which a specialist blew up, I felt the palpitations, the sweat, I was thinking 'ah I should say something – say we had meetings with the CEO, you can't ignore that, you can't say administration is deaf.' So I ended up raising my hand with sweat on my chest 'hum you forgot to mention the committees that were set up.' But it is my personality. There is shyness and that I am a general practitioner. (Medical director 17-SR, T1)

> I am a general practitioner, and as medical director I can see what is going on in other departments. As medical director, I think what is going on in cardiology makes no sense. But I am a general practitioner. What do I do? How do I intervene? Because when I get back to working as a simple physician, I have to collaborate with the cardiologists. I have to protect this medical collaboration. It is a difficult balance, because I also have to be able to address the problems I am noticing as medical director. (Medical director 17-SR, T1)

During our second interview in 2013, Dr. Clark still reported experiencing such tensions. The medical director indeed recalled dissociating from management when he attended the annual meetings of the medical community, but expressed a growing discomfort with this dissociation:

> I am a member of the [medical community], but when I go to the [annual] meetings, it's like I am not medical director anymore. It takes a lot of self-confidence to intervene during these

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meetings. I need to work on that. During the meetings, I am a physician but I am also medical director. I should play that role more. But I find it difficult. When there is a conflict or a hot topic and everybody is mad, it is difficult to be in the spotlight. I am going to have to stand up more as medical director. The [medical community] is like a bubble. The medical directors, we bounce on it. (Medical director 17-SR, T2)

At this point, Dr. Clark reported increasingly attempting to influence the management community, but experienced significant difficulties doing so. He indeed explained not always knowing how to proceed, and hence let his clinical co-director take the lead:

[My co-director] brought up something during a strategic meeting – honestly the way he presented it with the statistics, I couldn't have done that. In top management meetings, statistics are really important. Perceptions about what is going on in the front lines aren't well received there. [My co-director] gave them statistics on a nice piece of paper. It was revealing for the senior managers and for the first time, I felt that they were really interested in changing things. (Medical director 17-SR, T2)

Through his narratives in the second interview, Dr. Clark hence distanced himself from management and his strategic co-director. He nonetheless simultaneously presented himself as possessing significant influence by portraying himself as a decision maker, "We [my clinical co-director and I] are going to liberate nurses, attendants, managers, laboratory employees, pharmacists, all all all employees, and we are going to put them in a room for a focus group." (Medical director 17-SR, T2) This emphasis on influence was also obvious when Dr. Clark detailed the medical as well as organizational benefits that resulted from his activities as medical director:

It allows us to see more patients. And to treat them better. And it meets requirements regarding the population, quality, budgets, strategies, resources. For the patients, it reduces complications. For strategic management, is reduced the average length of stay, it has a significant impact on the budget. In the end, I only see improvements to the services we offer to the population. (Medical director 17-SR, T2)

At this stage, Dr. Clark seemed to emphasize his influence by explaining the significant pressures he was subject to and the importance of the decisions he had to make. Simultaneously, Dr. Clark seemed to increasingly associate with strategic management:

> It's like, "Yes, we know nobody wants to cut the services to the patients. Yes, we know the new doctors need equipment." There are no words to express the complexity of having to manage and develop services in a context of budget cuts. I always feel caught. The decisions are not easy to make, and they are made slowly. (…) Finding money in a context in which the budget is not red, it is really red. We are not tight in our pants – the pants are torn apart. (Medical director 17-SR, T2)

> Our decisions are so important that [my co-director] often needs to discuss it with the CEO before making decisions. The financial constraints are so important. (Medical director 17-SR, T2)

Consistent with this shift from operational to strategic management, Dr. Clark redefined his relationship with his co-leaders by portraying a rising dissociation from his operational dyad and a growing association with his strategic dyad. Dr. Clark for instance associated with his clinical co-director while distancing from Mary, the head nurse who acted as his co-manager at the operational level, "[My clinical co-director] and I, with Mary, we work really really really hard." (Medical director 17-SR, T2) He additionally reported having attempted to find another physician to fill his operational co-management role, "I offered the role of chief of the medical department to another physician. He said he wants to contribute, but he refuses the title. I asked Mary too, if she would prefer to have another physician than me as co-leader. She said she would prefer to keep working with me." (Medical director 17-SR, T2) While Dr. Clark usually dressed casually and used an iPad to consult documents during top management meetings, I noted he was wearing an oversized old-fashioned brown suit and using the big and old laptop administrators had given him when becoming medical director at a strategic management meeting I observed on September 4, 2013.

During the second interview, Dr. Clark positioned himself above the fight between physicians and managers by portraying himself as external to the medical and management worlds, as the one who is mixing two groups that do not easily mix, "We are mixing oil with balsamic vinegar. We have to mix more, but it's going to be so much better after. With some salt and pepper. It's going to taste better." (Medical director 17-SR, T2) Though this statement, by presenting the medical and management worlds as complementary, Dr. Clark is also legitimizing his position as change agent trying to link the two worlds.

In sum, Dr. Clark's narratives are characterized by his efforts to construct continuity and distance from traditional management, especially when I first met him. Dr. Clark's efforts to present himself as reinventing management, portray himself as a junior manager and detach from his strategic co-director were also especially important in 2011. At this stage, the medical director appears to be torn between the pressures coming from physicians and managers, but tries to maintain some distance from administrators. Differently, 2013 is characterized by his acknowledgement of the significant constraints and pressures he is subject to as decision maker, as well as by a reduction in detachment from the co-director. Dr. Clark's transition from operational to strategic management as time went by is mirrored by the evolution of his definition of his relationship with his strategic and operational co-leaders. Although Dr. Clark presents himself as an enhanced physician (having a better understanding and more influence than other members of the medical community) during the first interview, he portrays himself as above the fight between physicians and managers during the second interview. At this stage, the medical director is increasingly ignoring fellow professionals' pressures and complying with administrators' identity regulation.

In terms of the identity he constructs, Dr. Clark began his story by presenting himself as a physician, and then a successful operational project leader. The medical director's story continues with a representation of oneself as an operational medical-manager, then a junior manager, and finally, a decision maker. Although Dr. Clark portrays himself as possessing influence at the

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operational level throughout his story, he reports first seeing himself as a relatively useless medical co-director until constructing a turning point after which he slowly gains influence within his dyad at the strategic level. Dr. Clark then represents himself as possessing some influence in the management community at the strategic level, but until the end of his story acknowledges his limited influence within the medical community.

Dr. Clark's story is an illustration of the narratives of medical directors who are not entering nor exiting, but growing in the role. This story reflects especially well the narratives of the medical directors with a markedly ascending trajectory toward administration, especially when evolving in organizations such as the Semi-Rural or Regional HSSCs where important pressures are exercised by both physicians and managers to regulate the medical director's identity. In such context, the story built emphasizes reinventing management, positioning oneself above the fight between doctors and managers as well as increasingly allying with the co-leader.

3.6.3. Dr. Jensen

Dr. Jensen was the first medical director at a small Semi-Rural HSSC, joining the management ranks in early 2007 in a dyad mandated to experiment and develop the co-management model. Dr. Jensen's story constitutes an illustration of the evolution of identities and identity work of medical directors in the process of exiting their strategic management role. His description of himself emphasized his part in defining the co-management model, "we have been working hard to identify the roles and responsibilities of everyone…" (Medical director 16-SR, T1) During the first interview, Dr. Jensen explained how his involvement in management allowed him to gain an understanding of administrative constraints that his colleagues might not possess, thereby presenting himself as an enhanced physician:

> I understand how budgets work now. Physicians come to me, saying "we lack resources, we lack resources." Yes, we lack resources. No, we don't have money. We have to work with what we do have. You have to understand in what system you are working, and start from

there. My decisions are influenced by the understanding I gained of the system, of budgets, of unions, etc. (Medical director 16-SR, T1)

Omnipresent in the medical director's narratives was his representation of himself as an exiting medical director. From the very first time I met him, Dr. Jensen repetitively referred to his upcoming departure from the medical director role, as illustrated by the following excerpts extracted from our first interview:

> My plan is to leave in June 2013, when my clinical co-director is retiring. (Medical director 16-SR, T1)

> I don't think I am going to continue as medical director because I don't have the right actors around me to make the changes we would need to make. (Medical director 16-SR, T1)

When describing his contribution to the organization as medical director, Dr. Jensen insisted on wanting his medical background to be central:

> I can discuss as equal with physicians. I can get them to sit down and discuss with managers more easily. I invite them to participate. I understand their language when they explain what they are experiencing as practitioners. I understand - I practiced too - so I know what they are referring to when they are explaining why they can't achieve the objectives we set. [My co-director and I] set short and long term objectives, and we try to help the teams reach them. We try to make baby steps, mainly by mobilizing the medical community. (Medical director 16-SR, T1)

Through such comments, Dr. Jensen constructed continuity in his life story by positioning the medical profession at its core, and reinvented management by explaining his vision of the new role, a vision focusing on physician participation. The next quotes also suggested Dr. Jensen's attempt at presenting himself as reinventing management. In the first excerpt, the medical director described his efforts to develop communication paths to allow physicians to share their ideas with

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administrators. In the second citation, he explained trying to explain the administrative perspective to physicians:

> What we have to build, I think, are communication paths through which physicians, when they have something to say or have an idea, can say it. I am medical director but no one talks to me. (Medical director 16-SR, T1)

> What we are trying to do this year is to meet physicians and explain our objectives. Explain that we have objectives as an organization, and that from there we set objectives as a directorate. Then we identified targets and indicators. So what we want to do is explain, "If we push you, if we ask you to perform well, it is not to bother you. It is because we have objectives and constraints. It is because our budget depends on reaching those objectives" (Medical director 16-SR, T1)

Dr. Jensen's story of his efforts to reinvent management was often followed by explanations of his difficulties accomplishing his role according to his vision. Dr. Jensen was therefore positioning himself as both reinventing management and distancing himself from it:

> I want my contribution to be medical, clinical. That is what I see as my biggest contribution. And I want my point of view to reflect the opinion of my medical teams. To me, the best way to do that would be to participate to every meeting of every medical service and department. To discuss the directorate's objectives and issues, and to get the physicians' feedback: is it feasible? Is it realistic? What are the challenges? I would have a real understanding of physicians' perspective when going to management meetings. That's what I should do, but that would be a lot of meetings. That would be a lot more work. Right now, I don't even practice medicine in my own directorate, so I don't interact much with the physicians. (…) I find it hard to sit in a meeting, make decisions and represent the medical team of our directorate without really knowing their point of view. (Medical director 16-SR, T1)

Dr. Jensen's narratives contained numerous expressions of distancing from management in both 2011 and 2013. In the following quote, Dr. Jensen explains why he mainly remains quiet during management meetings:

> What I find difficult is to represent a large group of physicians, alone in a meeting. Decisions are made quickly. I find it hard to position myself because I would like to have the opinion of all my colleagues. But it would be too long. Often, during top management meetings, a decision is presented. We can say if we agree or not. But we don't have enough time to say, "Wait, I am going to consult my colleagues, I am going to see what others think about it and then come back with my answer." I don't interact much in management meetings because I don't know what my colleagues think. I have a few of my own opinions, but I don't want to share them. I want my contribution to reflect the point of view of all the physicians working in the directorate. (…) In the meetings where I am invited, I am still a spectator. I am spectator more than I influence decision making. (Medical director 16-SR, T2)

Through this comment, besides distancing himself from management, Dr. Jensen constructed continuity by explaining how central representing his professional colleagues is to his contribution to management. Dr. Jensen's distancing from management was also observable when the medical director admitted not attending many management meetings to which he is invited, "I don't go to all the meetings I am invited to. I think we, medical directors, are invited to the right meetings, but honestly I don't always go." (Medical director 16-SR, T2) In the lines below, Dr. Jensen explained his limited involvement in a strategic planning exercise in which he was invited and expected to play an active role:

> I didn't go to the two meetings in which medical directors were invited to discuss the organization's strategic planning. However, I discussed it with my co-director. [My co-director] discussed with his team to collect ideas for the strategic plan, and then he showed me what they came up with. It was mainly discussed in the top management team. Then [my co-director] showed me the plan, and I approved it. I didn't play a big role. I know it is a big thing for the organization…strategic planning and all that. I find it really good to have a

strategic plan, but I am okay with having someone else write it for me. To me it's obvious. It

always comes down to the same thing: offer the best services we can. (Medical director 16-

SR, T2)

During a clinical strategic meeting I observed on September 26, 2012, I witnessed an incident in

which Dr. Jensen publicly distanced himself from management and his co-director. Right after Dr.

Jensen's co-director was explaining an objective the directorate had to reach before 2015, Dr.

Jensen started laughing loudly, and said, "By 2015!? [Laughing] Oh sorry, we are together in this."

(Medical director 16-SR, T2) Besides the meetings, Dr. Jensen distanced himself by questioning his

contribution to his co-director's work, and by insisting on his lack of understanding of management

and unwillingness to invest time to learn more:

> I don't have as much time to invest in my role as medical director as my co-director. He
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> knows the issues much better than me. At one point I asked him, "How am I helping you?"
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> He said, "No no no you help me a lot." (Medical director 16-SR, T2)

> I don't have a complete understanding of all aspects of management. I don't want it either:
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> that would take too much time. (Medical director 16-SR, T2)

By such comments, Dr. Jensen positioned himself as an adjunct to his co-director, supporting the

latter's efforts whenever he has the time and expertise to do so. During our second interview, Dr.

Jensen's efforts to distance himself from management appeared more nuanced than during the first

interview. Indeed, the medical director's narratives of distancing focused on strategic management

as opposed to operational management, "I am a director, which is at the strategic level, but my

personality is operational. I like to be in the action and find ways to reach my goals. It bothers me

because I am in a strategic management role." (Medical director 16-SR, T2) Dr. Jensen's more

nuanced distancing also increasingly emphasized management in the Semi-Rural HSSC

specifically. Indeed, between 2011 and 2013, Dr. Jensen presented himself as being increasingly

involved in setting up a private clinic. For instance, when describing himself, Dr. Jensen explained

how his project of opening a private clinic reduced the time he was able to invest in his role as medical director:

> I identify with the healthcare centre. Less in the last two years because I am starting my own clinic, which is very demanding. I had to reduce considerably the amount of time I invest in my role as medical director. (…) I see myself as someone who can still contribute to the healthcare centre, even if I have less time to offer. I want to play a role – not too important. I see myself as a physician belonging to this healthcare centre who contributes to improving the organization…while trying not to burn myself out and to have activities outside the organization… (Medical director 16-SR, T2)

Dr. Jensen also explained how he benefited more from investing his time and energy in managing his private clinic that the healthcare centre:

> General practitioners are not in the healthcare centre that much. They practice in the healthcare centre about one quarter of their time, so they don't have much energy to invest in it. They invest their energy in the other three quarter: on how to improve the functioning of their clinic, how to make sure secretaries and nurses work efficiently, how to make their co-workers happy. They spend a lot of time on that. (…) If I send the nurse working for me in my clinic to a training session, then I can see more patients. I have a direct financial incentive to do it. (…) If I improve the organization of services at the healthcare centre, I have no direct benefit, except some gratitude and feeling oh so good. (Medical director 16-SR, T2)

Dr. Jensen hence distanced himself increasingly from management at the Semi-Rural HSSC where he reported feeling increasingly powerless, while associating with management at his private clinic:

> The HSSC is a big machine. It is not like a private clinic, where you can wake up one morning and decide to change the way things are done… starting tomorrow. It's a little bit destabilizing as a general physician, because three quarter of your time is spent in your private clinic where you do what you want. You decide how things will be organized, how your schedule will be, you hire people. We are employers when we own a clinic. And even

when we don't own it, we have a say. In the HSSC you can't say anything about the

employees, so it can be difficult. (Medical director 16-SR, T2)

Dr. Jensen's perception of being powerless in the organization was omnipresent in his story, but

increased between 2011 and 2013. This powerlessness, Dr. Jensen attributed it to the passiveness of

physicians when it comes to getting involved in management projects:

> What is difficult is to mobilize people. To convince them to work in the same direction as
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> you. Alone, it doesn't work very well. I had to do my job as medical director, and do the
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> chiefs' work because they were passive, and then at one point we didn't even have physicians
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> working with patients, so I had to do that too. (…) The actors are not right. I don't think I will
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> continue working as medical director because people are not motivated, things don't change,
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> and the actors – the chiefs - are not the right ones for change. (Medical director 16-SR, T2)

At this point, Dr. Jensen constructed continuity in his story by increasingly alluding to or explicitly

referring to his imminent departure while insisting on his desire to concentrate on practicing

medicine.

In sum, the story of Dr. Jensen is an illustration of the narratives of medical directors with a

trajectory toward management at first, and then away from it. At first, Dr. Jensen appears to

position himself above his medical colleagues upfront, explaining how his involvement as medical

director gave him an understanding of administrative constraints his colleagues do not possess.

Being a general practitioner nonetheless appears to be central to the identity constructed by the

medical director throughout his narratives. Dr. Jensen's significant work to construct continuity in

his story reflects this, especially when the medical director insists that his main contribution to the

healthcare centre derives from his medical background. Dr. Jensen's story starts with his efforts to

portray himself as reinventing management. He explains how he makes efforts to involve

physicians in his management projects, and open communication channels between administrators

and medical professionals. At this point, the medical director seems to position himself as a change

maker. Simultaneously, Dr. Jensen defines himself as an adjunct to his co-director, positioning himself more as a support to his co-director than as a manager himself. Thereby, the medical director appears to be crafting an identity as *co*-director as opposed to director.

Although he is subject to important identity regulation from both the medical and management sides throughout his story within the organization, Dr. Jensen's progressive withdrawal from the organization probably involves a decreased exposure to the pressures exercised by administrators. This reduced exposure could have caused the transition from first attempting to comply with administrators' identity regulation to increasingly responding to fellow physicians' pressures over time. Fellow physicians' passiveness appears to constitute a way to exercise pressure on the medical director, giving him a perception of powerlessness and causing him to withdraw from the role to focus on medicine. As his story progresses, Dr. Jensen's narratives appear to increasingly emphasize the medical director's efforts to distance himself from management, especially strategic management in the Semi-Rural HSSC. Toward the end of his story, Dr. Jensen presents himself as a general practitioner and the owner of a private clinic. Throughout his story, Dr. Jensen constructs himself as an exiting medical director, constantly withdrawing from the role and announcing his imminent departure.

Dr. Jensen's trajectory toward management and then away from it reveals how not only the nature and intensity of identity regulation, but also the level of exposure over time can shape identities and identity work. Dr. Jensen's story also suggests that active identity regulation is not necessary to shape identities. Passiveness can also send strong messages and put significant pressures. In this case, decreased exposure to administrators' regulation and physicians' passiveness seem to have encouraged detachment and distancing.

The narratives of the three medical directors presented in this section illustrate typical stories of identity work of the 20 participants. The next section compares the stories presented above with the data collected on the 17 other participants to uncover patterns.

3.7. The Identity Work of Professionals Entering Management Roles: A Process Perspective

From the narratives of 20 medical directors, I uncovered five identity work strategies individuals can use to deal with the tensions they are experiencing when subject to different and sometimes contradictory attempts at regulating their identity: constructing continuity, distancing oneself from management, reinventing management, positioning oneself above the crowd and defining the relationship with the co-leader.

Comparing the stories of all medical directors, the results suggest that soon after having entered their role, medical directors work to create continuity in their stories in an attempt to conform with professionals' identity regulation. This can be done by portraying management and medicine as interrelated, assigning a positive and central value to the medical perspective as contribution to management or insisting on one's constant involvement in management activities. Also aiming at conforming with professionals' pressures, medical directors simultaneously distance themselves from what they see as traditional management (top-down, controlling professional practice and changes making no sense) by insisting on one's inexperience in management, portraying managers negatively or dissociating from specific aspects of management.

As they describe their own management styles, medical directors then appear to be reinventing management by explaining what they see as the right approach to management (bottom-up, creative and consultative) and emphasizing the influence they are able to derive from their role. Reinventing management appears to be a strategy to conform to both professionals' and managers' identity regulation by presenting oneself as collaborating with managers in a way that respects the professional logic. Reinventing management appears to be done individually by some medical directors who detach from their co-manager and as a dyad by the medical directors who ally with the co-director. By defining their relationship with their co-leaders, participants conform with and resist identity regulation. Allying with the co-manager appears to constitute a way to conform to

managers' pressures, while detaching from the co-manager is a response to professionals' pressures not to change sides. Positioning oneself as an adjunct is a response to both pressures, allowing the medical directors to get closer to managers while staying at a safe distance.

The medical directors' stories suggest that a picture of oneself as being above the crowd is simultaneously constructed. In the medical directors' narratives, this identity work strategy is seen when presenting oneself as having an understanding or an influence that others don't possess, or when representing oneself as outside the conflict between physicians and managers. By portraying themselves above the fight, medical directors seem to respond to identity regulation by distancing themselves from both groups and attempting to construct a third position for themselves.

When medical director participants entered their strategic roles, they distanced themselves from traditional management; when they had occupied their management roles for a longer time they appeared to distance from strategic management in favour of tactical or operational management. As exiting the role becomes a possibility and when one's evaluation of what he has accomplished in the role is not satisfying, medical directors' narratives increasingly emphasize this distancing from management. Then, medical directors might return to a narrative of continuity, emphasizing how they will continue practicing medicine and manage, but at different organizational levels or in different settings.

In addition to the identity work strategies, my study reveals that entering a management role is less dramatic than we could expect for professionals. None of the medical directors I met constructed their experience in a management role as a rupture or dramatic transition. Coherent with Clarke et al. (2009)'s conclusions, the participants were able to create their narrative incorporating multiple antagonistic discourses. Like Watson (2009)'s Leonard Hilton, all the medical directors who participated in this study were able to build a story in which management roles are part of a normal career path, a story of continuity.

Dr. Graham was entering the role when I met her. This medical director appeared to be entering a trajectory toward management and away from her profession. Of the seven medical directors who were entering their mandate, five insisted on establishing their position above the fight between doctors and managers. Compared to medical directors interviewed who were mid-term or near the end of their mandate, these five participants were the ones exerting the most significant efforts to establish this position.

Dr. Clark is the case of a professionals neither entering nor exiting, but growing in the role. The medical director appears to have a definite trajectory toward administration. Of the seven medical directors interviewed more or less in the middle of their mandate, three medical directors appeared to have a growing association with strategic management, while four dissociated from the strategic level in favour of tactical and operational levels. Four medical directors presented themselves as becoming increasingly associated with their co-leader, while a fifth appeared to have a strong and stable alliance with the co-director. Furthermore, while four participants insisted on their work to reinvent management, two others increasingly portrayed themselves as decision makers. Overall, these findings suggest that medical directors in the middle of their mandates do generally associate with at least some aspects of management. In some cases, these medical directors identify with the strategic, tactic or operational levels. In other cases, they identified with a reinvented version of management, a co-director, or with decision making. Regardless of the specific aspect of identification, the data suggest that for these mid-term medical directors some identification with management generally exist.

However, Dr. Jensen's trajectory first appeared to be toward management, and then away from it. The medical director appeared to have never completely entered the role. Instead, from the very beginning, the medical director's narratives emphasized his upcoming departure. For different reasons (his involvement in starting his private clinic, his medical team's passiveness, etc.), Dr. Jensen appeared to use his imminent departure as an excuse not to be more proactive in his role as medical director. In total, six of the 20 medical directors we interviewed were close to exiting the

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role. Five of them presented themselves as 'stuck in the role' while three portrayed themselves as powerless, about to exit the role and dissociated from the organization. In sum, as we could expect, the results show that dissociation from the role and/or the organization are common for medical directors exiting the role. However, the medical directors at the end of their mandates did not automatically dissociate from management itself.

The findings also reveal that regardless of the stage they were in, medical directors' construction of their identity is significantly shaped by their relationship with their co-directors. For the participants, a dyad indeed appeared to constitute a space where medical directors have more flexibility to experiment and invent their management and co-management styles that allows them to reach a more comfortable balance of tension between conforming to and resisting management and professionals' identity regulation. In all cases, the medical directors reported having some influence within their dyad, but limited to having no influence in the wider medical and management communities. The relationship with the co-manager additionally appears to give medical directors the legitimacy to take a stance against administrators and for the clinic. I speculate that these wider communities constitute more bureaucratic settings where structural inertia might prevent the medical directors from playing an active role, especially during the early stages of implementation of the new role.

Another explanation for the complicity that seems to emerge between most medical directors and their clinical co-directors is that the medical director might not see his counterpart as being part of management. Many medical directors presented their dyad as working jointly (to various extent) against other administrators to develop and improve the services offered in their directorate. Interestingly, the medical directors usually portrayed the dyads as fighting senior administrators, but did not present the dyad as fighting physicians.

As we could expect, the medical directors' construction of their identity also appears to be shaped by the nature and intensity of the identity regulation they were subject to. At the University Health

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Centre, administrators appeared to be exercising significant pressures on the medical directors, while fellow professionals' regulation attempts were weaker. Compared with the participants from the other sites, the medical directors from the University Health Centre associated more with management and the strategic level. At the Regional HSSC and Semi-Rural HSSC, medical directors were subject to important pressures from both administrators and professionals. Although the narratives of the medical directors from the Semi-Rural HSSC varied significantly, the stories of the participants from the Regional HSSC were quite homogeneous in identity construction, emphasizing distancing oneself from traditional management, reinventing management, continuity of collaborations, association with the co-leader, as well as portraying oneself above the fight and other physicians. At the Primary Care HSSC, administrators' pressures were the weakest of all four cases while physicians exercised infrequent but strong pressures to stay true to the professional logic. The medical directors from the Primary Care HSSC exerted the most significant efforts to distance themselves from their organization, management and their clinical co-director. This group's narratives were also focused on establishing the continuity of the medical representation role (as opposed to a management role) and included only limited efforts (or none) to present oneself as reinventing management.

In sum, as illustrated on figures 3.3, exploring the identity work of medical directors from a process perspective and comparing the process in different contexts of identity regulation, we learned that the professionals first construct a narrative of continuity and distance from management. Efforts to portray oneself above the crowd and as reinventing management are then deployed. This redefinition of management seems to extend for some time, and the relationship with the co-manager is redefined over time to respond to identity regulation. As exiting the role becomes an option, distancing from management and constructing continuity become central strategies again.
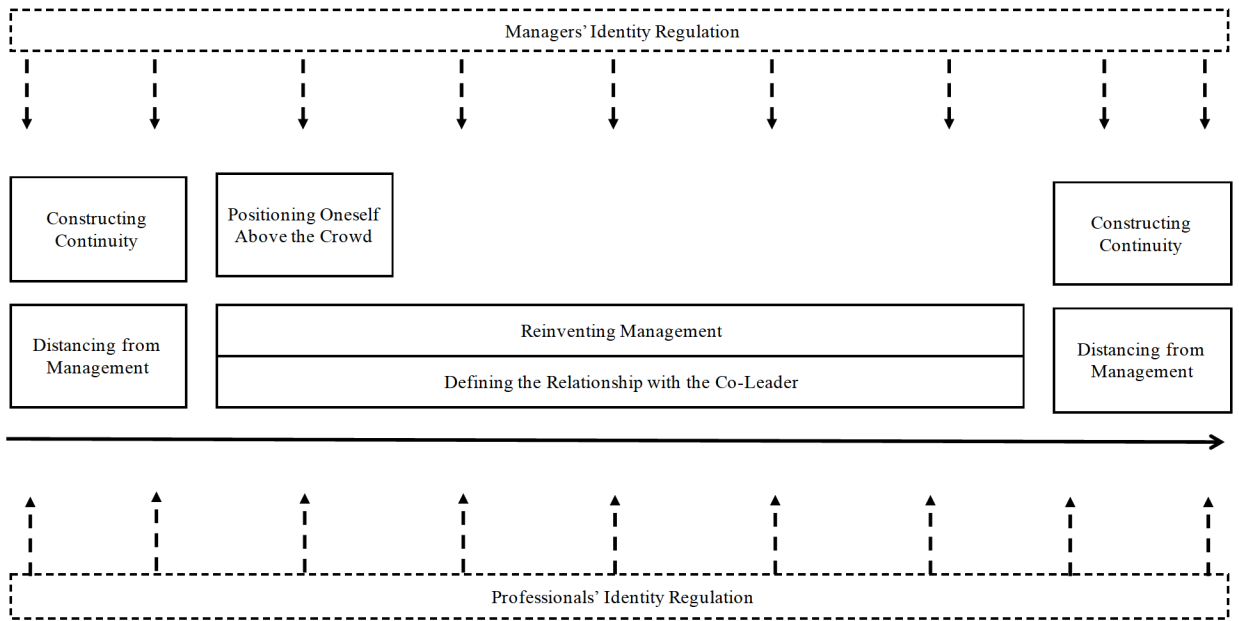
Figure 3.3. The Identity Work of Professionals in Management in their Narratives Over Time

We also learned about the identity work of professionals at different stages in their integration in a management role, which is illustrated in figure 3.4. We saw that although their narratives generally follow the process highlighted above, entering medical directors work hardest to position themselves above the fight, while medical directors in the middle of their mandates generally do identify with some aspects of management. Exiting medical directors differently dissociate from their role or the organization, although they do not necessarily dissociate from management itself.

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┆                      Managers' Identity Regulation                          ┆
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   ▼    ▼    ▼    ▼    ▼    ▼    ▼    ▼    ▼    ▼
┌─────────────────────────────────────────────────────────────────────────────┐
│                   Defining the Relationship with the Co-Leader               │
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│ Positioning Oneself Above│  │ Associating with Aspect(s)│  │ Dissociating from        │
│ the Fight                │  │ of Management             │  │ Organization and/or Role │
└──────────────────────────┘  └──────────────────────────┘  └──────────────────────────┘
                                                                          ───►
┌────────────┐              ┌────────────┐              ┌────────────┐
│ Entering   │              │ Middle of  │              │ Exiting    │
│ the Role   │              │ Mandate    │              │ the Role   │
└────────────┘              └────────────┘              └────────────┘
   ▲    ▲    ▲    ▲    ▲    ▲    ▲    ▲    ▲    ▲
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┌─────────────────────────────────────────────────────────────────────────────┐
┆                    Professionals' Identity Regulation                        ┆
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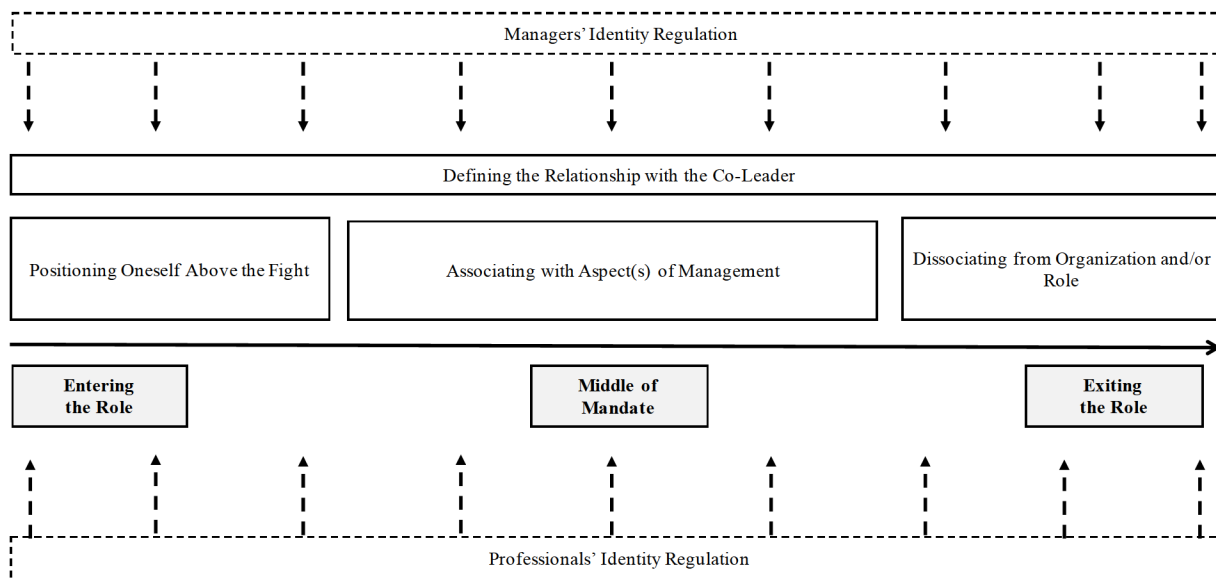
Figure 3.4. The Identity Work of Professionals in Management at Different Stages in Their Management Mandates

From comparing the identity work of individuals who are subject to different identity regulations, we learned that for medical directors from organizations where significantly more pressures come from the management side, a stronger association with management is observable. When individuals are subject to important regulation from both sides, their narratives emphasize distancing oneself from traditional management, reinventing management, continuity of collaborations, association with the co-leader, as well as portraying oneself above the fight and other physicians. When subject to infrequent but strong pressures from the medical side combined with weak pressures from the management side, individuals work hard to distance themselves from their organization, management and their co-manager and establish the continuity of the medical representation role (as opposed to a management role). In figures 3.3. and 3.4., the different regulations which modulate the represented overall processes are reflected by the doted arrows representing the varying regulations exercised by managers and professionals over time. In the discussion, I will compare and contrast my findings with existing models and theories of identity work.

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3.8.   Discussion

Interesting links can be made between the strategy I uncovered and previous research on identity work. Globally, the identity work strategies reflect the underlying needs to find a balance between the need for inclusion and assimilation in social groups, and the need for differentiation from others (Brewer, 1991; Kreiner et al., 2006). All the strategies I uncovered represent ways of responding to identity regulation by integrating with the management group while simultaneously differentiating sufficiently from this group to preserve their membership in the professional group. Contrary to previous research, the participants are not working to find a balance between integration in and differentiation from a single group, but to become members of one group (the management community) by differentiating sufficiently from this group to preserve their membership in another group (the medical community).

Looking at the strategies individually, I note that two of the strategies I uncovered, reinventing management and positioning oneself as above the fight, echo Llewellyn (2001)'s observations that physicians in management roles work to redefine the categories commonly relied on in healthcare organizations: the medical/management divide. Llewellyn (2001)'s medical directors create a new difference: medical management/non-medical management. Similarly, the results indicate that professionals in management roles attempt to redefine the categories readily available (medicine and management) and add categories (by creating a third position involving 'managing differently') to get closer to medicine as they are performing their management role. This way, professionals respond to both regulations simultaneously.

Kreiner et al. (2006)'s conclusions also echo our "reinventing management" strategy. The authors refer to an identity work strategy of integration through which individuals infuse self-aspects into their tasks, thus reinventing their role based on who they are. The results interestingly contrast with McGivern, Currie, Ferlie, Fitzgerald, and Waring (2015)'s conclusions. Indeed, while the authors' participants performed identity reconciliation work to construct their own understanding of professionalism, the participants attempted to construct their own understanding of management as

they were reinventing management. McGivern, Currie, Ferlie, Fitzgerald, and Waring (2015)'s identity reconciliation work strategy nonetheless seems to align with the participants' efforts to construct continuity in their story. In both studies, interprofessional teamwork and medical representation were used as resources by participants to construct this continuity between medical and management work. The authors' 'using and integrating managerialism and professionalism' strategy also aligns with what I see as a construction of continuity. Indeed, I see the portrayal of aspects of the management and medical logics as embedded, interrelated or complementary as an attempt to construction continuity. McGivern, Currie, Ferlie, Fitzgerald, and Waring (2015)' representing and protecting professionalism, a strategy involving the glorification of past professionalism and demonizing of managerialism's bean-counting approach, can also be seen as a strategy aimed at distancing oneself from management. Croft et al. (2015) described the same kinds of efforts when observing nurse hybrids' efforts to distance themselves from managerial leader identity in order to retain influence on fellow nurses. The idea of "distancing from management" that emerged from our data is also reflected in three of Kreiner et al. (2006)'s differentiation strategies, that is creating an identity hierarchy, separating the role from the identity and flipping the on/off switch of the role. I observe the latter strategy when, for instance, some medical directors explain that in meetings in the medical community, they are doctors, not medical directors.

Distancing oneself from management was also discussed by Thomas and Davies (2005) who observed how individuals differentiate from what is creating discomfort by presenting themselves as different, the "self as other." The authors' "self as maverick" strategy reflects the participants' efforts to present themselves as enhanced physicians and above the fight. McGivern, Currie, Ferlie, Fitzgerald, and Waring (2015) also discussed this type of positioning when explaining how hybrids tried to position themselves collectively as an elite within their profession. In Pratt et al. (2006)'s work, this idea is echoed by the notion of identity patching, the strategy used by surgical residents who started seeing themselves as "most complete doctors" able to perform surgery in addition to generalist work. Finally, Pratt et al. (2006) discuss how individuals can use a prior identity as a splint to protect a fragile identity until it becomes stronger. The authors refer to this process as

identity splinting. In my study, some medical directors appeared to rely on similar strategies when positioning themselves as co-leaders as opposed to managers, presenting themselves as junior managers or when insisting on their inexperience in management. By doing so, the medical directors whose identity as managers was too fragile used a prior or less threatening identity as a temporary splint.

Our results differed from past studies in various ways. McGivern, Currie, Ferlie, Fitzgerald, and Waring (2015) report some hybrids' use of organizational processes such as appraisals to discipline poor professional practice or resistance to service improvements. Differently, we have not witnessed significant efforts at regulating or auditing professionalism. The medical directors and their collaborators reported being scared to make such attempts and as a result tended to hide behind managers or avoid intervening when regulating or auditing might have been necessary. Contrary to Croft et al. (2015), the participants did not avoid emotional attachment to the professional identity. My study differs from Ibarra (1999)'s work in two ways. First, the role of medical director was a relatively new role during the data collection period. Furthermore, in three of the four organizations, the medical directors were generally isolated from one another, having little contact with one another. As a result, the medical directors did not have many role models to observe in order to develop a repertoire of attitudes and behaviors to experiment with. Second, although the medical directors were autonomous professionals, the risks of experimenting with attitudes and behaviors might have been significant for professionals in management roles due to a potential perception by fellow professionals of them having entered the enemy camp. This perception could significantly hurt their relationship in the medical community. As a result, contrary to management consultants and investment bankers, medical directors might not have had as much space to experiment with different attitudes or behaviors.

Finally, the process perspective of this study reveals the numerous ways in which identities and identity work can evolve over time, supporting the idea that static descriptions provide an incomplete understanding of the dynamics. Kreiner et al. (2006) explored the evolution over time of

priests' preference for integration or differentiation strategies while Pratt et al. (2006) examined the sequence in which identity customization strategies might be used. This study went further than showing how professionals' identity work strategies change over time. I also explored how the 20 participants' narratives about their identities changed over the course of the 21 months of data collection, how individuals construct an evolution of their identities within their narratives of their life stories as well as how individuals use the different identity work strategies at different stages of their involvement in management (arriving, in the middle of or exiting the management role). The contribution of the process perspective to the understanding of identity is best highlighted by contrasting the findings with Pratt et al. (2006)'s conclusions. The authors believe identity patching and splinting might precede identity enriching. In this study, participants positioned themselves as 'most complete doctors' (that is, an enhanced physician) only after having constructed continuity and distanced themselves from management. The participants created this continuity and distance by presenting themselves as junior managers or insisting on their inexperience in management. As argued earlier, these strategies echo the notion of identity splinting. In other words, the results suggest that participants might rely on a splint (a prior or less threatening identity) before presenting themselves as 'most complete doctors." The results also suggest that identity work strategies are used alternatively and simultaneously, and interact with each other in an effort to position oneself in a tension infused context.

3.9. Conclusion

In this study, I explored how professionals navigate identity tensions in their narratives over time as they take on management roles. To answer this research question, I examined how 20 physicians who had entered medical director roles position themselves during interviews. The professionals were subject to identity regulation of different types and intensity coming from both managers and fellow professionals. The exploration of the identity work used by autonomous professionals to respond to identity regulation coming from different sources simultaneously differentiates this study from previous ones.

I found five ways in which medical directors perform identity work in their narratives as a response to the identity regulation they are subject to: constructing continuity, distancing oneself from management, reinventing management, positioning oneself above the crowd and defining the relationship with the co-leader. I uncovered how these different strategies can be used alternatively and simultaneously to respond to identity regulation. In this study, the professionals first constructed a narrative of continuity and distanced themselves from management. Then, this distancing was combined with attempts to portray oneself as above the crowd and as reinventing management. This redefinition of management seems to extend for some time, as professionals are explaining their activities as managers and the positive results of their work. At the same time, the relationship with the co-manager was redefined over time to respond to identity regulation. As exiting the role became an option the identity work of professionals progressively seems to revert to more distancing from management and construction of continuity.

Beyond this process, this study shows that professionals entering management roles construct their story as one of continuity as opposed to rupture. When entering their new role, professionals deploy significant efforts to position themselves above the fight between doctors and managers. Professionals in the middle of their management mandate appear to construct their identities in different ways. While some explain increasing association with strategic management, others gradually dissociate from the strategic level to associate with the tactic and operational levels. The association with the co-manager as well as efforts to redefine management also characterize this mid-term group. However, in contrast, the professionals in the late term process of exiting presented themselves as 'stuck in the role', about to exit the role, powerless and dissociated from the organization. No matter at which stage, professionals in management roles' construction of their identity appeared to be significantly shaped by their relationship with the co-leader. The co-management arrangement in which the professionals performed their management roles constitutes a contextual factor further differentiating this study from previous ones. However, the main contribution of this study stems from the process perspective. Although Pratt et al. (2006) and Kreiner et al. (2006) explored identity work processes, this paper makes the temporal aspect central

and explicit. Examining the process of identity work through multiple angles is also unique. More specifically, I explore not only how professionals' identity work strategies change over time, but also how the participants' narratives about their identities change over the course of the 21 months of data collection, how individuals construct an evolution of their identities within their narratives of their life stories as well as how individuals use the different identity work strategies at different stages of their involvement in management.

A contribution of this research stems from the boundary conditions in which the participants evolve. The professionals are indeed subject to identity regulation from multiple sources. From the management side, pressures to conform to the managerial logic are exercised. From fellow professionals, pressures to stay true to the professional logic are exerted. I hence explored the identity work done in different contexts of identity regulation. When administrators exercised strong pressures while fellow professionals' regulation attempts were weaker, the professionals generally associated more with management and the strategic level. When both administrators and fellow professionals exercised important pressures, the stories often emphasized distancing from traditional management, reinventing management, continuity of collaborations, association with the co-leader, as well as portraying oneself above the fight and other physicians. When administrators' pressures were weaker but fellow professionals exerted infrequent but strong pressures, individuals deployed the most significant efforts to distance themselves from their organization, management and their co-leader. These professionals also attempted to establish the continuity of the medical representation role (as opposed to a management role) and made only limited efforts (if any) to present oneself as reinventing management.

Although this research contributed to understanding the way professionals position themselves in their narratives when facing identity tensions as they enter management roles, more research would be needed. Indeed, five participants joined senior management only about one month before the end of this study in one organization. Although the interviews were rich and the participants reflective, our understanding of their identity would have been enriched by more data on these participants.

Hence, future research should involve collecting data over a longer period of time and interviewing the participants more often (twice a year perhaps). Explorations of the identity work of members of other professions and professionals entering *solo* management positions (as opposed to *co-management* roles) could also help test and enrich the strategies and process of identity work I uncovered. Additionally, this research was focused on one country and a single profession. Studies on the identity work of other professionals (lawyers, university professors, etc.) and in different settings and cultures could hence enrich the theory.

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Appendix 1 - Additional Illustrations of the Five Identity Work Strategies

Table 3.1. Additional Illustrations of the Five Identity Work Strategies

Quotes	2nd Order Themes	Aggregate Dimensions
In the past, I was invited to attend management committees, which wasn't usual for physicians. I discovered the huge divide – huge – between administrators and physicians. I thought we couldn't coordinate the services adequately if we couldn't work together. When the medical director position opened, I thought about it… I like to bring people together. I am good at it and I like bringing people together. I like when physicians and managers collaborate, I like teamwork. The position was an opportunity to continue bringing people together. (Medical Director 9-R, T2) All the decisions I make impact the administrative side, and vice versa. (Medical Director 5-U, T1) I tend to believe I couldn't make administrative decisions if I wasn't a physician... if I wasn't practicing in the organization. What allows me to manage well is that I practice on a day-to-day basis in the sectors I am shaping. (Medical Director 1-U, T2) Administration and medicine are seen as two worlds completely apart. Not true. What helps me the most in management is my training in psychotherapy because 90% of the problems are related to humans. We manage human resources. Whether I am with a patient or as an administrator, I reach the same conclusions. The language is different, but once you translate, it's pretty much the same thing. (Medical Director 4-U, T1) I am a physician first, and because of it, I practice, I teach, I do research, I manage. (Medical director 7-U, T1)	Portraying management and medicine as embedded or interrelated	Constructing Continuity
To my co-leader, I bring the perspective of doctors: we are facing this problem, we have that problem with this nurse, things like that. I bring the medical perspective. (Medical Director 6-U, T2) Where my co-manager has more difficulty, where I complete him, is with the medical perspective. (…) For instance, I could say, "You forgot that if nurses start doing X, it will have this impact on physicians and this impact on patients." He wouldn't have seen it or thought about it. We are not looking at things through the same lenses. And I understand how physicians react, I know if they are going to support or resist a change. (Medical Director 1-U, T2)	Valorizing the medical perspective as contribution to management	

I try to bring my co-manager the point of view of physicians, and what decisions mean for patients. (Medical Director 2-U, T1) I tend to believe I couldn't make administrative decisions if I wasn't a physician... if I wasn't practicing in the organization. I am a good manager because I practice on a day-to-day basis in the sectors I am shaping. (Medical Director 2-U, T2)		
[The co-management structure has been implemented a few weeks ago], but our dyad is not that young. We have a history of collaboration together. (Medical Director 11-R, T2) I built a medical department in 1991 in another HSSC. I was chief of the department until my departure in 2001. In this organization, I have been chief since 2001. I also applied to be medical co-manager (Medical Director 6-U, T1) We have been working together for four, five years. When I was chief of a medical department, my co-director was already the director. I was collaborating with him and we learnt to work together. So I don't think we have any problem working together. (Medical Director 10-R, T2) Medical management is something I have done throughout my career. Even when I tried to stay away from it, it was difficult. I was often joking that – have you ever heard of the twelve step program of the alcoholics anonymous? I founded and was the only member of the Medical Managers Anonymous. I tried not to touch it. I tried not to get involved again and to just practice medicine. But medical management gives a meaning to my work. (Medical Director 12-R, T2)	Presenting oneself as an experienced medical-manager	
I wasn't involved in the selection of my next co-leader. I asked the CEO if I could be. They had not planned on involving me. I am not administrator enough to participate in hiring a top manager. I am not administrative enough, I don't have any training or knowledge of how to choose between two individuals. I don't see myself as having an influence on this decision. I don't think they would listen to me. The director of human resources and the CEO, they know what they are looking for. (Medical Director 14-SR, T1) [My co-manager has a lot more experience than me.] I am beginning as co-leader. She is the most experienced administrative co-leader. She has been doing that for a long time. She is preoccupied – much more than me – with budgets, human resources… When a project is presented to me, I can say if it makes sense from a medical point of view. But I don't evaluate all the impacts. I don't see them, but she does. (Medical Director 6-U, T1)	Insisting on inexperience in management	Distancing from Management
Let's say we are in a working session, [my co-director and I]. My co-director takes her laptop and writes. I give her information that she finds relevant. She works on the document, then she gives it to her secretary who formats the document. Then they send it to me and I correct everything. (…) I changed everything. (Medical Director 14-SR, T1)	Portraying managers negatively	

What they call proximity management, [freeing time to meet with the staff], we hear about it, we see that everybody is proud and that they congratulate themselves. They are proud of the results and that it changed the way we do things. That's on the administrative side. Doctors…the only things we see is that now, all meetings are on Tuesday. (Medical Director 2-U, T1) [My relationship with my co-director] is a little bit like my relationship with nurses. The nurse at the clinic, she sees patients and when there is a difficulty, she comes to see me. I give her the solution. I say, "We are going to do this, this and this." I have more knowledge and I can take more responsibility, so I decide. Because I am a physician. Her responsibilities are more limited, and she doesn't have the knowledge required to decide. So I solve the problem. I can analyze. My co-director has management competencies. When she is struggling, she comes to see me, "What do I do in this situation?" I give solutions or I solve the problem, and she is happy about it. (Medical Director 14-SR, T1) Their [administrators'] hands are tied and they are muzzled. (Medical Director 12-R, T2)		
My fear is to be assigned all the projects that physicians are irritated with. The issues that the director of professional services or my clinical co-director don't want to address. (…) I tell them, "No, it is everyone's responsibility, not just mine." Because physicians fear lacking means to care for patients and that someone controls their practice. I have to avoid being seen as a physician trying to control his colleagues' practice. (Medical Director 8-R, T2) [During the selection tests for the position of medical director,] they gave me a pile of paper with organigrams, memos, etc. They gave me a lot of data, but some information was lacking and other information was contradictory. I had three hours to finish the management simulation, but after an hour I got up and put my pen down thinking, "if that is the role of medical director, it's not for me. It's clearly not for me, and I clearly am not the right person for the role. I'm leaving." (…) Then I remembered that these tasks would be [my co-director's] role – not mine. I didn't understand why they were asking me to do these simulations. I sat down and suffered through the last two hours. The result was probably terrible, because I asked for feedback and they don't want to give it. They probably pity me. [Laughter]. (Medical Director 12-R, T2) I am very operational. To be coherent with top managers' vision of the role, I should be more strategic. I am not. We manage the way we are. (…) Currently, there are local, operational issues. It's not glamorous, but that is where I am comfortable. I am not a glamorous person, but theoretically I should be involved more in strategic decision making. (Medical Director 1-U, T1) I was concerned that would be a rubber stamping role. It's a two hours a week job, so of course it could be just rubber stamping, and then administration could say, "Dear doctors, stop complaining – we consulted the medical director so shut up." I was worried about that. (Medical Director 10-R, T1)	Dissociating from aspects of management	

I don't think they wanted to work in silos, but the structure did not allow working any other way. But when we work in silos, it's clear, it's every man for himself and you put your own interests first. (Medical director 7-U, T2)		
I am going to give you an example. We had a strategic meeting about a medical service. We invited all the physicians that would be affected by a change in the service. Not just the physicians actually performing the service. All those that could be affected. Some administrators criticized my decision to invite all these actors, but they changed their minds. I got e-mails from physicians who were thanking me for involving them so soon in the process. For involving them in making the decision as opposed to simply involving them in applying the decision. Sometimes they weren't even asked what they thought about a change, they were simply told a change was being implemented. (…) Some physicians asked me why I invited them so early, why I made them waste their time in a meeting where we didn't make any decision. They said, "You are inviting us too early." I said, "You complained for not being involved early enough, and now you are complaining for being involved too early?" I reflected on it, and concluded that I would always invite them early in the process. (Medical Director 13-R, T2) In the organization, interprofessional collaboration disappeared. My role is as a practitioner, and to try to create links between the different professionals. We are doing it less and less, and I am trying to encourage it again. I see my role as trying to influence so that we get back to the kind of team work we had before between nurses, physiotherapists, etc. It was more natural before than it is now. (Medical Director 17-FL, T1) I think we need more frequent moments of… discussing more often. I don't know what it could be, but administrators need to have physicians' perspective more often, and physicians need to know what decisions administrators are making and the reasoning behind it. (Medical Director 16-SR, T1) The challenge is that we have two parallel structures. It would simplify things if we could integrate the two structures. (…) We want to integrate the doctors on the administrative side but how can we integrate the administrators on the medical side? (…) It would be relevant and interesting if my clinical co-director could come to our medical department's meetings. (Medical Director 9-U, T2) When my current clinical co-director arrived, he was new in the organization. He was not marked by the events of the last ten years. We had to build a dyad together. It think it is much easier to build something from scratch than to start with old stuff. It's like when you are renovating. Sometimes it is better to destroy your house completely and then rebuild it. That is what we did. It was very positive for me. It is since his arrival that I have been experiencing real co-management. (Medical director 7-U, T1)	Explaining one's management style: The right way	Reinventing Management

If some dyads are not working well, we have to dissolve them. We have to take people who want to work in co-management and fully agree with the model. Otherwise the whole system is vulnerable… (Medical director 7-U, T2) Administrators are listening. They want the medical perspective. They expressed that they thought that the quality of the discussions changed during meetings. They unanimously expressed it, "The arrival of the medical directors changed things." (Medical Director 11-R, T2) I think we made the role [of medical director] evolve considerably – significantly – in the last two or three years. (Medical director 7-U, T2) We are imposing a new organizational model – imposing in the positive meaning of the word – that allows us to be more efficient. (Medical director 7-U, T2) The operation room is the centre of the hospital, so I can say, "This is how it is going to work", and they listen to me. (Medical Director 2-U, T1) As a physician, as chief of a medical department, as director of whatever – I am in a stronger position than my co-director. It can create difference of status within the dyad, but I am not allowing it. (Medical director 7-U, T2)	Emphasizing influence	
Physicians' vision is more: I am with my patient and it is this patient that must care for. They don't have a systemic vision much. We have to try to get physicians to see beyond their own little misery. They struggle to have a systemic vision. To see beyond the individual patient they have in front of them. (Medical Director 12-U, T2) As medical director, I am not a physician with privileges. In that role, I am an employee of the hospital, not an autonomous worker. As a practitioner with patients, I am autonomous. When I graduated in the 70s, I was taught that I was accountable to god and to my patient. It changed a lot, because I am responsible for the population, for my patient and I have responsibilities in this organization. (Medical Director 4-U, T2) Before getting involved in administrative work, I had a tendency to be critical and say, "Administrators live in an ivory tower, they cost a lot of money and don't contribute much to patient care." I was very critical. I thought, "Why can't they change things faster?" Once I was on the other side, I realized that perhaps I was very critical, and that I am not any better, and that I am not changing things faster. (Medical Director 1-U, T1) Saying, "Somebody should do something about it", it doesn't work. I realized pretty quickly that we are autonomous professionals, so most of the time, "somebody" can be me. And if it is not me, I need to find out	Representing oneself as an enhanced physician	Positioning Oneself Above the Crowd

who it is and make sure he or she knows there is something to be done. Does that somebody knows what to do? Have I tried to find a solution? Have I explained that solution to him or her? (Medical Director 10-R, T1) What some people say reflects a misunderstanding of other people's efforts to improve the situation. It bothers me. (…) We have a responsibility – it is not always other people's fault. It bothers me… on the medical side. When you are complaining about something, there is nothing better than trying to help solve the problem. Usually when you do that your understanding of the situation evolves. (Medical Director 3-U, T1) I think it is the medical and clinical co-directors' responsibility to work toward – it's like an ant colony: every single ant should become part of a bigger whole. Physicians should feel involved in our organization, not simply do their own thing and constantly ask for more resources for themselves. (Medical director 7-U, T2)		
It's difficult. There is a divide between physicians and managers. My role is to fill this void, to build bridges. That is one of my main roles right now. (Medical Director 10-R, T2) We went from doctors controlling everything in hospitals to administrators managing everything. In both cases, there were problems. I believe we are in a hybrid period in which physicians and managers are getting closer. They need each other. There are budgetary constraints, union constraints, medical constraints. All those constraints are unavoidable, so the two groups have to work together. (Medical Director 3 U-, T2) When I arrived in this organization, the managers were on one side, the physicians on the other side. When I arrived, they weren't talking to each other. It took me six months of going from one side to the next before I could get then to sit down in the same room. (Medical Director 5-U, T1) The medical directors, we are told by the clinical co-directors, by the CEO, by the deputy CEO, that our arrival changes the dynamics. That we discuss the clinical aspect and not only budgets and purely administrative things in meetings. I don't know why the changes are so important, but there are changes. I think that because we still practice medicine, we can bring a vision different from what administrators can bring. We can link the clinical and administrative sides. (Medical Director 10-R, T2) I see my role as a public health role: to define the orientations of the hospital with administrators, with the health minister's orientations in mind. I am not there to reconcile physicians' and administrators' every desires. (Medical Director 14 -SR-, T2)	Presenting oneself as above the fight between doctors and managers	
We have been working together for four or five years. When I was chief of a medical department, I was already working very closely with my current co-director, so we learnt to work together. We don't experience any problem working together. It's going really really really well. (Medical Director 1-R, T1)	Allying with the co-leader	Defining The Relationship With The Co-leader

We have a common goal, we are looking in the same direction, we are side by side looking in the same direction. (Medical Director 4-U, T2) I had to interact with my co-manager before we became a dyad as chief of medical department. She was also working in the department, so I knew who she was, I interacted with her and I liked the way she worked. We didn't have to agree, but we explained our position and moved things forward. When I was asked to become co-director, I didn't know because it meant additional tasks. I said, "It's okay because Beth will be my co-leader. I know her, and I know I can work with her. Without her, I wouldn't have made the same decision." I told the director of professional services, "I'll do it if Beth is the co-leader. If you take her away tomorrow, I don't know if I can do it." (Medical Director 3-U, T1) We have always decided by consensus in the past, and we keep doing it. It's usually pretty easy to reach a consensus between us. (Medical Director 10-R, T2) We can really jointly do things simultaneously considering the patient's problem, the medical world, all the professionals working for the patient, and management: the budgets, the procedures, things like that. I think that is the strength of the dyad: the interaction. Crossing the expertise. Interacting with a common objective. (Medical director 7-U, T1)		
We joke about it and say that [the clinical co-director] has undergone a transplant of a doctor's head. That doctor's head, that's me. (Medical Director 10-R, T2) Was I useful as medical director? I don't know. I tried to do what I had to do. At first I didn't really know what was expected of me, but I tried to be useful and so what I ask asked. (…) The way we work together is: she works on projects and when she needs me she lets me know. (…) My co-director leads projects alone, and once in a while she asks me my opinion. (Medical Director 14 SR-, T1) My co-manager takes care of most problems or projects. When she is uncertain about something, she asks me. She is in the driver seat, and I am the passenger. (Medical Director 3-U, T2) When I work with my co-director, I bring a perspective she doesn't have, the medical perspective. It seems to help her. She looked happy to have my point of view. (…) The way we work is, she works on her projects and she tells me when she needs me. (Medical Director 14-SR, T1) I am in charge of certain things, but in general she is in the driver's seat. (Medical Director 8-U, T1)	Portraying oneself as the adjunct of the co-leader	
To me, the role of medical co-director is pure fiction. They had to put a name in the box because the law requires it. (Medical Director 18-FL, T2)	Detaching from the co-leader	

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I stopped being medical co-director because it wasn't going anywhere and because I didn't understand my role. It's not clear for me. I asked many times to be invited when projects or issues concerning my directorate were discussed, but they don't invite me, or they invite me and they cancel the meeting without telling me. I have other things to do, I have to see patients, so I decided to stop playing the role. I stopped and no one made any follow up. No one asked me why I wasn't participating anymore. Nothing. (Medical Director 17-FL, T2) We are working separately. He works on his side, I work on mine. (Medical Director 5-U, T2) We talk when there is a need. There is no project that could make us work together and put extra efforts. (Medical Director 20-FL, T2)		

CHAPITRE 4

ARTICLE II: Co-Leadership Dyads in Professional Organizations: Bridging Professional and Managerial Logics?

Abstract

In pluralistic settings, groups possessing different and sometimes contradictory sets of norms, cultures and rules prescribing their interpretations and ways of functioning - that is, institutional logics - evolve side by side. How organizations may respond to this institutional plurality still intrigues scholars. In this study, we explore the potential of a different mechanism involving the sharing of leadership roles by members of the different logics. Dyads of co-leaders are then created and jointly mandated to ease coexistence, represent both logics in decision making and mobilize professionals and managers toward common goals. We seek to explore *whether and how co-leadership models contribute to bridging different institutional logics.* Drawing on a qualitative study of 20 co-leadership dyads across four organizations, we identify six configurations of collaboration that express different relations between the co-leaders and different forms of mobilization of institutional logics within the discourse of dyad members: dyad of one, professional consulting, boundary duo, management duo, management unit and mission unit. Among these, three forms appear to offer some potential for combining logics, while three others either involve cooptation within the managerial logic or continued separation. We conclude that the co-leadership form does offer potential for bridging but that it is certainly not a panacea. The complexities of role-sharing can inhibit the ability of co-leadership dyads to realize their potential.

Nicholas Van Schendel, Ann Langley and Jean-Louis Denis are co-authors of this article. They agreed that the article could be included in this thesis (see the signed form in appendix 8). Nicholas Van Schendel participated in the data collection and analysis. Ann Langley and Jean-Louis Denis' contribution was to give feedback at different stages of the development of this article.

4.1. Introduction

Pluralistic settings pose particular challenges as different groups possessing different and sometimes contradictory ways of interpreting and functioning in the world evolve side by side (Denis, Langley, & Rouleau, 2005). The sets of norms, cultures and rules prescribing their interpretations and ways of functioning are referred to as institutional logics (Thornton, 2004). Significant tensions and rivalry may derive from the coexistence of opposing logics, and in particular those inherent to healthcare organizations (Reay & Hinings, 2009) where the multiple logics are core to organizational functioning and provide contradictory prescriptions for action (Besharov & Smith, 2014). Several authors have contributed to our understanding of mechanisms through which organizations respond to a plurality of logics (Battilana & Lee, 2014; Fossestol et al., 2015; Kraatz & Block, 2008). These may include for example mandating hybrid professionals – that is, professionals able to embody, translate and bridge the professional and managerial logics - to bridge divergent logics (Blomgren & Waks, 2015; Croft, Currie, & Lockett, 2014; Kippist & Fitzgerald, 2009) or various mechanisms aimed at separating or integrating them (Kellogg, 2009; Kraatz & Block, 2008).

However, a different mechanism involving the sharing of leadership roles by members of the different logics present in the organization has not been explored. This thus far marginal but increasingly common alternative involves the creation of dyads of co-leaders jointly mandated to ease coexistence, represent both logics in decision making and mobilize professionals and managers toward common goals (Gibeau, Reid, & Langley, 2015). Such co-leadership arrangements have been observed in creative organizations, professional service firms, healthcare establishments as well as in the education and media sectors (Denis, Langley, et al., 2012). However, dyadic co-leadership has often been decried as likely to fail because of its potential for confusion, conflict, ambiguity and lack of accountability (Fayol, 1949; Locke, 2003). The objective of this article is hence to explore *whether and how co-leadership models contribute to bridging different institutional logics.*

We define co-leadership as two people sharing organizational leadership roles (Gibeau, Reid, & Langley, 2015). Leadership in turn is defined as 'the process of inducing others to take action toward a common goal' (Locke, 2003): 271). Although we refer to the model as co-management in other parts of the thesis - which we define as the joint accomplishment of management activities of planning, organizing, commanding, coordinating and controlling (Fayol, 1949) - we believe that co-leadership is an appropriate framework for our study of co-management roles as bridging mechanisms. We chose to use the notion of co-leadership since the practices of co-management we witnessed were actually leadership activities, including mostly practices aimed at influencing managers and professionals to align their efforts toward a common objective. Some authors like Chreim (2015) use the terms leaders and managers interchangeably, arguing that leadership is socially constructed and hence that participants may attribute leadership to individuals focused on activities typically associated with management such as risk minimization. Others distinguish between leadership and management. For instance, Kotter (1995) views minimizing risk and overseeing operations as management activities, and believes that leadership involves activities aimed at creating change. Crevani, Lindgren, and Packendorff (2010), among others, differently argue that leadership is not solely associated with formal managerial positions (Chreim, Langley, Comeau-Vallée, Huq, & Reay, 2013; Uhl-Bien, 2006). We agree with the latter authors and recognize that co-leadership and co-management are not synonyms; the former involving two individuals jointly inducing others to take actions aimed at attaining a goal while the latter focusing on planning, organizing, commanding, coordinating and controlling activities (Fayol, 1949). Although the two notions are distinct, we believe that they may partly overlap since in this case, co-management entails significant co-leadership activities.

To answer the research question, we examine the way in which different institutional logics are mobilized in the discourse of 20 co-leader dyads over time and relate these to patterns reflecting the way in which the members of the dyads jointly construct their roles, generating different configurations of co-leadership work. More specifically, the article proceeds as follows. First, we expose the literature that served as the theoretical foundation of this investigation. The methods

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section then details the context of the study, data collection methods and data analysis strategies. Based on our data, we then develop a typology of configurations of co-leadership dyads and analyze their evolution over time. We conclude by discussing the theoretical and practical implications in terms of the capacity for a co-leadership model to traverse different logics.

4.2. Co-Leadership to Bridge Institutional Logics: A Literature Review

Although the way in which dyads of co-leaders may bridge institutional logics has not been directly explored in the literature, three streams of research may offer some insight into this concern. First, studies of organizational responses to multiple institutional logics – also known as "institutional complexity" (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011) – offer a portrait of different ways through which logics may coexist. Second, the literature on individuals' response to organizational complexity – including hybrids - offer insight as to the way individuals positioned at the boundary of institutional logics or co-leaders may individually respond to institutional complexity. Third, the literature on co-leadership includes studies on different aspects of the model in contexts of institutional complexity, that is, in settings in which incompatible prescriptions originate from multiple logics.

4.2.1. Organizations' Responses to Institutional Complexity

In recent years, researchers have become especially interested in the way organizations respond to multiple logics (Greenwood et al., 2011; Reay & Hinings, 2009). Table 4.1. summarizes the responses discussed in the literature.

	Organizational Responses to Complexity				
	Separation of logics	**Rejection of one logic**	**Partial conformity to all logics**	**Integration of logics**	**Alteration of demands to form something new**
Battilana and Dorado (2010)	-	-	-	Creating a common organizational identity balancing the logics	-
Battilana and Lee (2014)	**Separating**: compartmentalization demands	**Dismissing**: rejecting one institutional demand	-	**Cumulating**: aggregating all demands	**Creating**: integrating demands to form something new
Fossestol et al. (2015)	**Negative hybridity:** dividing demands	**Non-hybridity**: ignoring the demands originating from one logic	**Ad hoc hybridity**: vacillating obedience to both demands	**Positive hybridity**: integrating demands	-
Greenwood et al. (2011)	**Structural differentiation:** separating subunits to deal with particular logics	-	-	**Blended hybrids:** combining practices from different logics	-
Kraatz and Block (2008)	**Compartmentalize:** relating independently to different constituencies and their demands	**Denial:** escaping some demands by questioning its legitimacy or controlling it	**Rein in**: balancing demands or finding cooperative solutions	-	Forging an identity of their own
Mair, Mayer, and Lutz (2015)	-	**Conforming:** prioritizing one logic	**Dissenting by selective coupling:** selecting elements associated with both logics	**Dissenting by defiance:** balancing the prescriptions of logics, actively refusing to choose between logics	**Dissenting by innovating:** developing novel practices integrating the logics
Noordegraaf (2015)				Mixed structures Mixed coordination Mixed managers Mixed management of professionals Mixed professionals Mixed organizational professionalism	

Oliver (1991)	-	**Defiance**: rejecting at least one logic **Avoidance**: making some demands unnecessary	**Compromise**: conforming partially to all demands	**Acquiescence**: adopting all demands	**Manipulation**: modifying demands
Pache and Santos (2010)	-	-	Adopting a combination of intact practices from either logic	-	-
Pratt and Foreman (2000)	**Compartmentalization**: maintaining each organizational identity independently	**Deletion**: eliminating one or more identity(ies) and associated demands	-	**Aggregation**: forging links between the different identities	**Integration**: creating a new whole composed of the different identities
Reay and Hinings (2009)	Differentiating decisions belonging to each logic	-	Seeking informal input from constituents adhering to the other logic	-	Working together against a third party Jointly innovating
Skelcher and Smith (2015)	**Segregated**: compartmentalizing functions in separate but associated organizations **Segmented**: compartmentalizing functions within the organization	**Blocked**: inability to resolve tensions	**Assimilated**: core logic adopting practices and symbols of the new logic	-	**Blended**: incorporating elements of logics into a new contextually specific logic

Table 4.1. Overview of the Responses to Institutional Complexity at the Organizational Level Discussed in the Literature

For example, Fossestøl et al. (2015) suggested four answers to institutional complexity: non-hybridity which involves ignoring the demands originating from one logic, ad hoc hybridity which is defined as vacillating obedience to both demands, negative hybridity or the division of demands, as well as positive hybridity or the integration of demands. Battilana and Lee (2014) propose a similar typology which includes dismissing (the rejection of one institutional demand), separating (the compartmentalization of demands), cumulating (the aggregation of all demands) and creating (the integration of demands to form something new). Pache and Santos (2010) discuss how organizations may hybridize by adopting a combination of intact practices from either logic rather than by hybridizing each practice. Finally, Smets and Jarzabkowski (2013) argue that logics may first be constructed as strange and kept separated. Then, efforts to maintain one's logic may coincide with attempts to disrupt the other logic. The authors claim that the logics would eventually be reconstructed as compatible, and then as complementary in a cyclical process which may start again. These typologies, as shown on table 4.1., all fundamentally reflect responses involving the separation, rejection of one logic, partial conformity, integration of logics and alteration of demands to form something new.

Although the literature on organizations' responses to institutional complexity provides important insight as to the way divergent logics may coexist, the way co-leadership structures can help cope with such logics has not been investigated. Before examining the insight provided by the literature on co-leadership, we discuss the way individuals may embody multiple logics, emphasizing more specifically hybrids and professionals.

4.2.2. Individuals' Responses to Institutional Complexity

The question of how individuals, and especially hybrids, respond to competing logics was significantly less investigated than responses at the organizational level, but received some attention in recent years. Some scholars developed typologies of responses, some of which mostly mirror the types developed at the organizational level. We identified five responses discussed in the literature:

conforming to one logic, rejecting a logic, separating logics, integrating logics and importing

aspects of another logic. Table 4.2. illustrates these types using responses discussed in the literature.

		Response & Author(s)
Individuals' Responses to Complexity	**Conformity to one logic**	**Ignorance:** being unaware of a logic (Pache & Santos, 2013) **Compliance:** adopting a logic (Pache & Santos, 2013) Adopting a dominant logic (Fjellvaer, 2010)
	Rejection of a logic	**Defiance:** rejecting a logic (Pache & Santos, 2013) **Circumventing**: opting out of a practice (Waring & Currie, 2009)
	Separation of logics	**Compartmentalization:** segmenting compliance with logics (Pache & Santos, 2013)
	Integration of logics	Balancing several logics at the same time (Fjellvaer, 2010) Alternating between logics in a cyclical manner (Fjellvaer, 2010) Creatively reassemble logics (McPherson & Sauder, 2013) **Combination:** blending logics (Pache & Santos, 2013) Multiple logics guide different dimensions of work (Goodrick & Reay, 2011) *Bricolage*: assembling elements of different logics (Valette & Burellier, 2014)
	Importing aspects of another logic	**Co-optation:** re-anchoring practices in another logic (Waring & Currie, 2009) **Adaptation:** transforming a practice to fit another logic (Waring & Currie, 2009)

Table 4.2. Overview of the Responses to Institutional Complexity at the Individual Level Discussed in the Literature

On individuals' responses to hybrid contexts, Pache and Santos (2013) argue that depending on

their degree of adherence to the multiple logics, individuals may respond by ignorance (a lack of

awareness of a logic's influence), compliance (fully adopting a logic), defiance (explicitly rejecting

a logic), compartmentalization (segmenting compliance with competing logics) or combination

(blending competing logics). McPherson and Sauder (2013)'s findings support the idea of

combination. Indeed, the authors view individuals as using multiple logics as resources to achieve

their objectives, solve problems and manage complexity. These findings allow the authors to

uncover and challenge the often held assumption that actors adhere to the logic of the group

(professional or organizational) they belong to, and consequently encourage scholars to examine instead of taking for granted the adherence of co-leaders to logics. Similarly, multiple logics have been found to shape individuals' professional work simultaneously by guiding different dimensions of it by Goodrick and Reay (2011). Such integration of logics has also been uncovered by Fjellvaer (2010) in a study of unitary and dual leadership in 27 pluralistic settings. In the next section of the literature, we will discuss her conclusions at the level of the dyad, but the three modes of integrating competing logics by unitary leaders she identified are worth noting: adopting a dominant logic, balancing several logics at the same time and alternating between logics in a cyclical manner. Finally, Valette and Burellier (2014) concluded that professionals in management may struggle to identify with management but become hybrids in their day-to-day management work by assembling different elements of different logics, a process they call "bricolage".

Studies focusing specifically on hybrids offer additional insight as to how individuals may respond to institutional complexity. Hybrids who, coherent with Blomgren and Waks (2015)'s definition, "developed a certain competence outside their main area of expertise and therefore are likely to have the capacity to bridge divergent logics" (p. 79) are especially relevant for our purposes because they are positioned at the boundary and may embody multiple logics. The extent of this embodiment may vary, as reflected by Causor and Exworthy (1999)'s typology of hybrid professional-managers. The authors divide hybrids in three groups: the "quasi-managerial practitioners" who perform management tasks which are not formally assigned or rewarded, the "managing professionals" who are formally responsible for the work of fellow professionals and may practice their profession or not as well as the "general managers" who are accountable for performance results and are located at the apex of organizations.

Professional hybrids are currently receiving significant attention in the healthcare literature. These roles are expected to help connect professional work with the organizational context in which it is taking place (Denis & van Gestel, 2016) and cope with the tensions caused by the coexistence of the professional and managerial logic (Rotar et al., 2016). Authors shed light on the widely held

assumption that professionals in management roles adapt their professionalism to align it with the managerial logic (Correia & Denis, 2016) and showed that although some professionals are willing and able to create such alignment, the majority struggle in their management role and the idea that clinical leadership does not have to equate dismantling professionalism even years after entering it (Kuhlmann, Rangnitt, & von Knorring, 2016; Lega & Sartirana, 2016). Hybridity might therefore not be as easy to develop in professionals in management roles as generally suggested (Kuhlmann et al., 2016), and although they are readily conceived as bridging actors, hybrids may in fact constitute agents of management used to control professionals (Kirkpatrick, 2016). Without discussing the issue at length, some authors quickly highlight how the professionals able to perform in a management role should be supported by different means including pairing them with non-clinical managers to allow them to contribute to strategic and clinical management while practicing (Lega & Sartirana, 2016). The potential and interest of the co-leadership model is hence acknowledged, but remains under-investigated.

Despite the attention given to hybrids and other individuals' response to institutional complexity, insufficient efforts have been deployed to understand the potential of such dyads of co-leaders to embody and bridge multiple logics. Although one or both co-leaders in dyads may be hybrids, our study differs from previous ones on hybrids by exploring whether logics can be bridged at the level of the dyad. In the literature on co-leadership which we explore next, different aspects of such an arrangement in contexts of institutional complexity have been examined. However, the mobilization of institutional logics and configurations (that is, the ways co-leaders may jointly play their dyad's role) has not been directly addressed. Such research on day-to-day practices has been called for by many authors who argue that logics inform individuals' practices which in turn shape the logics (Lok, 2010; Powell & Colyvas, 2008). However, as highlighted by McPherson and Sauder (2013), we still have a limited understanding of the complex interplay of completing logics at lower levels of analysis. Hence, the wider relevance of this studies lies in the idea that institutional logics are sustained and transformed through day-to-day practices in a process which remains thus far unclear (Battilana, Leca, & Boxenbaum, 2009; Lok, 2010).

4.2.3. Co-Leadership in Contexts of Institutional Complexity

The second stream of literature offering some insight examines co-leadership arrangements that occur in contexts of institutional complexity without necessarily focusing on how they manifest themselves concretely in these arrangements. 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 how they were managed. 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' discourses and practices of collaboration. However, there are some contributions that focus specifically on the way in which roles may be shared in co-leadership arrangements, and these could offer some basis for answering our research questions.

First, in their study of the education sector, Gronn and Hamilton (2004) propose that co-leaders may be seen as a "form of shared role space inhabited by a distributed mind" (p. 3). In a subsequent theoretical paper, Gibeau et al. (2015) propose different ways in which co-leaders can occupy these 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 work of Hodgson et al. (1965) on "executive role constellations", that is, the way executive groups play their roles. Hodgson et al. (1965) discuss 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.

The only study that explicitly relates co-leadership arrangements with institutional logics directly is that of Fjellvaer (2010). The author built on the three modes of integrating competing logics by unitary leaders discussed above to develop a typology of how dyads of co-leaders integrate logics. She found three possible ways or configurations. 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 is when one co-leader tries to balance the demands of different logics while the other co-leader adheres solely to one logic. The dominant-dominant configuration is recognizable when the co-leaders follow different logics without considering the other logic. Overall, there is a clear need for further study of how co-leadership arrangements play out in a context of competing logics, and in particular in healthcare organizations. This is the focus of the current paper.

4.3. Methodology

To answer our research question, we realized a longitudinal qualitative case-based study in four healthcare organizations. These professional contexts constitute typical settings in which a plurality of logics may be problematic. In professional organizations, it is from the coexistence of a managerial logic alongside the professional logic that might stem such tensions (Noordegraaf, 2011). The next sections describe this context as well as the data collection and analysis process.

4.3.1. The Context: One Pilot Project, Four Organizations, 20 Dyads

In 2010, the *Association québécoise d'établissements de santé et de services sociaux* (AQESSS) brought together different stakeholders from the medical and healthcare management communities in Quebec to analyze and improve the current state of the relationship between the two communities in healthcare organizations in the province. The committee was also aimed at developing a new model of organizing intended to further medical professionals' aspirations while ensuring their

collaboration in reaching organizational objectives. Three main elements composed the model, that is, the implementation of co-leadership at the strategic level, the addition of medical co-director positions in the organization's structure and the participation of these medical co-directors to strategic meetings. Co-leadership is defined as "a situation in which two people share leadership roles" (Gibeau et al., 2015). The dyads of co-leaders are composed of a medical co-director and a clinical co-director. The medical co-director is usually a former medical representative assigned a top management role and mandated to represent the medical perspective in strategic decision making and share the administrative point of view in the medical community. The clinical co-director possesses a training and experience in both a (non-medical) clinical profession and in management. Generally, the clinical co-directors managed the directorate single-handedly before the implementation of the co-leadership structure. Our research team was asked to study the implementation of the model in the four organizations over approximately two years in order to evaluate the model's potential to improve decision making and the relationships between the medical and management communities. The four Health and Social Service Centres (HSSC) 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. They thus constitute a maximum variation sample. Table 4.3. illustrates their particular characteristics.

	University Health Centre	Regional HSSC	Semi-Rural HSSC	Primary Care HSSC
Short Term Care Facilities	2 major	3 hospitals	1 small hospital	No hospital
Number of Long-Term Care Facilities	4	4	3	8
Number of Community Centres	5	3	3	7
Number of Employees	5500-6000	5000-5500	100-1500	3000-3500
Number of Physicians	600-650	450-500	50-100	200 - 250
Teaching & Research	Central	Present	Minimally present	Developing

Table 4.3. Characteristics of the Organizations

Within these organizations, a total of 20 dyads were created at the strategic level: 9 at the University Health Centre, 4 at the Regional HSSC, 4 at the Semi-Rural HSSC and 3 at the Primary Care HSSC. The 20 dyads were solicited to participate in this study and all agreed.

4.3.2. A Longitudinal Qualitative Study

This project was designed as a qualitative case-based study taking an inductive approach. Interviews, observations as well as documentary analysis were the methods, allowing a deep understanding of micro dynamics with the dyad as units of analysis. The reliance on mixed methods made triangulation possible, allowing for the weaknesses of one method to be compensated by the strengths of the other, and contributing to establishing the trustworthiness of the study (Lincoln & Guba, 1985).

The data collection process proceeded as follows. Phase 1, spreading from February 2012 to August 2012, involved document analysis, observation and interviews. Document analysis and observation continued from September 2012 to April 2013. Phase 2, spanning from May 2013 to October 2013, involved the continuation of document analysis and observation, combined with a second round of interviews. The specificities of the interviews and observations are detailed in the following paragraphs, and are illustrated in table 4.4.

	Interviews		Meetings Observed (Number)
	Phase 1 (T1)	Phase 2 (T2)	
University Health Centre	16	12[4]	• Executive Committee (3) • Clinical Programs Committee (5) • Strategic Project Management Office (4)
Regional HSSC	-[5]	8	• Executive Committee (4) • Council of Physicians, Dentists and Pharmacists (2) • Chiefs of Medical Departments Committee (8) • Strategic Consultation Meetings (4)
Semi-Rural HSSC	6[6]	6	• Executive Committee (9) • Clinical Executive Committee (5) • Co-leadership Implementation Committee (8) • Council of Physicians, Dentists and Pharmacists (5) • Chiefs of Medical Departments Committee (5) • Strategic Consultation Meetings (6) • Co-leadership Training Sessions (1) • Clinical Programs Committee (2)
Primary Care HSSC	6	6	• Executive Committee (1) • Clinical Executive Committee (6) • Clinical Programs Committee (6) • Medical Teaching Committee (1) • Chiefs of Medical Departments Committee (1) Council of Physicians, Dentists and Pharmacists (4)
Total	28	32	77

Table 4.4. Data Collection Details

Throughout the duration of the data collection, all internal and external documents likely to help gain an in-depth understanding of the four organizations studied were gathered (history, structure, culture, changes undertaken, strategic plans, etc.). Document analysis constituted an unobtrusive opportunity to gain a deeper understanding of the external and internal environment of the organization as well as the terminology specific to each organization (Marshall & Rossman, 1995). Especially interesting were the various documents describing the roles and responsibilities of the co-leaders, giving us a vision of how different actors described the configurations of the dyads. The latter documents included for instance written exercises done during co-leadership training sessions

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[4] Four dyads were interviewed only once at the University Health Centre. Three of these dyads were only interviewed during the first phase while the other was only interviewed during the second phase. Changes in dyad members explain this discrepancy.
[5] The Regional HSSC had not implemented the co-leadership model during the first phase of interview. The model was implemented a few months before phase 2.
[6] At the Semi-Rural HSSC, one dyad was only interviewed during phase 1 while another was only interviewed during phase 2. Once again, changes in dyad members explain this discrepancy.

to identify the responsibility of each member of the dyads in terms of decision making, follow-up, information dissemination, etc. The way in which logics were mobilized and combined in the co-leaders' discourse was most evident in the documents produced by the co-leaders themselves such as minutes of meetings, information letters sent to employees and supporting documents distributed during meetings.

Non-participant observation was also performed throughout the three phases of data collection, that is, from February 2012 to October 2013. In general, day-to-day observations provide a profound and nuanced understanding of the organization, demonstrations of the co-leaders' way 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 the routine or situation-specific dynamics. Long-term observation additionally contributes to the credibility of the study (Lincoln & Guba, 1985). 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 individual role as members of a duo.

As mentioned previously, interviews were performed during phases 1 and 3. Questions were asked relating to the participants' academic and professional history, currently held 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 as bridge between the two communities. These last questions, inspired by the critical incident technique, as well as the discussions on the current role played provided information as to the way in which the dyads jointly played their roles (that is, the configurations). Although the way institutional logics were mobilized and combined by the co-leaders appeared everywhere in the data, these questions were especially insightful.

4.3.3. Data Analysis

Data analysis was carried out using a grounded method to uncover the different configurations and their evolution over time. To begin the analysis process, we 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 the dyads function (the quality of the relationship, the co-leaders' understanding of their roles and the way they communicate together) as well as the individual characteristics (such as attitudes toward the role, co-leaders' qualities and competencies). We uncovered seven configurations which can be divided in two categories: vertical and horizontal configurations. Vertical configurations include (1) a professional supported by an administrator, (2) a professional acting as consultant for an administrator as well as (3) an administrator assisted by a professional. Horizontal configurations include (1) an influential professional working with an administrator who is managing the team, (2) a professional managing the team accompanied by an administrator, (3) a professional and an administrator jointly and equally managing and leading a team, and (4) a professional and an administrator acting as one in managing and leading a team.

The second step involved coding all excerpts reflecting (either or both simultaneously) the management or professional logic in the discourse of co-leaders. Coherent with McPherson and Sauder (2013), we carefully examined the logics individuals mobilize instead of taking for granted the adherence of the co-leaders to the logic of their occupation. Inspired 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, the managerial logic includes 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 "managerial logic." At this stage, we noticed three ways in which these logics interacted and coded

all the excerpts as: (1) pure management or professional logic, (2) opposition of the logics and positioning in one logic and (3) mix of the two logics.

In doing this, we noted that a third important notion seemed to interact with the two logics: 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 combining or bridging of the two logics. Inspired by Kraatz and Block (2008) who discuss how organizations may construct their own identities by integrating or transcending the socially-given identities composing it, we see the "mission" as a way for dyads to forge their own guiding principles to transcend the logics. Contrary to past research on logics in healthcare systems (Reay & Hinings, 2009) which embeds constructions of "patient(s)" within the professional and managerial logics, we conceived the "mission" as a different notion co-leaders may mobilize to bridge the logics. We hence coded for mission in all 60 interviews. We then developed a typology of ways in which the logics and/or mission were combined in the discourse of participants. The following four types emerged: (1) *pure* when only one logic is mobilized, (2) *opposing and positioning* when two logics are presented as conflicting and the participant explains preferring one over the other, (3) *converging* when logics are presented as parallel considerations eventually 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. Table 4.6. in appendix 1 of this article defines these four codes and illustrates them using excerpts from various interviews.

The third and final step involved developing a typology reflecting both the way co-leaders jointly play their roles and the way they combine institutional logics in their discourse. This typology (including the dyad of one, professional consulting, boundary duo, management duo, management unit and mission unit) will be explained in the result section.

4.4. Findings

This section is divided in two parts. First, we explain the six types of configurations we uncovered. Then, we discuss the way in which these configurations change over time in the 20 dyads studied.

4.4.1. A Typology of Co-Leadership Configurations

We propose six configurations, illustrated in figure 4.1., reflecting both the way dyads jointly play their leadership role and the way co-leaders combine logics and the mission in their discourse: dyad of one, professional consulting, boundary duo, management duo, management unit and mission unit. On figure 4.1., we grouped the configurations based on the logics represented. In all configurations on the top row, the management is dominant in different ways while the other logic disappears. In the configurations included in the lower row, the professional logic is maintained in different manners. Hence in these three configurations, both logics coexist. Furthermore, the configurations reflect a growing integration and duplication as we move to the right. The highest level of integration is expressed using the label "unit" in the configuration title. The configurations in the middle column, which reflect Gibeau et al. (2015)'s "duplication" and "distribution" configurations, both refer to dyads in which the co-leaders play roles of similar scope covering the entire shared role space. In the upper "management duo", the common focus on the managerial logic creates duplication while the different emphasis of the lower boundary duo prevents this. These co-leaders' roles somewhat overlap to allow coordination between them. The term "duo" is used to identify these configurations. Finally, the configurations on the left column, the dyad of one and professional consulting, reflect the most disintegration. In Gibeau et al. (2015)'s words, the configurations reflect different levels of disconnection and dominance.

On the figures, "P" refers to the professional co-leader (who in our case is a medical director) while "A" refers to the administrative co-leader (who in this case is a clinical co-director). In the next pages, we define and illustrate these configurations using the example of typical dyads. Then, we explore the way the configurations evolved over time. Table 4.7. located in appendix 2 provides

further illustrations of the configurations with supporting quotes extracted from the discourse of the 9 dyads not directly referred to in the results' section.
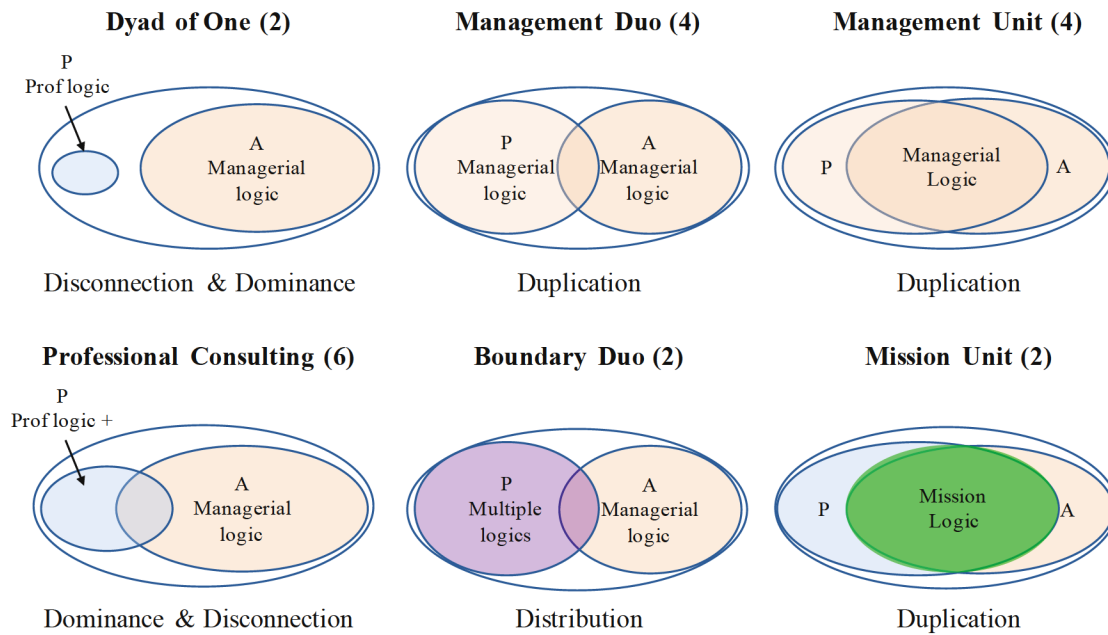
Figure 4.1. – Illustration of the Six Configurations

4.4.1.1. *The Dyad of One*

The first configuration, the dyad of one, represents two dyads in which one co-leader, the clinical co-director, accomplishes the bulk of the work. Typically, the medical director more or less actively but always unsuccessfully attempts to get more involved. These efforts emphasize the professional logic and usually involve trying to access budgets, represent colleagues and have a say in the allocation of resources. Figure 4.2. illustrates the configuration.
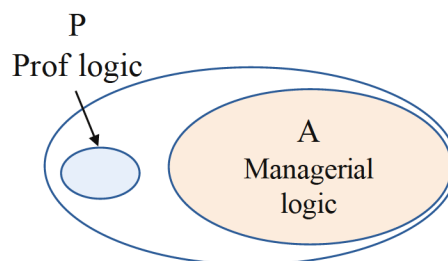
Figure 4.2. – Illustration of the Dyad of One

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For instance, a medical director explains how she views the HSSC as a provider of resources for which she needs to fight, "The HSSC 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). The statement reflects the role of representation specific to the professional logic and a view of resources as a source of anxiety. The statement also exposes the medical director's efforts to get involved as well as the failure of these attempts.

The clinical co-director, who single-handedly led and managed a directorate before the implementation of the co-leadership model, continues to independently execute her work and does not make space for the medical director in the dyad. The following statement of 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 mobilization of one logic. In this case, the statements reflect "pure professionalism" as it mobilizes the typically professional ideas of representation and fighting for resources the organization should provide. From the point of view of the clinical co-director, the medical director's attempts to get involved reflect her desire to further physicians' interests. The clinical co-director believes that clarifying the roles of the dyad and of the co-leaders would be helpful:

> Physicians need to understand what they are getting into when accepting co-leadership roles. It is not only about seeing the budget and trying to control. It is about getting involved in the organization. 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 said it many times: let's define the role of medical directors, debate it, present it, agree on what it is. (Clinical co-director 18-PC, T1)

The clinical co-director's discourse reflects her emphasis on formal mandates and hierarchical structures, a point of view typical of the managerial logic. The medical director differently does not see her role as guiding her behavior, and does 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. They kept bringing it up and insisting so we agreed to give them a name so they would stop talking about it. That's how I became medical director. (Medical director 18-PC, T2)

As a result of the co-leaders' divergent logics and probably because the clinical co-director had been playing her role for a long time when top managers decided to implement little defined medical director roles (without much efforts to ensure the success of the implementation – see article 3), the clinical co-director was managing the directorate alone, mostly ignoring the medical director's attempts to get involved according to her professional logic. These attempts seemed to be perceived as inappropriate by the clinical co-director belonging mostly to the managerial logic. In Gibeau et al. (2015)'s words, the dyad of one simultaneously reflects the configuration called "dominance" in which one co-leader occupies far more space than the other and "disconnection" since the members have little interactions (if any).

4.4.1.2. *Professional Consulting*

The second configuration shares some similarities with the first one, that is, the clinical co-director accomplished the biggest portion of the dyads' work. However, the medical director in this second configuration is more involved, providing his (or her) expertise or leveraging his influence on specific issues when invited to, "I contribute when needed. There is no mobilizing project that could make me put extra efforts. It has been about routine work. (…) But when I am asked to contribute, I make sure I respond." (Medical director 20-PC, T1). Figure 4.3. reflects the professional consulting configuration.
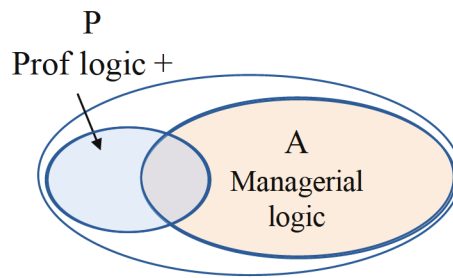
Figure 4.3. – Illustration of the Professional Consulting

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. I try to share the vision and transmit the messages of my colleagues when presented issues or when I bring up issues because we want change" (Medical director 20-PC, T1). The medical director believes that when asked to contribute, his point of view is taken into consideration, "I never had any problem being heard if I had ideas to defend. (…) I can express my doubts and administrators take them into consideration when making decisions" (Medical director 20-PC, T1). These narratives constitute "pure" expressions of the professional logic as it refers to professional representation. In parallel, the discourse reflects the managerial logic when he states that this role guarantees that his point of view will be taken into consideration. For instance, the professional logic is embedded in the managerial logic in the following excerpt. This pattern of mobilization of logics appears as the medical director explains how having a formal role in the organizational structure (managerial logic) ensures that he will be able to play his representation role (professional logic):

> 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. Theoretically, it will facilitate things and we will make progress faster. (Medical director 20-PC, T1)

Such comments suggest that the medical director also adheres to the managerial logic, which emphasizes how formal roles and positions in organizational structures provide authority and influence. While he sees his role as providing authority in the managerial community, the medical

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director does not believe that such influence is granted to him on the basis of his role in the professional community:

> 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. (…) In this context of scarcity, we are even less able to impose things on people. When you know that people can turn around and resign, you do not hit the table very hard. I have never had big enough problems to feel the need to do it anyway. If I had a problem with a colleague important enough to think about firing him or her, I would be torn. (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 positions in a hierarchy. From the point of view of the clinical co-director, better defining the roles and responsibilities associated with different co-leadership roles allows the co-directors to go further with this new model:

> We had to work on the definition of everyone's roles and responsibilities. How can I contribute, what competencies need to be developed? (…) We have an idea, but we can define it more. I think that we have to go further. We had successes, which is encouraging. Co-leadership scared everyone because we were wondering how far the medical director could go, how far the dyad could go. (Clinical co-director 20-PC, T1)

The managerial logic appears in its "pure" form through this explanation of the importance of defining roles. In sum, the professional consulting configuration involves a clinical co-director doing the bulk of the work and requesting the contribution of the medical co-director on specific issues when his expertise is needed. Six dyads function as "professional consulting" in which the managerial logic is dominant in the clinical co-director's discourse while the professional and managerial logics are intertwined in the medical director's discourse. If the frequency and nature of the references to the mission vary significantly in the discourse of the five medical directors, the

mission is almost absent from the clinical directors' narratives. In the specific example exposed above, the mission was almost absent from the discourse of both co-leaders. Like the dyad of one, professional consulting is a form of configuration characterized by the dominance of one co-leader and some degree of disconnection between the members (Gibeau et al., 2015).

4.4.1.3. *Boundary Duo*

The third configuration, the boundary duo, reflects the two dyads in which both co-leaders actively play a role and possess influence. Work is typically distributed based on expertise, but some issues are jointly addressed. The "boundary" element of this type reflects that the members of these dyads are at the boundary between different logics as one co-leader mobilizes predominantly one logic while the other is a hybrid mobilizing both logics in his/her discourse. Hybrids are individuals who internalized both logics' imperatives (Blomgren & Waks, 2015). Mirroring this, the co-leaders typically divide their work based on the logic they predominantly adhere to. Hence, a clinical director would perform management tasks and adhere to the managerial logic, while a medical director would predominantly act on issues concerning the professional community and conform to both logics. Figure 4.4. provides an illustration of the boundary duo.
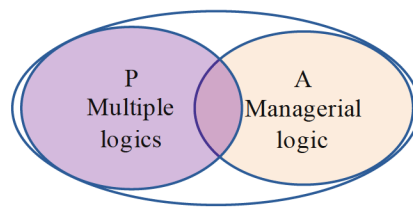
Figure 4.4. – Illustration of the Boundary Duo

Although the co-leaders mostly play their respective roles independently, the two members of the dyad coordinate 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. (Clinical co-director 1-U, T1)

Coherent with the managerial logic, the clinical co-director insists on the dyad's efforts to clarify the roles and responsibilities of the co-leaders, "We had to sit down and say, 'I am going to be responsible for this.' We established rules for our dyad. For instance, in meetings, do we speak immediately or do we wait to discuss it together and then come back with our joint position?" (Clinical co-director 1-U, T1)

When discussing his role in strategic management, the medical director's discourse reflects both logics. In the following quote in which he contrasts the professional logic characterized by autonomy with what he believes is the right way to play this role which involves respecting formal mandates, the medical director positions himself within the managerial logic:

> Administration pays me to be a medical director. I cannot take that money and act like an autonomous professional. I am a hospital manager. If I weren't paid, I would go more as an autonomous professional. I would go there to make gains. But I have to think like an administrator a little bit. I am a member of the top management team. The decisions made in those meetings, I have to support them even if I do not agree with them. (Medical director 1-U, T2)

The managerial logic is also clear when the medical director comments on how decisions are shaped by financial and ministerial issues in the Health Centre, "When I arrived here, I had more access to my superiors, the CEO, top managers. You start understanding how it works a bit more. The minister gives you an amount X. 50 people want a part of it. (…) The system is very complex." (Medical director 1-U, T1)

Commenting on different actors' credibility in the Health Centre, the medical director emphasizes how competencies are central (as opposed to positions in a hierarchy). This perception reflects the professional logic:

> I think there are human factors too. [The senior medical top manager] is a good politician. He is intelligent and has clear ideas. It helps transmit messages. When we listen to him, we do not feel like it is pointless. The clinical co-directors also built their credibility. Schemers are not accepted. I think – physicians think that it is pointless. But my [co-leader] and another clinical co-director inspire respect. It helps. The choice of the clinical co-directors is important. If the guy is arrogant or wants revenge, it will not work. (Medical director 1-U, T2)

The professional logic appears in the notes we took during a management meeting when the medical director represents physicians in attempting to gain resources, that is, push for the acquisition by the Health Centre of very expensive specialized equipment:

> For physicians, it is clear that "We do not have a choice. We must acquire the [specialized 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 sum, the boundary duo is composed of two individuals performing distinct parts of the dyads' tasks in a coordinated way. The two members jointly work on some issues, but mostly divide the work. The clinical co-director is guided by the managerial logic while the medical director's discourse reflects both the managerial and professional logics. The mission sometimes also appears, but does not appear to be central. The medical directors in boundary duos mobilize the mission discourse more than their clinical counterparts. Of all the configurations we are proposing, the boundary duo is the closest one to Gibeau et al. (2015)'s "distribution" configuration in which co-leaders' roles are specialized, differentiated and complementary.

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4.4.1.4. *Management Duo*

Like the boundary duo, the management duo is composed of two members coordinating their work but mostly working independently. Unlike the previous configuration, both members of the four management duos primarily emphasize the managerial logic in their discourse, as shown on figure 4.5. Although the references to the mission vary significantly from one dyad to the next, it is predominantly embedded in the managerial logic in the co-leaders' narratives.
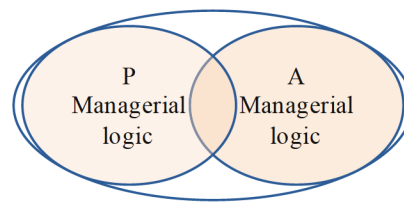
Figure 4.5. – Illustration of the Management Duo

Both members of a management duo describe the way they coordinate the work they independently execute:

> 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. (Clinical 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 managerial logic as the co-leaders explain how patients are part of their decision making process when managing resources. The managerial logic is also mobilized independently in the co-leaders' narratives. For instance, the clinical co-director expresses 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. It wasn't their part. They were saying, "We are practitioners." We are starting to get those doctors who practice to understand that they cost something.

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They do not even know the price of things. We are telling them, "every time a nurse is doing nothing, it is a waste of productivity." (Clinical co-director 6-U, T1)

In the medical director's discourse, the managerial logic is "pure" when he explains the efforts made to establish his dyad in the hierarchy by preventing physicians from bypassing it:

> 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, your project has to be presented to them."… (Medical director 6-U, T2)

In sum, the management duo is a dyad in which the two members emphasize the managerial logic when accomplishing independently but in a coordinated way the tasks associated with their role. Although the managerial logic is predominant in the co-directors' discourse, the mission seems to be embedded within as it guides decision making. Gibeau et al. (2015)'s "duplication" would be closest to this configuration as both co-leaders' focus on the managerial logic creates some overlap and little differentiation between their roles, interests and expertise.

4.4.1.5. *Management Unit*

The management unit is composed of two interchangeable members, both guided by the managerial logic. This configuration, illustrated on figure 4.6., was observed in four dyads.
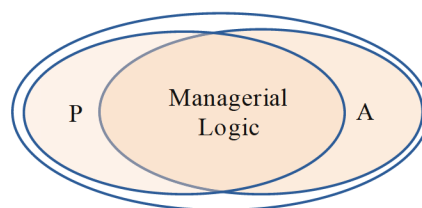
Figure 4.6. – Illustration of the Management Unit

As a clinical co-director and his medical co-director respectively put it, the dyad functions 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. (Clinical 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 is especially clear when he explains his vision for the organization, emphasizing budgets, human resource management and performance indicators:

> I want to prove… I want proofs that it [co-leadership] works. I want to become the highest performing Health Centre financially, in terms of human resources, but also in terms of care indicators. It is not currently the case. (Medical director 4-U, T1)

Both directors' perspectives appear in their analysis of one key organizational decision, the purchase of expensive specialized equipment. Both quotes reflect "pure" mobilizations of the managerial logic by emphasizing financial considerations and human resource management:

> An equipment that we wanted to acquire, we [administrators] wanted that physicians analyze it the same way [as managers] …with the same constraints: financial and human resources. (Clinical co-director 4-U, T2)

> We decided to purchase a very expensive equipment. The cost of operating it is very high. We said, "Here are the sources [of money]…here is how we can find the money to operate it." At the following meeting, the question was brought up again [by a physician], "How are we going to find the money to operate it? If we cannot find the money, what are we going to

do?" So the understanding of the different elements to consider to make a decision is not as instantaneous for them as it can be for me who almost spend 100% of my time doing management work. (Medical director 4-U, T2)

In two other statements reflecting the managerial logic, the co-leaders hence try to coach the physicians in management roles to explain and encourage them to consider the latter logic:

Often the medical directors will approve a research project – and it's okay, but the [implications of the project] haven't been analyzed (…) in terms of resources, changes in other professionals' practice. (Clinical co-director 4-U, T1)

Being in management as a "pure" medical director, I have many elements and a lot of information to answer people correctly. Not just in terms of the medical reality but in terms of organizational reality. [My arguments are so good that] people can only agree with me. Recently, I was asked "Why don't you hire nurses from private companies." I answered, "We do not want to have problems with expertise, competencies, because the sectors where we need nurses are often critical care units, emergency care. These nurses do not necessarily have the expertise to work in these units. And the minister set a limit on the percentage of nurses that can come from the private sector. We are bringing it down to zero. It wouldn't be a good idea to develop something that we do not have." This doctor had her answer. It made sense for her. She sat down and stopped there. It gives credibility to the organization when we can address not just the medical aspect but also all the organizational aspect in the explanations. (Medical director 4-U, T1)

In sum, the management unit is a configuration in which two members of a dyad are interchangeable and emphasize almost exclusively the managerial logic. Like the management duo, this configuration can be seen as "duplication" since the co-leaders' roles, interests and expertise may overlap significantly, if not completely (Gibeau et al., 2015).

4.4.1.6. Mission Unit

Two additional dyads were, like the management unit, acting in an integrated way. However, contrary to the previous configuration, the members of these dyads primarily emphasize the mission in their discourse, although the managerial logic also appears. The configuration is illustrated in Figure 4.7.
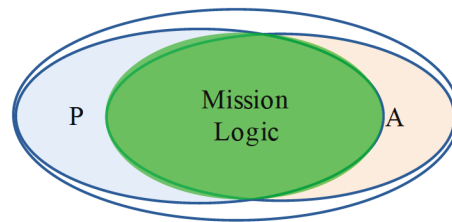
Figure 4.7. – Illustration of the Mission Unit

One of the mission units is described as accomplishing their 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 his directorate directly or indirectly – then they reflect together and really share." (Medical director 5-U, T1)

The clinical co-director refers to the mission frequently. In the following excerpt, the mission is embedded in the managerial logic as the director explains 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. We share the responsibility. (…) We have been deploying more efforts to break these silos for a year. Some people were confronted. The patient is OUR patient. If some people do not want to take care of them, we are going to move them aside. (Clinical co-director 5-U, T2)

The clinical co-director also mobilizes the managerial logic, which appears in the following quotes in which she insists 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. (…) We support the medical directors in their roles and responsibilities so when they accept the title, they have to accept what comes with it. (Clinical co-director 5-U, T1)

The medical director also emphasizes the managerial logic. His discourse repeatedly expresses 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. We also changed the structure of all our programs. (Medical director 5-U, T2)

Beside the managerial logic, the mission seems to guide the medical director's discourse. In the following quote, he explains how his role as medical director involves not only responsibilities toward patients but also toward the organization. Thereby, he frames the mission and managerial logic as converging:

I am the employee of a 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 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 Centre. Yes, I represent my patients and their needs in the Health Centre, but at the same time I have a responsibility toward my Health Centre who has the same mission as I have, which is to offer quality services. (Medical director 5-U, T2)

In sum, synergy is created by shared values (that is, the emphasis on the mission) in mission units. The co-directors act in sync to meet patients' needs. Beside the mission, the managerial logic seems to dominate the co-leaders' discourse. The two logics are mainly embedded or converging in the narratives. The mission unit may be closest to Gibeau et al. (2015)'s "duplication" configuration and involve a lack of differentiation in the co-leaders' roles, interests and expertise.

The six configurations illustrate the way dyads may play their co-leadership roles. However, dyads may share roles differently over time. The next section explores the evolution of some dyads' configurations.

4.4.2. The Evolution of Configurations Over Time

Of the 20 dyads we studied, the configuration of five duos changed over the course of the 21 months of the study. In this section, we explore these changes. Two of these dyads evolved toward more integration while two moved toward disintegration. The fifth dyad evolved in two phases: first toward more integration and then a growing disintegration. The configurations of the remaining 15 appear to be relatively stable over time.

We speculate that this stability may be explained by different factors such as these dyads' younger age and the nature of the efforts deployed to solidify the dyads in different organizations. At the Centre where no efforts were done, the little integration of dyads did not change over time. Stability was also noticed at the Centre where the dyads had been working together for only a few months when we met them during the second and final interview phase. At the two Centres where more efforts were deployed, we note changes toward more integration in the dyads who were most exposed to these attempts at stimulating integration. The dyads which remained relatively stable in these two Centres generally participated less in these efforts (such as training sessions, mentoring of dyads, etc.).

The first progressively integrating dyad first went from a professional consulting relationship to a boundary duo, and then to management duo. In the following quotation, the medical director describes her consulting relationship with her co-leader, "I think that I was able to contribute my understanding of clinical work, which she [the clinical co-director] was lacking a lot. (…) At first,

she was explaining issues to me, and once in a while, I had a little information to give her" (Medical director 17-SR, T1). The medical director then explains the turning point, an incident after which she collaborated on a more equal footing with her co-leader:

Something happened in February. The director of professional services was absent, and my co-director needed to talk to the director of professional services of another organization to solve a problem. I said, "I am going to take the phone and make the call. We have to discuss that doctor to doctor. As medical director, I think this is my role. " I think it was a turning point. I think my co-director realized I could be useful, that I was not an ornament. That the CEO had not told him, "Here, we are going to put an ornament by your side, dust is going to accumulate but once in a while ask him what he thinks." No no no. I wasn't an ornament anymore. I had moved and shaken things up. From that moment on, we have been working together on common projects (Medical director 17-SR, T1).

At this stage, the dyad constitutes a boundary duo since the co-leaders work independently and the medical co-director's discourse reflects both the professional and managerial logics. A second step of evolution in this dyad's configuration involved moving from boundary duo to management duo as the medical director's discourse increasingly reflects almost solely the managerial logic. In this quote, the centrality of the financial issues in the medical director's discourse is noticeable, "The deficit is huge. I feel the pressure. A lot. I feel the pressure on [my co-leader]." (Medical director 17-SR, T2).

The medical director's new emphasis on the managerial logic increasingly became apparent in the issues brought up during meetings:

I was present at the meeting [aimed at solving problem X], but people didn't recognize that I have the authority to make decisions. It was as if I were just a doctor. (…) We cannot define the roles among ourselves [the group of co-leaders at the strategic level]. We have to involve other directors so they understand that we are working in co-leadership and that when they

are talking to me, I am not just a doctor, I have the power to make decisions. They have to stop going beyond my back to my co-leader to confirm what I say. (Co-leadership implementation committee -SR, January 10, 2013)

In this excerpt, the medical director is emphasizing the managerial logic by insisting on how formal roles should dictate authority and influence.

Following a similar evolution, a second dyad went from a professional consulting to a management unit. The professional consulting configuration is expressed when the medical director explains how he shares his expertise with his co-leader:

> I contribute first as a physician, and second as a professor of medicine. My academic perspective shapes the way I see how a teaching hospital should function. It might be what I am bringing. And I am the representative of my patients. (…) I am not only there to represent the physicians of the directorate, I am there to represent the patients. (Medical director 7-U, T1)

The clinical co-director illustrates this consulting relationship when describing the importance of the medical directors' contributions to administrative work:

> Organizing services has never been their thing. They want to know if we can give them the team to do it. They do not want to start hiring nurses and deal with job types. They want to express the need and that we organize it. I do not know if we always need to be together. (…) I strongly believe that we need to hear what they have today about the organization of services. (Clinical co-director 7-U, T1)

Hence, the duo's configuration was first characterized by the clinical co-director's accomplishment of most of the dyad's work and the medical director's contribution as representative of physicians and patients. The medical director then comments on the evolution of the dyad's configuration, arguing that the relationship between the co-leaders is increasingly integrated:

I think the medical dimension of co-leadership is changing, it is progressing. I think that the co-leadership dyads are closer and closer. Our expertise increasingly intersect. Before, I felt stuck in my medical expertise. I cannot speak for [my co-leader], but I think that he felt stuck in his role too, in his expertise. We are now trying to create a mixed expertise, we [co-leaders] are forced to share a lot more. We [medical co-directors] are forced to gain administrative expertise and our co-leaders are forced to gain some kind of medical expertise for our expertise to meet and to really discuss together. (Medical director 7-U, T1)

This growing integration is also portrayed by the clinical director, "We complete each other better and better. (…) We are like a brain. The creative part to the left and the organizational, methodical part to the right." (Clinical co-director 7-U, T2)

The configuration of two other dyads is evolving in the opposite direction, with a growing disintegration. The first dyad's members describe their initial consulting relationship by highlighting the nature of the contribution of the medical director:

My influence is in my medical expertise: what do I want as a physician in this directorate. I try to influence administrators to help not only me and my close colleagues, but all the physicians working in the directorate. (Medical director 19-PC, T1)

[The medical co-director] brings her knowledge of the needs in the community, all the needs we need to fill. She feeds me. She is well connected. (Clinical co-director 19-PC, T1)

During the second round of interviews, both co-leaders painted a different picture of their dyad, insisting on the decision of the medical co-director to withdraw her involvement in the role. The co-leaders are hence describing a dyad of one:

I stopped going to meetings. (…) I said I was willing to participate to decision making, but that I wanted to be invited when issues concerning me were being discussed. (…) I have

other things to do, I have patients to see. So I decided to stop. Nobody contacted me. Nobody – [my co-leader], administrators – nobody asked me why I wasn't coming anymore. Nothing. Zero. (Medical director 19-PC, T2)

[My co-leader] was absent, I tried to contact her a few times but had no answer. After I learnt that she was on holidays and we were involved in a big project. I didn't communicate with her after that. (…) I am not looking for the guilty. I tried to reach her a few times but she never called back. (…) Co-leadership is a shared responsibility. We both have to keep it alive. (Clinical co-director 19-PC, T2)

Another duo went from a boundary duo to professional consulting configuration. The medical director explains this transition by highlighting his limited power:

At first, I was very motivated. As soon as I got an e-mail, a demand, a problem, I tried… I am a man of action. I have to find solutions and move forward. I hit a wall. Right from the start, during the first months. I realized that I had been given responsibilities but very limited power and means. I like to pedal when there is a chain. When I pedal and the bike is not moving forward, I keep my energy for something else. So I stepped back a little bit, and I became less proactive. I wait. When I am asked to do something, or what I think about something, I respond. I make propositions, and say, "Go ahead, test it. Ask those who have power if they are interested in using my solutions." But I do not do it myself anymore. (Medical director 9-U, T2)

Both co-leaders describe the consulting relationship by painting a similar image of their dyad:

He is going to let me lead many projects that are more administrative. Some more strategic decisions, we make together. Other things, he says, "It's okay, take care of it, I have too much work anyway." (Clinical co-director 9-U, T2)

My co-leader takes care of most projects. She solves many problems. I know that if she is not sure she is going to discuss it with me. If she needs a medical opinion, she is going to ask me.

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But she is in the driver's seat. I am beside her. She sometimes lets me drive, but in general she is in the driver's seat. (Medical director 9-U, T2)

The fifth dyad first went from professional consulting to boundary duo, and then back to a professional consulting configuration. In the following citation, the medical director describes the initial relationship between the co-leaders as involving sharing his expertise and bringing physicians and managers together when asked to:

My role definition… the difficulty as a physician in management is the time I have to offer. I am paid 4 hours a week. The rate is much lower than what I make in a clinic. (…) You are asking me about my role and I am starting by saying that it is hard to accomplish because I do not have much time to offer while [my co-leader] is working 50-60 hours a week in the directorate. I spend 4 hours and some weeks I cannot even do it. Hence, my role is to support [my co-leader], to bring my medical knowledge, to facilitate communication between physicians and managers, to give my point of view on the services we are organizing. The official definition is wider than that, but… (Medical director 16-SR, T1)

The clinical director commented on the growing integration in the dyad, attributing it to the efforts made by the co-leaders to function in a more structured manner: "We had more structured meetings, we planned them taking our constraints into account. Now we write the objectives of our directorate together. We choose the performance indicators together." (Clinical co-director 16-SR, T1)

The co-leaders then work independently to achieve these objectives. Acting as a bridge between physicians and administrators to explain both groups' perspectives is the main contribution of the medical director:

What I can contribute to [my co-leader] is to be able to talk on an equal footing to physicians. I can sit them down around a table when I invite them to participate. I can understand their

language when they explain what they see in their practice. I understand, I have done the work myself, I know what they are talking about regarding the scarcity of nurses and their difficulty reaching specific objectives. I understand this side. (Medical director 16-SR, T1)

At later stages, the dyad went back to a professional consulting configuration in which the medical director reduced his involvement and bridging activities to contributing on demand. He describes how he stopped attending the meetings to which he is invited but shares his point of view when asked to:

I haven't been to the two meetings in which physicians were invited to participate to strategic planning process. I discussed it with [my co-leader]. He asked his teams to gather ideas. He showed me the result. The planning was mostly done in the top management team. They made a plan, [my co-leader] showed me and I approved it. I didn't play an important role. I know it is important for the organization, strategic planning and all that. (Medical director 16-SR, T2)

The clinical director describes the configuration in a similar manner:

I inform the physician. I must inform him a lot of what is happening in the directorate, the services we offer, the ministry's requirements. Then we look at the statistics, the performance indicators. I paint the portrait of the situation. He might say, "This is missing." (Clinical co-director 16-SR, T2)

Beside the six dyads we used to illustrate our typology and the five dyads whose configurations evolve over time, we studied the role playing, discourse and bridging activities of nine additional duos. The configurations of these additional dyads are illustrated by quotes in table 4.4. located in appendix 2 of this article. In the next pages, we discuss the theoretical implications of our findings.

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4.5. Discussion

In this study, we investigated *whether and how co-leadership models enable the bridging of different institutional logics.* Our results suggest that the minimal equilibrium between the logics required to bridge them appears to be very difficult to achieve and maintain within dyads. Configurations tend to result in the separation of logics, the submission of one logic and/or the cooptation of one co-leader. Hence, the tensions between the logics present at the organizational level appear to be mirrored within the created dyads. Nonetheless, it appears that co-leadership models possess the greatest potential for bridging logics when the dyads function as boundary duos. Except for these duos, most co-leadership arrangements are dominated by one logic, either because the member adhering to the other logic seldom contributes (as in dyads of one), or because both members predominantly represent the same logic over time (as in the management duos and management units). Co-leadership may also help bridge logics when both co-leaders repress their original logics to focus on a third overarching principle. In this study, the mission units demonstrated this type of bridging. Co-leadership models may additionally be an interesting strategy to reinforce the dominance of one logic. Indeed, the model appears to ease the cooptation of individuals embedded in a secondary logic.

In the next pages, we position the results in relation to existing studies. Table 4.5. provides an overview of this discussion by highlighting how the configurations fit in relation to existing typologies of configurations of dyads and theories on responses to institutional complexity.

		Studies on Configurations of Dyads		Response to institutional complexity at the level of the dyad (based on the typology developed in the literature review at the organizational level)	Co-leaders' individual response to institutional complexity (based on the typology developed in the literature review at the individual level)
		Fjellvaer (2010)	Gibeau, Reid, and Langley (2015)		
Configurations	**Dyad of one**	Dominant-dominant	Disconnection and dominance	Separation of logics	Conformity to a logic and rejection of the other logic by both co-leaders
	Professional consulting	Dominant-dominant	Dominance and some disconnection	Separation of logics	Conformity to a logic and rejection of the other logic by both co-leaders
	Boundary duo	Dominant-balancing	Distribution	Integration of logics and possible partial conformity to all logics	*Professional co-leader:* integration of logics *Administrative co-leader:* conformity to a logic and rejection of the other logic
	Management duo	Dominant-dominant	Duplication	Rejection of one logic	Conformity to a logic and rejection of the other logic by both co-leaders
	Management unit	Dominant-dominant	Duplication	Rejection of one logic	Conformity to a logic and rejection of the other logic by both co-leaders
	Mission unit	Balancing-balancing (mission and managerial logics)	Duplication	Alteration of demands to form something new	(Not reflected in the typologies in the existing literature)

Table 4.5. Table Positioning the Results in Relation to Existing Theories

Previous studies on co-leadership configurations identify three kinds of configurations: balancing-balancing, dominant-balancing and dominant-dominant (Fjellvaer, 2010). Our typology reflects these configurations, but contributes by showing that co-leaders' individual patterns of mobilization of logics does not automatically translate at the dyad's level. Indeed, our results suggest that dyads in which both co-leaders follow *different* dominant logics may experience growing disintegration, sometimes leading to one co-leader's withdrawal from the role. As a result, only one logic characterizes these dominant-dominant dyads' work. Likewise, when both co-leaders emphasize the

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same logic, only one logic is represented in these dyads of dominant-dominant. 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 managerial logic with the mission. We did not witness balancing-balancing configurations in which both members would be balancing the professional and managerial logic. 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 generally dominates.

Other typologies suggested in the past classify four configurations: distribution, dominance, duplication and disconnection (Gibeau et al., 2015). Our boundary duos reflect the authors' "distribution" configurations, and seem to be closest to "ideal" 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 very little interactions, if 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 and conflicts of the configurations caused by the lack of differentiation between the roles, interests and expertise of the co-leaders, 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. Professional colleagues may indeed be reticent to accept the

leadership of a co-leader having been coopted into the managerial 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 de-emphasis by both co-leaders of the logic of their original profession and their mobilization of an overarching principle expressed in this case by the "mission". This conclusion is coherent with Dass (1995)'s observation that joint broader objectives allow dyads to effectively work together and could be seen as integrating and revising demands to form something new (Battilana & Lee, 2014; Kraatz & Block, 2008; Mair et al., 2015; Oliver, 1991; Pratt & Foreman, 2000; Skelcher & Smith, 2015). Reay and Hinings (2009)'s mechanism of working together against a third party (in their case the government) to manage the rivalry of competing logics is also coherent with this configuration since the co-leaders were joining forces to work for the patient, often positioning themselves as working "against" top managers. This de-emphasis does not mean that the individual is not embedded in either the professional or managerial logic, but that he or she reordered the logics when playing his/her co-leadership role.

Our findings also have theoretical implications in relation to the literature on organizations' responses to institutional complexity. As Greenwood et al. (2011) would put it, the organizations implementing a co-leadership model are attempting to move from a structural differentiation to a blended hybrid structure. Although this model might be seen as positive hybridity (Fossestol et al., 2015) or a cumulative response (Battilana & Lee, 2014; Kraatz & Block, 2008), the configurations of the dyads might actually reflect different responses. Indeed, when dyads constitute management duos, management units or dyads of one, the response to institutional complexity might actually reflect non-hybridity (Fossestol et al., 2015). When dyads embody boundary duos and professional consulting configurations, we are witnessing negative hybridity (Fossestol et al., 2015). Ad hoc and positive hybridity may actually be more marginal, although some boundary duos may create these forms of hybridity.

Likewise, our results suggest that the configurations mostly reflect Battilana and Lee (2014)'s dismissing of institutional demands from one source (in the dyads of one, management duos,

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management units and mission units) and separating or cumulating of demands (in the case of boundary duos and professional consulting). The creative response involving the integration of demands to form something new appears limited. Instead, our findings corroborate Pache and Santos (2010a)'s conclusions that combinations of intact practices from different logics are more likely than hybridization. The mission unit nonetheless can be seen as a creative response.

At the individual level, the results suggest that the administrative co-leaders mostly remain anchored in the managerial logic, although the logic may be less predominant when mission unit configurations emerge. The professional co-leaders, although they are professionals playing management roles, do not necessarily become hybrids. This result supports Lega and Sartirana (2016) and Kuhlmann, Rangnitt, and von Knorring (2016)'s claim that hybridity may not be easily achieved. As Correia and Denis (2016) suspected, it cannot be assumed that professionals in management will adapt their professionalism to managerialism. Instead, the professional co-leaders may remain loyal to the professional logic (in the dyad of one and professional consulting) or be co-opted in the managerial logic (in the management duos and units). In all these cases, the co-leaders can be seen as responding to institutional complexity by compliance to one logic and in some cases defiance of the other logic (Pache & Santos, 2013). The professional co-leaders may alternatively mobilize multiple logics in their discourse as in the boundary duo and mission unit. In the first case, the professional co-leader can be seen as a hybrid embodying both the professional and managerial logics who, in Pache and Santos (2013)'s words, combines the two logics to respond to institutional complexity. McPherson and Sauder (2013) would see them as creatively using multiple logics to reach their objectives. Taken at the individual level, the mission unit suggests an alternative response to institutional complexity that has not been discussed at the individual or dyadic level, the subordination of the original logic to a third overarching principle or logic. Coherent with McPherson and Sauder (2013)'s conclusion, these results suggest that the logic individuals adhere to must be examined carefully since the commonly held assumption that individuals will predominantly mobilize the logic of their group (professional or organizational) does not hold. Similarly, professionals in management cannot be assumed to be hybrids as some may

predominantly mobilize only one logic despite their bridging role. Beyond this discussion at the individual level, our objective was to understand the potential of co-leadership to bridge logics at the level of the dyad. These results suggest that dyads may bridge logics when one member becomes a hybrid, when a dominant co-leader sporadically exploits the expertise and influence of his counterpart who embodies a different logic or when both co-leaders de-emphasize their original logic to focus on an overarching principle.

Over time, there appears to be little change in the logics the co-leaders mobilize, which suggests that working in close collaboration with an individual embedded in another logic has little impact on the logics reflected in one's discourse. We nonetheless noticed a few medical co-directors' movements toward the managerial logic. More generally, our results indicate that the pattern of mobilization of logics may not be predictable or sequential as suggested by Blomgren and Waks (2015). Although the configurations of most dyads did not change over time, our results suggest that dyads whose configuration changed may go toward either more integration or disintegration.

In sum, the co-leadership model's potential 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. In itself, the model can contribute to bridging logics, separating logics or reinforce dominance.

4.6. Conclusion

Overall, the study contributes to the literature on responses to organizational complexity by exploring a different way of bridging logics: co-leadership. 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 counterpart who embodies a different logic or when co-leaders dampen their original logic to an overarching

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principle. The model also seems to be useful to reinforce the dominance of one logic when both co-leaders follow one dominant logic, whether the co-leaders' logics are the same or different. The study also reveals that the balance between different logics is not easy to establish and maintain within a dyad, the tensions present at the organizational level being mirrored within the dyad. Separation, submission or cooptation of one logic often results.

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 an hybrid (Blomgren & Waks, 2015)). Although it 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 also may 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 to invest in developing management skills are indeed more limited. Finally, cultivating mobilization toward an overarching principle in the dyad helps bridging. Management duos and units, differently, can be exploited to coopt members of a different logic.

From a process perspective, the results suggest that the configurations of the dyads should not be expected to evolve naturally toward more integration over time. If more integration is hoped for, concrete efforts would probably need to be deployed to force closer collaboration. Similarly, co-leadership does not appear to lead naturally to major changes in adherence to logics. Different initiatives to force greater socialization such as training, joint meetings or coaching may be necessary. In this vein, the co-leaders should have regular scheduled meetings to interact together and ensure that the collaboration is constructive.

The conclusions also suggest practical implications for the selection of the co-leaders and definition of the roles. Mutual selection of the co-leaders would contribute to developing a better relationship between the two. Cognitively, the co-leaders should be neither identical nor opposites to allow complementarity, differentiation and specialization. Role definitions should not be too specific or ambiguous to allow a basic common understanding of the role while giving space for maneuvering.

The study has some limitations. First, we study organizations in one sector. Additional insight could be derived from studying organizations from other sectors such as law, education, media or creative organizations. The specificities of these settings might offer a different understanding of the dynamics. A second limit stems from our decision to focus on the strategic level in this study. Different findings might result from exploring co-leadership at the tactic or operational levels. In this study, we focused on the configurations and their evolution. However, it would be interesting to explore how the emergence and transformations of these configurations may be explained at the individual, relational and organizational levels. Professional co-leaders' self-selection, the nature of the connection and communication between the co-leaders, the mutual selection or imposition of co-leaders, the extent of socialization and the degree of role specification or ambiguity may constitute factors shaping the configurations.

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Table 4.6. Definition and Illustration of Codes

Code	Definition	Typical Quote
Pure	When only one logic is mobilized.	[Pure professional logic] It's obvious that our first preoccupation is interference. We always feel that they try to make us do what they want, but we are physicians, we are autonomous professionals. (…) We must be the first to say what our needs are, not them imposing, "You are going to practice this way." Recently, it happened again. We were thinking, "It's horrible, they cannot impose that." (Medical Director 18-PC, T1) [Pure managerial logic] I think it takes a clear revision and an official document to define the roles and responsibilities. (…) The board decided that co-leadership would be our governance model here. If the board decides this, people must submit to it. When it doesn't work for them, people have questions to ask themselves. Should they continue working here or…? We do not make the board change. The orientations have been defined. I think it is going to be done here. We just need some time for the CEO to position things clearly. (Clinical Director 13-R, T2) [Mission] I am not shy to say, "What we need to do is humanize care." (…) It is a message and this message must be repeated. It must be simple, clear and repeated. I do that with administrators and with physicians. (…) I try to stay calm, stay positive, stay optimistic and repeat a simple and clear message. Ad nauseam. (Medical Director10-R, T2)
Opposing and positioning	When two logics are presented as conflicting and the participant explains preferring one over the other.	[Opposing the management and professional logic. Positioning in managerial logic.] The vicious aspect of the scarcity of physicians is… In interviews, they say, "I want to work in the intensive care unit." We say, "Our needs are at the long term care facilities." They answer, "No, I want to work at the intensive care unit." We accepted that person and did not send her to the long term care facilities. Today, we say, "We need you at the long term care facilities." If she answers "No, I want to work at the intensive care unit", then "Sorry, this is all we can offer you." Physicians always got what they wanted, but not anymore... (Clinical Director 10-R, T2) [Opposing the management and professional logic. Positioning in managerial logic. Mission is embedded in the professional logic] [Being involved in management] allows you to see that, to understand that budgets are not unlimited, that we cannot do everything and that often physicians are not aware of that. They think that the best if for the patient in front of them at

		that time. But we have to look at the big picture. When you look at the big picture, you see that if we do X for patient Y, we are eventually going to have difficult choices to make. (Medical Director 6-U, T1) [Opposing the management and professional logic. Positioning in professional logic.] No one can force me to deny reality. I don't have an ejectable seat. We all know that you can make numbers say anything. I don't depend on anybody, I have a liberal profession. If what I am told is not true, I am allowed to say it. It is my responsibility to say it well for the common good. 99.9% of administrators are good people. They hope to improve things, but their hands are often tied. Even more often, they are not allowed to talk. But they think the exact same thing. (Medical Director 7-R, T2)
Converging	When logics are presented as parallel considerations eventually leading to the same actions or decisions.	[Mission and managerial logic] The project is amazing. It is going to take us forward. I am going to use it to push things that I want, and it is going to make us move forward. It allows me to see even more patients. And to offer better care. It will contribute to meet clients' needs, quality standards, budgetary constraints, strategic orientations, resource management. It is as much a tool to touch more patients directly and to reduce complications, as a strategy to reduce the average length of stay. It impacts the budget, it will impact other directorates. (Medical Director 17-SR-T1) [Mission and managerial logic] The effect of the aging population on our region was studied. We always plan three years in advance, but we wanted a longer prevision so we made prevision until 2020. What we notice is that almost 500 places will be missing. It is major. What do we do to counter that? What do we do to support and maintain people at home as long as possible? And there is a strong pressure coming from hospitals. Many people are waiting for a place in a long term care facility in the short term care facilities. How do we accept these people if we have no space? While these people are waiting in hospitals, they cannot fulfill their short term care mandates. It becomes very complex. We develop all sorts of strategies. We don't always have money to do it. We work very hard to optimize our use of resources. As clinical director and as tax payer, I want to make sure that our use of resources is optimal before we consider investing. (Clinical Director 10-R-T1) [Mission and managerial logic] I am able to identify the needs of my employees, the needs of the clients, the path they need to follow, the support they need. (Clinical Director 4-U-T1) [Mission, professional and managerial logic] The most important is that our expertises cross. This interaction allows us to jointly accomplish things that take into consideration the problem of the patient, medical considerations, all the professionals working around the patient and

		management preoccupations - budgets. That is the strength of the co-leadership dyad. (Medical Director 7-U-T1)
Embedding	When one logic is presented as being inserted in another or as the basis for actions and decisions within another logic.	[Mission embedded into the managerial logic] The influence of dyads in other directorates remains limited. In our directorate, the position of dyads evolved significantly, but it needs to be improved in other directorates. I think that we are going to succeed only if we are able to manage patients' trajectories at the strategic level. We are currently deploying – implementing the trajectory in [gynecology]. As soon as each directorate is able to position itself on the trajectory, we will be able to change the culture and the links between people. (Medical Director 4-U-T1)

[Managerial logic embedded into the professional logic] [Forcing the replacement of a chief of medical department] was pretty simple. We discussed our dissatisfaction in a top management meeting. (…) We decided to organize a meeting – I organized a departmental meeting. All the members told me, "Thank you, we haven't had a meeting in nine months. We are happy." They were all present. (…) I talked to the chief of medical department before the meeting, "I heard that you don't want to be chief anymore. Are you ready, because it is going to happen during the next meeting." The team knew who was interested to take on the role, but we did a little voted. (Medical Director 16-SR, T2)

[Mission embedded into the managerial logic] The ministry is making demands, that some patients be seen in specific delays. Cancer patients must be operated within four weeks. Patients with cataract within X weeks. I would like the chiefs of medical departments to organize their service and distribute their resources to permit that these delays will be respected. (Medical Director 1-U, T2) |

Appendix 2 - Table of Supporting Data Illustrating the Configurations of the Additional 9 Dyads

Table 4.7. Table of Supporting Data Illustrating the Configurations of the Additional 9 Dyads

Type[7]	Dyad	Configuration
Professional Consulting	Dyad 15 - SR	I built the action plan, but [my co-leader], that's her strength, that's her expertise. I built it, but she read it and made comments. (Clinical co-director 15-SR, T1) When I work with [my co-leader], I bring a point of view that she does not have, a medical perspective. It seems to help her. It seemed to help her. She looked happy to have my opinion. (…) The way we work is, she works on projects and she lets me know when she needs me. (Medical director 15-SR, T1)
	Dyad 13 - R	I am not omniscient. I do not know much in medicine. Physicians know about medicine. When you organize services, there are two things: the medical part for the patients we care for and the development of a care plan. It belongs to the medical part. However, how to manage the care plan is administrative. It belongs to me. (…) To put patients at the core of our preoccupations, we need to have medical and administrative co-leadership. (Clinical co-director 13-R, T2) We do not have rules stating how we should function. It means that if – let me give you an example – they do not want my opinion for a situation tomorrow, they can because I have an advisory role. So if they ask my advice, yes, but they do not have to. (…) I do not have this role of saying, "I need to be informed of this." (Medical director 13-R, T2)
	Dyad 8 - U	There is the vision, the medical side, which is why we are developing one service instead of the other. How are we going to mobilize physicians to change. To talk to a physician, it takes a physician. It's okay, but this leadership needs to exist, and sometimes these are issues. Issues of compensation, issues of professional development. It can be any issue that [my co-leader] has access to but I do not. That input is important. To see from a medical standpoint where we want to go, how are the teams going. I manage managers. I try to see where they stand and if they are comfortable in their role and what the difficulties are. (…) I was physically [in establishment X] for a year but [my co-leader] wasn't there much. I played that role a lot of trying to see where they stand, what they want to do. To bring the information to [my co-leader] Sometimes I was wondering if I was going beyond my role. (Clinical co-director 8-U, T1) It is only when there are problems that are impossible to solve in the department – we discuss it together. Otherwise, human resource problems, [my co-leader] is taking care of that. They rarely talk to me about problems with secretaries or day-to-day problems. (Medical director 8-U, T1)

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[7] Note that only the configurations of the 9 additional dyads are represented in this table. Hence, not all the configurations are illustrated here.

Boundary Duo	Dyad 12 - R	We are discussing how to articulate our services together to have a vision that makes sense, cohesion in our services, to connect our preoccupations or the medical vision with the administrative vision. We bridge a little bit. We try to bridge and decide on a common direction that would meet all our needs, all our realities. There is some negotiation. We sit down and discuss, "How do you see this?" In the end we reach a compromise that is realistic for both of us, that challenges us both. I think that [my co-leader] is aware that often, there aren't easy solutions. Usually, when one of us says that there is an easy solution, within 5 minutes we agree, "Maybe it was just my vision which was easy." In reality there is a reality that we do not know, but we are learning about it. (Clinical co-director 12-R, T2)
		The way we decided to conceptualize it, (…) I am a kind of "symbiote". [My co-leader] is the clinical co-director. The clinical co-directors are lacking two things: vision and medical expertise. (Medical director 12-R, T2)
		As administrators, we open management to the medical side, but the medical side does not open to management. [The medical co-directors] must bridge the two, but I am struggling to see the other bridge. I enjoy having this bridge, but at the same time I think that it is one sided right now. We are the ones working to adapt and saying, 'We have to work together.' But beside that one doctor (the medical co-director), how is the rest following? I have no idea. The medical co-director is getting closer to me, to all the top management team, she works with all the administrators. My only link remains that doctor. I do not have more links with the medical representatives… So I am not closer. I am closer to one physician who currently is the bridge. (Clinical co-director 12-R, T2)
	Dyad 2 - U	Having worked with [my co-leader] in the past, having known him for a long time, and I think that there is a good chemistry between us. I think it is very interesting. Often, I think that we use each other, "What do you think of this? How do you see this?" Sometimes I bring the medical aspect. We experienced this problem with the staff and things like that. Perhaps I bring the medical aspect. [My co-leader] is going to tell me, "The nurses, the staff had this problem with physicians." (Medical director 2-U, T1)
		I like co-leadership because I do not see myself dealing with nursing problems without the nursing training. I think that [my co-leader] is happy that I can discuss ideas with physicians, and that he does not have to do it. But that we defend ideas together. (Medical director 2-U, T1)
	Dyad 3 - U	I take care of human resources, administrative work, budgets. [My co-leader] is more involved in the medical decisions. But curiously, whether it is a medical decision or an administrative decision, we make it together most of the time. We discuss it and take time to… Generally, if I decide to add a position, I am going to discuss it with him. If I decide to cut a position, I am going to discuss it with him. Same thing if we want to implement a new analysis. It is going to require mostly his expertise. (Clinical co-director 3-U, T1)
		There are things that [my co-leader] does that I am not involved in. Human resources planning, for instance. I don't get involved unless it concerns doctors. Regarding the information system, I contribute my knowledge of the clinic, of the medical practice. [My co-leader] can't have that. Some projects I organize. I plan the sequence of events for the years to come. I do my part. But the financial aspect, I don't touch it. (Medical director 3-U, T1)

| **Management Unit** | Dyad 11-R | When I was a medical representative, [my current co-leader] was director and we were working very closely together. We learnt to work together. I do not think we have problems working together. It is going very very well. Very very well. (Medical director 11-R, T2)

We meet once a week [my co-leader] and I to discuss everything we are trying to implement. We sometimes have joint meetings, sometimes he has meetings, we discuss it. Every week, we discuss the different projects. We take concerted actions. For instance when there are problems with the teams, we take concerted actions. We discuss the budget, we talk about the managers, we talk about the difficulties with the medical practice. It is quite large. (Medical director 11-R, T2)

I have been very lucky because [my co-leader] and I already knew each other. I have a plan. [My co-leader] participated in developing the plan so she already knew the priorities. (Clinical co-director 11-R, T2)

Medical director 11: The medical directors are not accepted in my directorate, they do not even talk about us. How can you manage at the strategic level when your role isn't accepted at the operational level? (Notes taken during a top management meeting-R, October 23, 2013)

Medical director 11: Our roles have to be clarified. (Notes taken during a top management meeting-R, October 23, 2013) |
|---|---|---|
| | Dyad 14-SR | Increasingly, we do not waste our time explaining all sorts of things. We say, "We were asked to do this, what do you think? What decision do we make?" (Clinical co-director 14-SR, T2)

It is important to insist on the explanation of the co-leadership model. It think that there is work to be done with medical representatives as well as top managers. Some issues, I believe, should be left for us to solve when they are brought up too high in the hierarchy. I think. We would avoid losing legitimacy. I am not asking for more work. I have plenty. But if we do not have any credit, there is no point [to these co-leadership roles]. (…) If we are seen as an obstacle to avoid, there is no point in co-leadership. I think top management should say, "We cannot respond to your demand until the co-leaders examine it." (Medical director 14-SR, T2) |

Mission Unit	Dyad 10-R	I enjoy having a [co-leader] in a project of this scope. The project allows us to bond. It allows us to challenge one another and see how we converge. We both focus on the clients' needs. (…) [My co-leader] has the same perspective. I enjoy it: we are on the same page. The rest is easy. When you have strong values, that you are grounded, decision making and developing a vision is much easier. (Clinical co-director 10-R, T2) The status quo is not an option, and I think there is a nice chemistry between [my co-leader] and me. At first, we had a nice meeting. We discussed the vision. We have very similar visions. Our visions fit very well together. We feed each other. We really want to take elderly care to the same place. (Medical director 10-R, T2) Clinical co-director 13: We have the same vision. We are focused on the client. It's easy to manage and make decisions. We converge on the same values: the client. (Notes taken during a top management meeting-R, November 06, 2013)

CHAPITRE 5

ARTICLE III: Introducing Professionals to Management Roles: Enhancing or Weakening Decision Influence Through Legitimacy Work

Abstract

From originally being centred around and managed by the professionals themselves, some professional organizations such as healthcare systems evolved progressively through the integration of management professionals to physicians being represented by only one individual on the top management team. Some efforts are currently deployed to bring medical professionals back into management through their integration into top management roles aimed at increasing physicians' influence on strategic decisions. However, creating the roles and identifying role holders do not guarantee their influence on strategic decisions. In this article, I hence examine *how and why does the introduction of professionals into senior management roles shape (or not) their influence on strategic decision processes over time?* I am hence uncovering the legitimacy work practices that can legitimize or delegitimize individuals' participation to strategy. I relied on interviews, observations and document analysis to answer this question. My results suggest that (1) proactivity and passiveness, (2) structural adjustment and inertia, (3) making and restricting space as well as (4) empathizing and misunderstanding are the practices used to respectively legitimize and delegitimize medical directors' legitimacy to influence strategic decision processes. My results also suggest that a surprising number of practices made to establish or solidify influence have unintended *de*legitimating consequences. Such practices seem to have significant consequences as they are often done publicly and by the actors attempting to implement the change.

Keywords: Strategic Decision Processes, Legitimacy Work, Influence, Physician Managers.

5.1. Introduction

Multiple and ambiguous objectives and values, shared power and influence as well as distributed knowledge required for decision making characterize a number of today's organizations. These pluralistic settings pose particular challenges as different, sometimes contradictory logics evolve side by side (Denis et al., 2005). These logics can be defined as "the socially constructed, historical pattern of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Ocasio & Thornton, 1999, p. 804). Confronted with such tensions, healthcare settings across Europe and North America have been deploying significant efforts to uncover mechanisms that would help generate coherence between the somewhat conflicting managerial and professional logics (Baker & Denis, 2011). Put simply, the organizing principle of autonomy core to professionalism dictates behaviours and decisions differing, occasionally even conflicting, from those prescribed by managerialism's search for efficiency, control and cost-cutting (Reay & Hinings, 2009).

The integration of medical professionals into senior management roles has been the cornerstone of recent efforts to bridge managerial and professional logics in the healthcare sector – a prototypical pluralistic setting. Behind these initiatives lies the hope that these participation mechanisms will contribute to bringing the management and professional communities to move forward constructively toward overarching goals (Denis, Langley, et al., 2012), as well as the assumption that organizations will benefit from involving physicians in the decision making process (Denis et al., 2013). For the purpose of this paper, I adopt Mintzberg, Raisinghani, and Theoret (1976)'s definition of strategic decision processes as "a set of actions and dynamic factors that begins with the identification of a stimulus for action and ends with the specific commitment to action… Strategic simply means important, in terms of the actions taken, the resources committed or the precedents set" (p. 246).

However, integrating medical professionals into management roles does not necessarily mean that

they will be able to exercise more influence. This study hence seeks to answer the following research question: *how and why does the introduction of professionals into senior management roles shape (or not) their influence on strategic decision processes over time?* I thus aim to uncover the practices that legitimize or delegitimize professionals' participation in strategy in the context of a structural change. Inspired by Suchman (1995), I see legitimacy as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions." (p. 574) Building on Treviño et al. (2014)'s work on legitimacy work practices, I define "legitimating practices" as the work individuals engage in to build legitimacy and "delegitimating practices" as the efforts deployed to limit or reduce legitimacy.

Beyond providing a new perspective on a different way for the professional and managerial logics to coexist: co-management, this study makes contributions to three debates in the literature. First, this study contributes to answering Fitzgerald and Ferlie (2000)'s and more recently Correia and Denis (2016)'s calls for efforts aimed at better understanding professionals' responses to events and part in shaping them, going beyond the more widely investigated impact of changes on professionals (see for instance (Adler, Kwon, & Heckscher, 2008) or the assessment of managements' practices in shaping events (Gillies et al., 2001). Second, this research contributes to our understanding of structural changes by uncovering mechanisms through which new positions are legitimized (as opposed to simply implemented) in a structure to allow role holders to perform their role (in this case influencing strategic decision processes). Indeed, I argue that creating a role and assigning it to an individual is not sufficient to guarantee that this individual will be able to accomplish his or her role, especially in positions of leadership and influence or in professional contexts (Baker & J.-L. Denis, 2011). Third, I contribute to the literature on legitimacy work by identifying practices used to legitimize and delegitimize as well as their use over time. Reaching beyond Reay and Golden-Biddle (2006) and Reay, Golden-Biddle, and Germann (2006) who mobilized institutional theories to uncover role holders' actions to establish their new positions, I explore the efforts of all internal stakeholders. I argue that other members of the organization must

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adapt to varying degrees to the new role for its establishment. Through these adjustments, actors may create space to allow the holders of the new role to exercise influence. Further, actors may be guided by different interests, some even overtly or covertly not wishing for the introduction of the new role. These actors' efforts, I argue, cannot be ignored. Put simply, I am trying to uncover how the activities of multiple actors within the organization contribute to enabling (or not) newly appointed individuals in new management roles to exert influence on strategic decisions. Beyond these contributions, the article constitutes a response to Kirkpatrick's (2016) call for research on the impacts of integrating professionals in management roles.

The current body of knowledge offering a foundation to my efforts to answer the research question is limited. Nonetheless, the next section explores existing research on legitimacy work. An explanation of the methodological choices made follows. The findings will then be presented, followed by a discussion. Future research avenues will finally be put forward, and the limitations of the study acknowledged.

5.2. The Literature on Legitimacy Work

The body of literature on legitimacy work mainly focusing on new occupations, roles or practices is growing, yet still limited and fragmented. Some scholars explored organizational legitimacy (Elsbach & Sutton, 1992; Golant & Sillince, 2007; Kostova & Zaheer, 1999) and the legitimation of new organizational forms (Suddaby & Greenwood, 2005; Zucker, 1989). Others examined the legitimation of new occupations (George, 2008, 2013; Sherman, 2010), roles (Goodrick & Reay, 2010; Reay, Golden-Biddle, & Germann, 2006; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014) or practices (Kellogg, 2009; Reay, Goodrick, Casebeer, & Hinings, 2013; Vaara, Tienari, & Laurila, 2006). To assist us in answering the research question, I focus on the studies discussing the practices of new organizational forms, occupations, roles and practices, which I summarized in table 5.1. I assemble this literature in three groups which will be explained in the next pages: studies on the discursive strategies of legitimation, work on the actual practices of legitimation and research exploring different actors' legitimacy work.

Author(s), Publication Year	Research Question or Objective	Method(s)	Key Findings and Contributions
Burns and Baldvinsdottir (2005)	Examine the extent to which normative claims might accurately reflect role(s) development in practice and the nature of role(s) change as institutionally conditioned processes.	Analysis of 24 interviews in the context of the transition to a new team/process-oriented roles for hybrid accountants.	The authors highlight the managers' efforts to develop the new hybrids' skills and competencies as well as the significant influence of the credibility of the main change agent to encourage the acceptance of the new hybrid roles.
Cahill (1995)	Examine the relations between the past and present rhetoric of North American funeral direction.	Analysis of 5 months of participant observation in a mortuary science program.	Funeral directors argue the legitimacy of their profession by comparing it to medicine and using medical terminology as well as by relying on a theologically tinged discourse or narratives of therapy.
Daudigeos (2013)	How staff professionals build perceived legitimacy and exert unobtrusive influence tactics to maneuver around social constraints?	Analysis of 58 interviews, observation and archival data in the French division of a major construction company.	The author concluded that occupational safety and health professionals overcome their lack of legitimacy by developing connections within and outside the organization, adapting the framing of issues to different audiences and manipulating the information flow.
Demers et al. (2003)	How do firms legitimize changes in their official announcements to employees in the context of "corporate marriages"?	Narrative approach to analyzing four merger or acquisition announcements.	Managers attempt to win employees' commitment by proposing a glorious project and appealing new firm as opposed to responding to their employees' concerns.
George (2008)	How personal trainers legitimate their contributions for potential clients?	Analysis of a range of service interactions in personal training sessions over a year in 5 sites and interviews with 20 trainers.	The authors argue that personal trainers' own body, an authoritative stance indicating competence, keeping up with the ever-changing literature and the application of new techniques can contribute to demonstrate professionalism and build legitimacy.
George (2013)	How life coaches defines their work as a profession and themselves as professional people?	Analysis of 25 in-depth, semi-structured interviews with life coaches.	Build legitimacy by comparing the work to well-known forms of work, using voluntary certifications, striving to regulate accreditation systems and arguing how their experience makes their contribution important.
Goodrick and Reay (2010)	How changes in the professional role identity of registered nurses are legitimized in nursing textbooks?	Analysis of 1482 pages of text from nursing textbooks.	Five ways of rhetorically legitimizing a new professional role identity: naturalizing the past, normalizing new meanings, altering identity referents, connecting with the environment, and referencing authority.
Green, Li, and Nohria (2009)	How does one know when persistent material practices are institutionalizing—that is, acquiring legitimacy?	Textual analysis of the rhetoric of total quality management: 93 interviews and selected journals, and newspapers articles.	Describes acquiring legitimacy as a cognitive process through which practices and entities become embedded in taken-for-granted assumptions. Rhetoric is used by institutional entrepreneurs to build the cognitive legitimacy underlying institutional orders and changes.
Kellogg (2009)	How is change in institutionalized practice accomplished in response to regulation?	15-month ethnographic study of two U.S. teaching hospital responding to new regulation.	Conclude that it is possible to change a practice by creating a relational space, that is, an area of isolation, interaction, and inclusion where reformers may form a unified group supporting the change.

Reay, Golden-Biddle, and Germann (2006)	How do individual actors institute change in established ways of working?	33 interviews, 25 observations, and archival documents collected when implementing the role of nurse practitioner.	Three "interdependent, recursive, situated microprocesses" to legitimize new practices: cultivating opportunities for change, fitting a new role into prevailing systems, and proving the value of the new role. Multiple small wins can contribute to both consolidate and facilitate change.
Reay et al. (2013)	How new interdisciplinary practices became legitimized as the new accepted working standards?	Analysis of 150 interviews during a change from a physician-focused model to an interdisciplinary team approach.	New practices are implemented and legitimized only when managers facilitated behavioral change. Creating space for disagreement, focusing on the overall objectives and keeping all actors engaged during times of uncertainty contribute to legitimating new practices.
Sherman (2010)	Examine the rhetorical struggles of personal concierges to seek legitimacy for their products and themselves.	160 hours of observation, 23 interviews and documents (newspaper, websites, etc.)	Concierges frame the need for free time as legitimate, portray themselves as competent, autonomous professionals and skilled entrepreneurs, and draw strong boundaries against socially subordinated domestic labor.
Suddaby and Greenwood (2005)	How are symbolic resources used to persuade a community of actors to accept profound institutional change in the absence of objective information?	New organizational form (multidisciplinary partnerships) following the acquisition of a law firm by an accounting firm.	The authors show how rhetoric can be used to expose and manipulate institutional logics to shape a change. Five 'theorizations' of the change used as rhetorical strategies are identified: teleological, historical, cosmological, ontological, and value-based.
Treviño, den Nieuwenboer, Kreiner, and Bishop (2014)	What challenges do Ethics and Compliance Officer (ECO) face in their work and what are the sources of these challenges? What tactics do they employ as they try to overcome these challenges?	Grounded theory approach to analyzing 40 interviews with ECOs.	The authors put forward the notion of legitimacy work, which they define as the work individuals engage in to build legitimacy and identify four legitimacy work tactics: making the business case, relabeling Ethics and Compliance, leveraging synergies between Ethics and Compliance, and creating trusting connections.
Vaara and Monin (2010)	How legitimacy and illegitimacy are constructed through specific discursive strategies and how these discursive constructions are linked with organizational action and the interests of particular actors?	Multimethod approach to analyzing interviews of 15 managers and company documents discussing the merger of two French pharmaceutical companies.	Highlights discursive strategies for legitimation and delegitimation, sense-giving and sense-hiding in discursive legitimation, the unintended consequences of discursive legitimation and the importance of integration results. Concludes that legitimation strategies followed the announcement of the merger while delegitimation strategies were used when the change process became problematic.
Vaara and Tienari (2008)	What are the textual strategies used to legitimate controversial actions in MNCs?	Critical discourse analysis approach to studying media texts dealing with a production unit shutdown.	Discursive strategies (authorization, rationalization, moralization, and mythopoesis) constitute concrete means to legitimate controversial actions. Interests and voices are reproduced or silenced through such textual strategies.
Vaara, Tienari, and Laurila (2006)	What are the discursive strategies used when legitimating industrial restructuring in the media?	Analysis of media texts following a Finnish–Swedish merger.	The authors identify five legitimation strategies: (1) normalization, (2) authorization, (3) rationalization, (4) moralization, and (5) narrativization.
Wry et al. (2011)	How nascent collective identities become legitimated?	Theoretical paper	A clear collective identity story identifying the purpose and core practices can help build legitimacy. Expansion may bring discrepant actors and practices, which may undermine legitimacy.

Table 5.1. Overview of the Literature on Legitimacy Work

5.2.1. Discursive Strategies of Legitimation

Research on discursive strategies of legitimation suggests that legitimating is primarily done through rhetoric (Alvesson & Karreman, 2000; Goodrick & Reay, 2010; Green, Li, & Nohria, 2009; Vaara & Tienari, 2008). Different discursive strategies have been identified by various authors who argue that legitimacy can be established through explicit and implicit references to authorities, moral or examples of success (Cahill, 1995; Vaara & Tienari, 2008; Vaara & Tienari, 2002, 2011; Wry, Lounsbury, & Glynn, 2011). For instance, from their study of the rhetorical legitimation of a new professional role identity, Goodrick and Reay (2010) identified five strategies: naturalizing the past, normalizing new meanings, altering identity referents, connecting with the institutional environment, and referencing authority. Vaara and Monin (2010)'s study of the dialogical process in organizational storytelling in the context of merging multinational corporations similarly shows how different actors use (de)naturalization, rationalization, authorization and moralization as strategies to legitimize and delegitimize the change. The authors found that legitimation strategies followed the announcement of the merger while delegitimation strategies were used when the change process became problematic. Also studying narratives to legitimize mergers and acquisitions, Demers, Giroux, and Chreim (2003) found that managers may use means-ends rationality, construct continuity with the past, put forward inspiring visions of the change as a leap into the unknown or compatibility arguments to build legitimacy and win employees' commitment. Differently, Sherman (2010) examined the rhetorical struggles of personal concierges to seek legitimacy for their products and themselves as its providers. The concierges frame the need for free time as legitimate, portray themselves as competent, autonomous professionals and skilled entrepreneurs, and draw strong boundaries against socially subordinated domestic labor.

Contrary to the few past studies taking a process perspective, I explore not only the sequence in which legitimation and delegitimation efforts are performed, but see the two types of practices as potentially simultaneous and intertwined throughout a change process, often in the same discourse or action. I hence avoid assigning positions to different actors (for instance, opponent and proponent as in Suddaby and Greenwood (2005)). Furthermore, while Vaara and Monin (2010) shed light on

some unintended consequences of legitimation discourse, I explore how legitimation efforts can have delegitimating consequences. Thereby, I am adding to the few studies exploring reversals in legitimation or delegitimation and respond to Vaara and Monin (2010)'s call for more work on delegitimation practices. Finally, the present study complements previous work by exploring (de)legitimating practices, as opposed to the discursive (de)legitimation of actions or simply rhetorical strategies.

5.2.2. Beyond Discourse: Legitimating Through Actions

The second stream of research goes beyond discursive strategies of legitimation and looks at actual practices of legitimation. Authors explored the legitimacy work associated with emerging occupations (George, 2008, 2013) as well as both new (Reay, Golden-Biddle, & Germann, 2006) and existing roles (Daudigeos, 2013; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014).

In her study of how personal trainers legitimate their contributions for potential clients, George (2008) noted how a trainer's own body, an authoritative stance indicating competence, keeping up with the ever-changing literature and the application of new techniques can contribute to demonstrate the professionalism of this rapidly expanding yet not fully credentialized profession. In a more recent study exploring how life coaches seek to legitimize their occupation, George (2013) observed that life coaches compare their work to well-known forms of work (that is, occupational analogies), use voluntary certifications to formalize their knowledge, training and practice, strive to standardize and regulate their accreditation systems, and highlight how their talents and past experiences made their contribution important. Looking at the legitimation of the new role of nurse practitioner in Alberta, Reay et al. (2006) uncovered three microprocesses used by the role holders to legitimate their role: cultivating opportunities for change, fitting a new role into the prevailing system and proving the value of the new role. The authors also highlighted how the nurse practitioners leveraged their embeddedness in the system to build a history of slow, of continuous and under the radar small "wins" testifying the value of their new role. While George (2008, 2013)

focused on new occupations and Reay et al. (2006) were interested in a new role, Daudigeos (2013) and Treviño et al. (2014) explored the legitimation of existing roles.

More specifically, Daudigeos (2013) explored how occupational safety and health (OSH) professionals built their legitimacy and influence. Such staff professionals are responsible for creating change while being embedded into the organization's established norms, beliefs and routines and not benefiting from the authority and legitimacy associated with ranks in the hierarchy. The authors concluded that OSH professionals overcome their lack of legitimacy by developing diverse and flexible connections within and outside the organization, adapting the framing of issues to different audiences, manipulating the information flow, as well as using their organizations' power to promote practices. In a similar study of the legitimacy of Ethics and Compliance Officer role, Treviño et al. (2014) put forward the notion of legitimacy work, which they define as the work individuals engage in to build legitimacy. The authors identified four legitimacy work practices: making the business case, replacing the terms ethics and compliance with terms fitting better with the organization (such as business integrity), leveraging synergies between ethics and compliance by simultaneously emphasizing values and culture building as well as standards, rules, laws, and employee accountability, and creating trusting relationships with organizational members.

From the literature emphasizing individuals' actions to legitimate roles and occupations, we learnt that building relationships (Daudigeos, 2013; Treviño et al., 2014), demonstrating and formalizing knowledge and expertise (George, 2008, 2013), framing the new role or occupation (Daudigeos, 2013; George, 2013; Treviño et al., 2014) as well as showing the fit and contribution of the new role or occupation (Daudigeos, 2013; George, 2013; Reay et al., 2006) are potential practices to build legitimation. Although they shed light on some practices to build legitimacy, these studies neglect to explore delegitimating practices. Furthermore, studies from this stream solely pay attention to the efforts of the holder of the new role or members of the new occupation. This study goes beyond these preliminary efforts by examining the efforts of *all* actors surrounding the new role to establish or limit the legitimacy of the new role and its holders. Indeed, I argue that when

new roles are created, other organizational members need to adjust to create space to allow the holders of the new role to exercise influence, which might generate tensions and rivalries. A limited stream of research did investigate the practices used by different actors. However, these studies, which I explore in the next section, assign polarized positions to actors and pay little attention to the process of legitimation over time.

5.2.3. Building or Weakening Legitimacy: Different Actors' Practices

The third stream of research emphasizes the practices used by different actors to build or question the legitimacy of a role, occupation or change. Some authors discuss the rhetorical strategies of proponents and opponents to a change (Suddaby & Greenwood, 2005), or suggest that managers and change agents possess significant influence on the legitimacy of new roles or practices (Burns & Baldvinsdottir, 2005; Kellogg, 2009; Reay et al., 2013).

Studying the role of rhetoric in legitimating institutional change, Suddaby and Greenwood (2005) found that proponents and opponents of a new organizational form theorize change in five ways: teleological, historical, cosmological, ontological, and value-based. Teleological persuasion emphasizes the "divine purpose" of the new organizational form, historical persuasion involves portraying change as a threatening break from the past, cosmological persuasion involves insisting on the inevitability of the change due to forces beyond actors' control, ontological persuasion focuses on what can or cannot co-exist, while value-based persuasion is based on wider belief systems defining what is good or bad. Suddaby and Greenwood (2005) also concluded that new organizational forms first gain legitimacy if they connect to the prevailing institutional logics. The authors believe that contradictions between the new form and the logics may become resources to contest the legitimacy of the change and that shifts in logics achieved (or resisted) through rhetoric may enable the new organizational forms.

Reay et al. (2013) and Burns and Baldvinsdottir (2005) focused on the work of proponents of new roles and practices, and more specifically on the role of managers and change agents. Looking at a

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specific case of change from a physician-focused model to an interdisciplinary team approach in primary healthcare organizations, Reay et al. (2013) found that new practices were implemented and legitimized only when managers facilitated behavioral change. The authors highlighted that it is not enough for actors to express their support for a new practice as individuals' actions and words don't always match, but instead that managers need to make the new desired behavior the easiest alternative. Otherwise, individuals may acknowledge the value of the new practice while continuing to function according to the old way of doing things. Reay et al. (2013) also suggest that creating space for disagreement, focusing on the overall objectives and keeping all actors engaged during times of uncertainty contribute to legitimating new practices. Burns and Baldvinsdottir (2005) explored different actors' involvement in changing a role. The authors studied the transition to a hybrid role for accountants in the manufacturing division of a multinational pharmaceutical organization. The authors highlight the managers' efforts to develop the new hybrids' skills and competencies as well as the significant influence of the credibility of the main change agent to encourage the acceptance of the new hybrid roles.

Although studies providing hints as to the establishment of new roles are not specifically focused on strategic decision making, it provides some basis to help us understand how the practices of different actors within an organization contribute to legitimating (or not) professionals appointed to new management roles to exert influence on strategic decisions. Nonetheless, it remains unclear how other actors act and react to enable (or not) the creation of space for role holders to occupy their role and exercise influence. Moreover, the evolution of legitimacy and legitimacy work over time is understudied, the actors' positions are polarized (proponents or opponents) or portrayed as static, and solely intentional practices to legitimize the roles are generally taken into account. Unsuccessful attempts or the unintended consequences of some actions are thus ignored. The literature presented before nonetheless provides a foundation to my investigation that guided my methodological decisions.

5.3. Research Methods

In this section, I explain the context of the study, the data collection and analysis processes as well as discuss the trustworthiness of the study.

5.3.1. The Context of the Study: Implementing Management-Physician Co-Leadership Initiatives

Four Health and Social Services Centres (HSSC) located in Quebec participated in this study. All organizations were partaking in pilot projects aimed at improving collaboration between their medical and managerial communities. The main change undertaken in the pilot projects involved implementing co-management. The pilot projects involved creating and assigning physician manager roles. Role holders possessed medical training and experience as well as different levels of experience in medical representation or management roles. The physician managers were mandated to manage clinical programs (a grouping of health services offered to a homogeneous group of patients) in close collaboration with the clinical co-leader. Originally, the clinical programs were led single-handedly by a clinical manager who possessed training and experience in a (non-medical) clinical profession as well as in management. The medical and clinical managers worked in a co-management arrangement, meaning they were jointly responsible for reaching the objectives of their program. It was hoped that the pilot projects would serve to encourage physicians to become active partners in working toward the achievement of organizational goals while furthering their aspirations. For the initiators of the pilot projects, inclusion of physicians in strategic decisions was key.

Before the arrival of the medical directors, the top management team of each HSSC included only one member possessing medical training and experience, the director of professional services. The role of director of professional services is defined in the law and remained unchanged throughout the pilot projects. It included coordinating the clinical activities in the HSSC by managing, coordinating and supervising the activities of the chiefs of medical departments.

The council of physicians, dentists and pharmacists is composed of all members of the latter professions, and is a structure existing in parallel to the administrative structure. The members elect an executive committee which reports directly to the board of the HSSC. The executive committee is responsible for ensuring the quality of the medical, dental and pharmacy acts performed in collaboration with the director of professional services and through the practices of the chiefs of medical departments. The law states that the chiefs of medical departments are physicians responsible for coordinating the activities of professionals, for managing resources and for the quality of services in their medical department.

Although the roles of the directors of professional services, council of physicians, dentists and pharmacists, and chiefs of medical departments as defined by the law remained unchanged, the arrival of the medical directors involved different changes at all HSSCs.

The Primary Care Health and Social Services Centre

The Primary Care HSSC is a relatively small organization with no hospital but composed of eight long-term care facilities and seven local community services Centres. 3500 employees and about 250 physicians worked in the organization. At the strategic level, the structural change undertaken involved implementing medical director roles to co-manage the four clinical co-directorates with a clinical co-director. However, two of the four clinical co-directors refused to be paired with a medical counterpart. As a result, only two medical director roles were created. Initially, the director of professional services, assisted by one of his adjuncts (the director of medical teaching), was in charge of leading the change. As we will see later, this responsibility was fully assigned to the director of medical teaching toward the end of the data collection period.

The Semi-Rural Health and Social Services Centre

The Semi-Rural HSSC is a small organization composed of about 1000 employees and 100 physicians. The Semi-Rural HSSC had made a first attempt to implement a co-management model in the years before the pilot projects, and has already started implementing the co-management

structure when the research project started. The director of professional services, along with the director of human resources, led the project. Their co-management model included adding a medical director to every clinical co-directorate (four) as well as developing co-management at lower levels in the organization between the chiefs of clinical units and the chiefs of medical departments.

The Regional Health and Social Services Centre

The Regional HSSC is a large organization with three hospitals, approximately 5500 employees and 500 physicians. The structures of the HSSC was divided in four clinical co-directorates responsible for managing a group of patients having similar health problems. The Regional HSSC chose to place a medical director by the side of the four clinical co-directors. Although the pilot projects started in 2011, the implementation of the co-management roles for medical professionals was delayed until the summer 2013 at the Regional HSSC, mainly for financial reasons. The project was initiated and led by the assistant CEO. Although he was not originally convinced of the relevance of the new structure, the director of professional services started supporting the project before the introduction of the new roles. He later played an important role by co-managing the implementation of the new roles with the assistant CEO.

The University Health Centre

The University Health Centre is a large organization composed of two hospitals, about 6000 employees and 630 physicians. Besides offering healthcare services, medical and clinical research and teaching was at the core of the organization's mission. Throughout the project, the director of professional services was the only member of the top management team of the University Health Centre possessing a medical background, but seven of the 15 medical directors were systematically invited to attend the strategic management meetings. The structural changes implemented involved creating physician-manager roles at the tactic level mandated to co-manage a clinical program with a clinical manager. These new roles were referred to as medical directors, and their clinical co-leaders were called clinical co-directors. Seven of the 11 medical directors simultaneously occupied

roles of chiefs of medical department and medical chiefs of program. At the University Health Centre, all clinical programs were included within a clinical co-directorate led in a co-management arrangement by the director of professional services and director of nursing. The initiative to participate to the pilot project and implement medical directors in co-management arrangements was the director of professional services, but the responsibility to lead the change was shared by the tandem formed by the director of professional services and director of nursing.

5.3.2. Data Collection

Semi-structured interviews, non-participant observation as well as document analysis were the main methods relied on for this exploratory study. Data was collected over a 21 months period (that is, from February 2012 to October 2013) starting with the analysis of all external documents in order to gain a first understanding of the organizations' structures, cultures, as well as previously accomplished and intended changes linked to the pilot projects. Observation of meetings in which either or both of the co-leaders were present, as well as of meetings of different members of the management and medical communities at the strategic, tactic and operational levels was then initiated. A first period of interviews was simultaneously performed with key actors. All co-leaders, as well as key members of both the medical and management communities were solicited and all agreed to be questioned. At all four organizations, these key members included the CEO, deputy CEO, director of professional services, chiefs of medical departments as well as administrators involved in implementing the new structure (such as human resources directors). 27 interviews were conducted at the University Health Centre, while 11 interviews were realized at the Regional HSSC. Respectively 27 and 25 interviews were led at the Semi-Rural Health and Social Services Centre and the Primary Care Centre.

During interviews, questions pertaining to the past and current relationships between the medical and management communities were asked, as well as to how the medical and managerial logics are reconciled and weighted in discussions or decisions. Participants were also asked to describe situations in which this reconciliation was successful and unsuccessful, to explain if and how they

felt a difference since co-management was implemented at their and other hierarchical levels, as well as whether they believed members of the wider medical and management communities perceived a difference since the implementation of the new roles. Participants were also asked to describe in details how the new roles were implemented, and how the influence of the professionals in senior management roles was established and solidified.

All participants interrogated in 2012 (Phase 1 referred to as T1 in the next sections) were interviewed again in 2013 (Phase 2 referred to as T2), along with new key actors, to discuss their perception of the changes brought by the new roles (22 at the University Health Centre, 19 at the Regional HSSC, 18 at the Semi-Rural HSSC and 18 at the Primary Care Centre). Observation and document analysis continued over the 21 months of the study. Table 5.2. specifies the meetings attended.

University Health Centre	Regional Health and Social Services Centre	Semi-Rural Health and Social Services Centre	Primary Care Health and Social Services Centre
• Executive Committee (3) • Clinical Programs Committee (5) • Strategic Project Management Office (4)	• Executive Committee (4) • Council of Physicians, Dentists and Pharmacists (2) • Chiefs of Medical Departments Committee (8) • Strategic Consultation Meetings (4)	• Executive Committee (9) • Clinical Executive Committee (5) • Co-leadership Implementation Committee (8) • Council of Physicians, Dentists and Pharmacists (5) • Chiefs of Medical Departments Committee (5) • Strategic Consultation Meetings (6) • Co-leadership Training Sessions (1) • Clinical Programs Committee (2)	• Executive Committee (1) • Clinical Executive Committee (6) • Clinical Programs Committee (6) • Medical Teaching Committee (1) • Chiefs of Medical Departments Committee (1) • Council of Physicians, Dentists and Pharmacists (4)

Table 5.2. Meetings observed

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5.3.3. Data Analysis

My analysis of the qualitative data was inspired by grounded theory as suggested by Gioia et al. (2013). I first coded all the data using sensitizing concepts extracted from the literature (legitimating practices, delegitimating practices, access, attendance, participation, influence, perception of decision making), and were careful to let new codes emerge from the data. Professionals in management roles' access to forums debating the decisions, attendance at encounters, participation to the discussions as well as influence in decision processes reveal the nature of the actual changes to decision processes resulting from the practices made. These notions are inspired by Burns et al. (1989)'s distinction between inclusion and participation, and Neogy and Kirkpatrick (2009)'s exploration of presence in senior management as a separate notion to formal ability to influence the strategy. More precisely, access is defined here as membership in a committee responsible for making a particular decision, admission to the forums discussing the issue derived from the formal role, or access to information concerning the decision to be made. I view attendance as a physical presence during discussions, regardless of whether the individual is attentive to the conversation or taking part to the dialogues and debates. Participation is conceived as contributing one's point of view to the discussion, while influence is defined as one's point of view having an actual impact on the decision process, or being seriously taken into consideration.

Degree of Participation Reflecting Changes in Decision Processes	Definition
Access	Membership in a committee responsible for making a particular decision, admission to the forums discussing the issue derived from the formal role, or access to information concerning the decision to be made.
Attendance	Physical presence during discussions (regardless of whether the individual is attentive to the conversation or taking part to the dialogues and debates).
Participation	Contributing one's point of view to the discussion.
Influence	One's point of view having an actual impact on the decision process, or being seriously taken into consideration.

Table 5.3. Definitions of the Different Degrees of Participation in Decision Processes

These first order themes, which were kept close to the language of participants, were then grouped into second order themes. The second order themes were finally arranged into aggregate dimensions. I went back and forth from the data to the emerging theory until the relationships and arrangements I uncovered appeared solid. For clarity purposes, I divided my final data structure in two tables. Figure 5.1. exposes legitimating practices, while figure 5.2. shows the data structure for delegitimating practices. In the results section, the aggregate dimensions are referred to as types of legitimating and delegitimating practices, while the second order themes are referred to as "forms" of a specific practice. Furthermore, I label as "legitimacy work practice" all practices contributing to legitimize or delegitimize the influence associated with the new roles. Then, I differentiate between "delegitimating practices" and "legitimating practices", the former contributing to reduce legitimacy while the later contributing to strengthen it.

1st Order Concepts	2nd Order Themes	Aggregate Dimensions

- Medical director identifies objectives, performance indicators and sets the financial orientations with clinical co-director within the directorate.
- Medical director participates in strategic decision processes within the top management team.

→ Shaping strategy

- Obtaining the support of a private foundation in implementing the new model.
- Freeing different actors from their day-to-day activities to work on the new model.
- Hiring human resource advisors responsible to support and develop the medical directors.

→ Injecting resources

Proactivity

- Definition of roles and relationships in the committee responsible for implementing the new model.
- Making an administrator and a medical manager co-responsible for the implementation of the model.

→ Roles

- Revising of the structure of committees at the strategic level.

→ Structure of committees: routinizing and structuring involvement

Structural Adjustment

- Medical director asks to be involved earlier in strategic decision making instead of being asked his perspective on the orientations chosen.
- Medical and clinical directors try to educate others as to what their role entails to prevent them from bypassing the dyad.

→ Efforts to shape the role and impose oneself

- Medical director needs his clinical co-manager to explain his role and establish his credibility.

→ Establishing oneself through the clinical co-director

- Co-development sessions strengthen the bond between directors.

→ Creating and strengthening bonds within the top management team

- CEO and his assistant present the new model throughout the HSSC.
- Coaching dyads in identifying what each members' role might be, and in dealing with situations they are facing.

→ Informing about the new model

Making Space

- Imposing rules on when and where meetings should take place to respect physicians' constraints.
- Avoiding asking the medical director to confront his/her colleagues as they might see him/her as an enemy.
- Medical directors trying to convince administrators using arguments commonly accepted in the administrative community: statistics and indicators.

→ Considering the other groups' reality

Empathizing

Figure 5.1. Data Structure of Legitimacy Work: Legitimating Practices

1st Order Concepts

- Lack of efforts by the CEO or change leader to define the new medical director role and integrate them.
- CEO or change leaders loudly promising supporting actions but not doing it.

- Limited interest in/knowledge of the directorate.
- Lack of presence in the organization (attends few meetings he/she is invited to as medical director and does not practice medicine in the organization).

- Revision of the structure of committee to establish medical directors in decision making, but medical directors don't show up. When they do, they don't participate much.

- Offering co-directors to assist them in defining their roles, but the co-managers are passive in the process.

- Informing organizational members of the new model but few people attend the meeting.

- Decisions made by CEO and director of professional services without consulting the clinical or medical directors concerned or informing them.
- Director of professional services allows chiefs and physicians to bypass clinical and medical directors.
- Existence of an inner circle making the strategic decisions (from which medical directors are excluded)

- Clinical co-director does not want to share her power.
- Clinical co-director forgets to consult or inform the medical co-director.

- Attempting to impose oneself in decision making through the co-manager but the input is rejected.
- Trying to build relationships with chiefs of medical departments but chiefs reject input publicly.
- Attempting to access the committee of chiefs of medical departments but chiefs refuse the presence of the medical directors.

- Explaining the new model in management terms to physicians. Consequently, the majority of the physicians who are present don't understand the model.
- Presenting the new model to physicians the day before the adoption by the board, giving them no time to study the model or request changes.
- Physicians playing the management role as a medical representation role: representing, protecting and developing the department.

- Not inviting physicians to meetings, assuming they will not have time to attend.
- Not consulting physicians when planning projects, assuming they will not be interested or have time.
- Not organizing training sessions, assuming physicians will not be interested in participating.

2nd Order Themes

- Lack of internal and hierarchical support
- Self-exclusion of the medical directors
- Structure of committee but lack of participation
- Attempting to develop actors' co-management competencies but participation deficiencies
- Informing about model but participation problems
- Bypassing
- Clinical co-director not making space for medical director
- Attempts at creating relationships loudly rejected
- Misconceiving
- Overreacting

Aggregate Dimensions

- **Passiveness**
- **Structural Inertia**
- **Restricting Space**
- **Misunderstanding**

Figure 5.2. Data Structure of Legitimacy Work: Delegitimating Practices

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5.3.4. Trustworthiness

Various precautions have been taken in designing and performing this research project to ensure its quality. Lincoln and Guba (1985)'s framework for trustworthiness inspired my efforts. To ensure credibility, the qualitative equivalent of internal validity, I included different methods, types of informants and sites to allow for triangulation. Efforts were made to choose appropriate and recognized methods during the design stage. Early in the data collection period, I attempted to gain great familiarity with the sites, and used iterative questioning all along the project. Frequent debriefing sessions and member checks were also used throughout the research, while comparing emergent patterns with previous research findings as well as providing thick descriptions helped ensure credibility in the later phases. Transferability preferred by Lincoln and Guba (1985) to external validity, was increased by providing background information explaining the context of the study and phenomenon studied. Reliability, or in Lincoln and Guba (1985)'s words dependability, was reinforced in the design stage by selecting overlapping methods, and later by providing the methodological details necessary for replicating the research. Finally, confirmability was augmented by triangulation, detailed methodological explanations as well as transparency about the limits of the study.

5.4. Findings

My study of strategic decision processes suggests a number of legitimacy work practices used by different actors to legitimize or delegitimize professionals' participation to strategy, thus helping us explain *how and why does the introduction of professionals into senior management roles shape (or not) their influence on strategic decision processes over time?* To articulate my answer to this research question, I divided the result section in two parts. The first part explores the legitimating and delegitimating practices I uncovered in the data. The second part examines the unfolding of practices used by the four organizations, and assesses the changes in different actors' perception of the influence of medical directors on strategic decisions.

5.4.1. Legitimating and Delegitimating Practices

My data suggests that four types of legitimacy work practices were used to shape medical directors' influence on strategic decisions: (1) proactivity and passiveness, (2) structural adjustment and inertia, (3) making and restricting space as well as (4) empathizing and misunderstanding. The four types are symmetrical. Hence, the former component of each type is used to legitimize medical directors' legitimacy to influence strategic decision processes, while the latter component is a delegitimating practice. The next sections explore the use of these practices in more details.

Proactivity and passiveness

Legitimating practices belonging to the first type, proactivity, refer to medical directors' work to shape the strategy of their directorate or organization as well as change agents' efforts to inject resources to implement the new structure. More specifically, the first form of practices belonging to the proactivity type, strategy shaping, involves medical directors taking a position, bringing the medical perspective into strategic debates or contributing to the discussion regarding a strategic issue such as setting a directorate's objectives. One medical director, for instance, was legitimized when it became widely acknowledged that she contributed significantly to her directorate's orientations, priorities and plans, and was involved in implementing it. Her clinical co-director explains the significant involvement of the medical director in strategic decision processes in his directorate, "We had meetings to discuss our priorities, the orientations, our roles and boundaries, our links, the overlap between our responsibilities and important issues." (Clinical co-director 11-R, T2) Strategy shaping practices intended to legitimize can also have delegitimating consequences. For instance, a medical director from the Semi-Rural HSSC avoided getting involved in setting his directorate's orientations despite attempts by a number of managers to include him in the process:

> I didn't go to the meetings where medical directors were invited to participate to the strategic planning. I discussed it afterward with my clinical co-director, who had gathered everyone' idea. I approved the plan. I didn't play a big role. I know it is a big thing for the organization… strategic planning and all that. But to me it's always the same thing: offering the best services we can offer. (Medical director 16-SR, T2)

The second form of 'proactivity' practices involves injecting resources to support the efforts deployed to implement the new roles. These practices include the creation of new human resources roles responsible to support and develop the medical directors, or freeing actors from their usual tasks to work on the implementation of the new model. At the Semi-Rural HSSC, the support of an external private foundation was sought and obtained. The foundation accompanied the change agents over a five-year period, hired consultants to advise throughout the implementation process and donated a significant amount to develop the new medical directors' competencies in management through training, coaching and co-development sessions. The director of human resources of the organization highlighted the difference made by the foundation, "The Private Foundation will continue to assist us. They want to make a difference, and honestly if we didn't have their support, it would be very difficult to have coaching, to offer training sessions, and to pay the consultants." (Director of human resources - SR, T1)

The delegitimating equivalent of proactivity, passiveness, refers to different actors' lack of participation in different aspects of the implementation of the new role. For instance, I see change agents or CEOs' lack of involvement in the implementation process as a lack of internal and hierarchical support. During a meeting I observed on November 23, 2012 at the Regional HSSC, the deputy CEO was invited to present the new co-management model to the chiefs of medical departments. While he was presenting, the director of professional services (who is jointly responsible for implementing the new roles with the deputy CEO and is leading the committee of chiefs of medical departments) was constantly leaving the room to take and make calls, paying no attention to the presentation and even sometimes disturbing it with jokes. While observing, I noted how such behaviour appeared to send the message that she did not support the new model to the chiefs of departments. At the Regional HSSC, many actors insisted on the CEO's lack of support for the new role, and his lack of involvement in the implementation of the co-management model. The delegitimating effect was especially strong when the lack of support of the CEO followed a promise for support initially intended to be legitimating. For instance, the CEO of the Regional

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HSSC publicly promised numerous supporting actions for the physicians entering the new management roles. None of the promised actions were however organized, despite the medical directors' requests for training, coaching and other forms of support.

I also see as delegitimating passiveness some medical directors' self-exclusion from decision making processes. In some cases, the medical director does not get involved because he or she does not believe possessing the knowledge to participate in making the decision. In other cases, the medical director avoids getting involved as he or she cannot represent his/her medical colleagues' perspective because he does not practice in the organization. One medical director justified his self-exclusion from decision making by arguing that his private practice prevented his from attending meetings. The director of professional services of the organization reacted to this reasoning:

> There is a problem. We mentioned it a few times to him. We had two important meetings, and the medical director was not available. But as a family doctor in a private clinic, he has some flexibility. He can shape his schedule. He doesn't have to be there from 8 until 4 every day. And he never has emergencies, he is evaluating patients. You can postpone some appointments. He is paid to be medical director, so we expect him to attend important meetings about strategic planning or financial problems. He should be there to support his co-director and then share the information with the physicians in his department. (Director of professional services - SR, T2)

Passiveness can also contribute to making legitimating efforts have delegitimating consequences. At the Semi-Rural HSSC, a new structure of committees was implemented to give weight to the medical directors' influence. However, medical directors rarely attended the meetings and remained mostly quiet when they did, as commented on by the director of professional services, "The clinical strategic committee will be beneficial if [medical directors] attend the meetings. The problem is that very often, they don't show up. Or they come and leave after 15 or 20 minutes, so it is difficult." (Director of professional services - SR, T2) Similarly, at the Primary Care HSSC, change agents organized coaching sessions to help the medical directors clarify their role and develop the

competencies needed to accomplish it successfully. However, the medical directors and their co-leaders did not discuss their vision of the role before the meeting, and remained passive during the encounter. At both the Semi-Rural and the Regional HSSC, presentations to inform organizational members about the new roles were organized. In the former setting, the presentation was cancelled because only organizational members forced to attend the event were planning on being present, while at the latter organization, only four individuals attended the presentations.

Structural adjustment and inertia

Structural adjustment practices were mostly performed by the change agents. Such legitimating practice involves efforts at defining roles and responsibilities as well as practices modifying the organization's committee structure. Typical examples of structural adjustment practices include the division of the strategic committee in two sub-committees dedicated respectively to administrative and clinical issues, or exercises requiring the top management team to identify the roles and responsibilities of different actors in managing a typical project. The significant difference in actors' perceptions of roles and responsibilities revealed by the exercise at the Semi-Rural HSSC is summarized in the notes taken as I observed the exercise:

> The members of the [co-management implementation committee] do an exercise on the roles and responsibilities of the medical directors and other members of the top management team. The exercise "Who does what?" caused intense discussions and much disagreement. The exercise involved identifying who had what kind of responsibility (inform, consult, participate, execute, decision, control, etc.) in a project that was being worked on in the organization. Participant's vision of the way the project was done and of how it should be done varied greatly. [The medical director] usually assigned himself a responsibility to participate, decide and control. The CEO and a consultant assigned most actors "being informed". The director of professional services believed the [medical directors] generally had to "approve". (Notes taken during a co-management implementation committee, 20120528)

My data also suggests that some structural adjustment practices aimed at legitimating the medical directors' influence on strategic decisions had unintended delegitimating consequences. At the Regional HSSC, attempts were made to integrate medical directors as members of the committee of chiefs of medical department. However, the chiefs unanimously refused, agreeing that the new medical directors could attend only when officially invited. In this case, a structural legitimating practice's failure actually delegitimized the new roles.

Structural inertia mirrors structural adjustment practices, but has delegitimating consequences. Examples of structural inertia include the superiors of the medical directors allowing practitioners from their directorate to bypass them. I see bypassing as a structural practice because it involves a disrespect of the new organizational structure, which assigns medical directors responsibilities in managing the decisions from which they are excluded. Instead, actors bypassing the new roles conform to the old structure. Bypassing is also structural as it sometimes indicates an overlap between two roles. In the following quote, a director of professional services explains why he sometimes bypasses the medical directors:

> Sometimes the roles overlap: director of professional services and [medical director]. The physician and chiefs of medical departments come to the director of professional services for many things. But they should talk to the [medical director] too. I am going to listen to them, whether it is about development projects or complaints about the [medical director] or the way their department is organized. I am responsible for all that, including the [medical directors]. But they don't go to the [medical director]. And I have regular meetings with the chiefs of departments. Should the [medical director] come? We could think about it, but it is more time and money, so sometimes I am the intermediary. (Director of professional services - SR, T2)

Making and restricting space

The third type of legitimating practice, making space, involves efforts to create space in which the medical directors can play their role. Making space can take four different forms. First, medical

directors can deploy efforts to shape their role and impose themselves. Medical directors' attempts to impose themselves within their dyad or to be involved earlier in decision making would be examples of this first form. Medical and clinical co-directors' efforts to educate other actors as to what their role might entail also constitute an example of the first form. The second form of practice includes medical directors' attempts to establish themselves through their co-director, as illustrated in the following excerpt:

> I called a physician who was joining the organization. I said, "I am medical co-director. I work jointly with the clinical co-director." She knew who the clinical co-director was already. I had to explain my position in the organizational chart to explain why I was contacting her. I used my co-director to explain my position. My co-director has been in that position for years, everyone knows her role. I am not very often physically in the organization and I am not working full time as medical director. I felt the need to use my co-director to establish my credibility. (Director of professional services 15 - SR, T2)

The third form involves creating and strengthening bonds within the top management team. For instance, at the Semi-Rural HSSC, co-development sessions were organized to both solidify the relationships between the medical and clinical co-directors and help the participants solve the problems they are facing. Through the discussions taking place, participants clarified the new role together and adapted to one another's role, thereby making space for the new role holders. The fourth form, informing about the new model, includes practices such as the Regional HSSC's deputy CEO's efforts to explain the new model and the reasoning guiding it to organizational members to encourage them to adapt their behavior to the new role.

Some efforts at making space to legitimize the new roles had delegitimating consequences. The quotation below illustrates an instance of practice aimed at legitimating the new roles by making space, which had the opposite effect. In the excerpt, a director of professional services explains how she attempted to organize a presentation by a consultant to create a space for the new role by

clarifying the roles and responsibilities of all physician-managers. However, the consultant's position actually discredited the new role:

> I invited a [consultant] to give a training session. I didn't know his position. I am very
>
> naïve. I had requested, naively, a presentation on the management of medical departments. I
>
> thought, "we should make sure everyone's information is up to date and that the chiefs
>
> understand their legal roles and responsibilities." I thought that before the new roles are
>
> implemented and everything gets confusing, we should clarify roles and make sure
>
> everyone can ask questions. But it ended up being about the defense of the chief of medical
>
> departments' rights [which might be threatened by the new role]. (Director of professional
>
> services - R, T2)

Attempts at legitimating by making space can result in delegitimating medical directors' influence when, for instance, medical directors attempt to develop a relationship with other actors who strongly and publicly reject this attempt. The following quotation illustrates two medical directors' attempt as well as the repercussions:

> There was some clumsiness from two [medical directors] who, thinking they were doing the
>
> right thing, went to a meeting of department heads. They took too much initiative and it was a
>
> learning experience, unfortunately for them, because they brought up some issues. (…) When
>
> they go there in their administrative role saying, "we could do this better" – they did not get a
>
> good reception, to say the least. That kind of clumsiness of confronting chiefs on a financial
>
> efficiency issue – the chiefs didn't react very well… (Deputy CEO - R, T2)

While making space covers legitimating practices, restricting space encompasses practices delegitimating the new role. Practices to restrict the space the new role holders have to play their roles include, for instance, the clinical co-director or director of professional services not taking seriously the medical director's point of view during decision processes. A comment of the director of professional services reflects this idea, "Some clinical co-directors don't leave much space to the

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medical directors, "You are going to do this, this and this." But the two need to be equal. Not one serving the other. (Director of professional services - R, T2).

Empathizing and misunderstanding

The fourth type of legitimating practice, empathizing, refers to actors' efforts to understand and accommodate the other group's reality. It reflects cross-cultural sensibility. For instance, at the Semi-Rural HSSC, an event was organized to present the new model to physicians. In order to attract medical specialists, the event took place in the luxurious manor of the president of the private foundation who supported the implementation process, a highly successful man who was leading a telecommunication company before retiring and focusing on his foundation. At the University Health Centre, rules were imposed as to when and where meetings should take place. The constraints associated with practicing medicine were thereby taken into consideration. Indeed, these rules prevented meetings from being organized at the last minute on days in which physicians had appointments with patients, forcing these physicians to either be absent from the meeting or have to reschedule all their appointments. Other practices include clinical co-directors, medical directors and directors of professional services' efforts to ensure that medical directors were not involved, especially early in the implementation process, in projects that would cause fellow physicians to see them as enemy or having changed sides. The following quotes from interviews respectively with a clinical co-directors and a medical director illustrate this form:

> The medical director is able to defend administrators' positions, but physicians start seeing her as an administrator. As soon as someone is close to us, he becomes an enemy. If she becomes the enemy, her influence will decrease. The co-management model dies the day she becomes the enemy. (Clinical co-director 17 - R, T1)

> My fear is to be assigned all the projects likely to irritate physicians. To be assigned the issues the director of professional services and my clinical co-director don't want to deal with. (…) Physicians have many fears. Lacking resources to care for patients, that someone

tries to control their practice…I can't be seen as a physician trying to control other

physicians' practice. (Medical director 13-R, T2)

Practices suggesting misunderstandings contributed to delegitimize the medical directors. These

delegitimating practices take two forms: misconceiving and overreacting. Misconceiving is

recognizable when members of the managerial or medical communities try to interact with members

of the other group in a way that suggests a lack of understanding for the reality of the other group.

For instance, the change agents at the Semi-Rural HSSC organized entire days of training sessions

to present the new model to physicians, not recognizing some physicians' obligation to follow-up

on hospitalized patients. These sessions involved activities such as playing games, usual in the

management world but inadequate in the medical community. The presenters also explained the

new model using administrative language, making the new structure difficult to understand for

physicians, lower-level managers and employees. At the Regional HSSC, the deputy CEO

presented the new model to the chiefs of medical departments only a few days before presenting it

to the board, giving them no time to study the model or request changes. To the chiefs, secretly

developing the model and giving them no time to give their input was just another example of

administrators ignoring their demand to be involved early in changes affecting them. In some cases,

the medical managers' behaviors suggested misconceiving. For instance, in all four organizations,

some medical directors focused on representing, protecting and developing their own medical

departments as opposed to jointly making decisions. By doing so, the medical directors behaved

according to the customs of the medical community, suggesting their misunderstanding of what

managers expected from them and of administrative customs.

Misunderstanding can take a second form: overreacting. This form would be an extreme form of

cultural sensitivity in which actors are so concerned with the other groups' constraints that they

failed to even attempt actions. In other words, actors see obstacles to action before attempting to act,

and consequently do nothing. For instance, at the Primary Care HSSC, administrators often avoided

inviting physicians to meetings, assuming they will not have time to attend:

When I can't influence or when some issues overwhelm me, I won't go to the meeting. It would be useless, I have other things to do. It's the same for physicians. I understand them. It's like the pharmacist. She said, "I have so much work – if there is a problem with a patient's medication and you can't reach the patient's pharmacist, you can call me, but otherwise don't invite me." That's the reality in the healthcare sector. (Clinical co-director 18-PC, T2)

Administrators also avoided consulting physicians when planning projects assuming they will not be interested or won't have time, or decided not to organize training sessions assuming physicians will not agree to participate. A medical director commented on this tendency to overreact:

The excuse is "You are doctors, you have work to do, you have to see patients, we don't want to bother you." But it doesn't bother us. And if they don't discuss their projects with us, they develop things that make no sense. (Medical director 18-PC, T2)

Some physicians also overreacted. A medical director, for instance, explains how he doesn't even try to develop his sector, knowing financial constraints will cause administrators to block his projects, "Development projects, you don't have to ask, you know it won't be accepted." (Medical director 9-U, T2)

5.4.2. Legitimacy Work in Strategic Decision Processes: The Four Cases

My data analysis involved reconstructing the unfolding of legitimating and delegitimating practices used as the new roles were implemented. The next pages tell the story of these implementation processes with exemplary practices made in each organization. The perceived influence of physicians and managers on strategic objectives over time at each HSSC is also discussed. These processes are illustrated in figures following each story.

The Primary Care Health and Social Services Centre

At the Primary Care Health and Social Services Centre, the implementation of a co-management structure was the idea of an adjunct to the director of professional services, the director of medical teaching. The CEO and director of professional services accepted attempting to implement the model, and changed their organizational chart accordingly. The director of professional services was assigned the responsibility to lead the change. Originally, the new structure involved attributing medical director roles to four physicians who would co-manage directorates with clinical co-directors. However, only two medical director roles were created, the other two directorates remaining single-handedly led by the clinical co-director. In one directorate, the lack of a physician judged fit for the role by the clinical co-director justified not moving to co-management, while another clinical co-director felt uncomfortable working in a co-management relationship with a physician due to his lack of clinical experience and understanding, "The clinical co-director isn't comfortable with managing clinical issues, and I was taking care of all those issues: interprofessional collaboration, vaccination policies, etc. So he said, 'I would rather have you co-manage with the medical co-leader, and we'll see how it goes.' " (Director of medical teaching-PC, T1)

This partial introduction of the new roles can be seen as structural inertia having delegitimating consequences. Soon after the announcement of the new organizational structure, the director of professional services was made deputy CEO, a change which was thought would contribute to the legitimation of medical directors' position:

> I am now in a position in which I can mobilize directors around co-management. Before, I was a colleague. Now, as deputy CEO, I have a responsibility. The CEO expects me to mobilize them and implement co-management. Now it's clear. We expect my new position to help get directors involved in co-management, and I already see that they are more open to it. (Director of professional services and deputy CEO-PC, T1)

Beside this structural adjustment hoped to contribute to legitimating the new roles, adaptations were announced to the structure of committees to include the medical directors in strategic decision processes. Indeed, an intention to invite the medical directors to clinical strategic meetings when issues concerning them would be discussed was announced in an attempt to involve the medical directors in strategic decisions and legitimize their influence:

> They should be present when topics concerning them are discussed. If we don't talk about anything affecting their clinical programs, they don't have to come to meetings. But I think if the topics affect their program, they should always be there (Deputy CEO-PC, T1)

However, during the second round of interviews, participants reported that medical directors never were invited to participate to strategic discussions, making the legitimating action a delegitimating one. In this case, an attempt to adjust the structure turned into structural inertia:

> If we work in co-management, if administration considers us as a dyad, why aren't we invited as a dyad when there are meetings in the directorate or about the directorate? Something is not working properly. Why aren't we both called? I don't know. I understand we both have a job to do, but when it comes to things like the annual budget, we both should be invited to the meetings. They didn't realize that their system does not support what they claim – if we are a dyad, talk to both of us. Why are there important administrative meetings with the CEO… with only my co-leader? And me, I just meet with the director of professional services or his adjunct? (Tactic level medical co-leader-PC, T2)

> Chief of medical department, I think is a decorative role. We are not involved in major projects. (Tactic level medical co-leader-PC, T2)

Often, the clinical co-directors justified not inviting their medical counterparts by arguing that the medical co-directors would surely not have time to attend. Overreacting, the clinical co-directors not even trying to involve their vis-à-vis, assuming that their other commitments would prevent them from attending. I witnessed one instance in which a medical director was invited to participate

to a strategic decision process. However, the medical director's behavior delegitimized her position. Indeed, her discourse was one of recriminations, demands and critics:

> I don't know where it's going to lead us. (…) I felt like during these two or three meetings, we discussed our grudges. Explaining again and again why we are mad. That we don't like the situation, and that we want things to change. (Medical director 19-PC, T2)

Focusing on grudges instead of attempting to build collaboration reflects the practice of "misconceiving". Another example of misconceiving is the medical directors' lack of ability and willingness to represent the components of her directorate further, delegitimizing the position. Indeed, this refusal to build some kind of representation structure shows physicians' resistance to be sensitive to administrators' need for having one interlocutor as opposed to numerous:

> We don't want the four sectors to become one. Earlier when I was telling you that we felt obliged to assign someone the role of medical co-director… For us the medical manager of every sector should be able to negotiate. I am not the representative of the four sectors. The medical managers of the sectors deal directly with administrators when they need something. They don't go through me. They just inform me. We never wanted to merge the four sectors and have one medical director to represent the whole thing. So when there is a meeting, I let all the medical managers of the four sectors know, and they come if they want and are able to. (Medical director 18-PC, T1)

This unwillingness to actually play the medical director role lasted throughout the data collection. This can be interpreted as passiveness in playing the role contributing to delegitimize the new roles:

> [The clinical co-director] cannot have one co-director… one individual who would have a sort of influence on the four sectors or a kind of collective responsibility, the other medical managers wanting to protect their independence. (Deputy CEO-PC, T2)

> It's going to be very difficult to have co-management and find THE physician able to represent a directorate when the other physicians are practicing in different locations or are

almost never in the organization. They almost never see each other. The medical co-director doesn't represent her colleagues. She gets involved in managing a directorate, but she doesn't know the different sectors well because she doesn't practice in every location and the patients don't have the same profile. It's very complicated. (Clinical co-director 20-PC, T2)

The medical directors' tendency to get involved in operational issues and ignore strategic matters further delegitimized their influence at the strategic level by making the role holders seem passive in their strategic roles as well as by showing medical managers' lack of understanding of strategic management work (misconceiving):

As medical co-director, perfect in playing his role. But extremely affected by all sorts of daily operational issues. He tells me, "I don't want to change light bulbs anymore." (Director of medical teaching-PC, T2)

People are not at the same level. We have medical directors who want to discuss doorknobs, while administrators and clinical co-directors want to go further and discuss the organization of work, the roles of professionals, etc. It's difficult. It's difficult to find common grounds. Some medical directors almost say, "Let's fix the doorknobs and we'll see afterward." For us the discussion should be much wider. (Deputy CEO and director of professional services-PC, T2)

Getting back to the early efforts to implement the new structure, a training session was organized to help physicians understand financial statements and contribute to building the relationship between the co-directors. In other words, the objective was to make space for the new role. However, this legitimation attempt had the opposite effect when a medical director refused to be trained in the group, preferring to have an individual training session:

A training session was organized for medical directors to understand the budget. I announced the training, but one of the medical directors was absent. I told everyone that we were going to be trained together to hear the same thing. When I told the one that was absent, she

refused. She said she would prefer to have a one-on-one training session. I told her it wasn't what we were hoping, but she insisted. I was disappointed. It was an opportunity to do something together. (Director of medical teaching-PC, T2)

Here, organizational members are misconceiving which turned a legitimating practice into a delegitimating one. The organization of additional training sessions were also discussed, but never happened. As a result, throughout the data collection, participants reported a lack of vision, of will to implement the model and of clarity of the roles and responsibility of actors. The following quotes were extracted from the first round of interviews and illustrate these perceptions:

The first challenge is to agree on what co-management is. The CEO should be able to share his vision for the directors to adhere to the model. (…) I don't know why, but we haven't discussed our vision of co-management. We have to talk about it I think. We can read, theoretically. It's nice on paper, but in real life, if we don't take the time to share and explain our concerns, we are going to always remain a little bit reticent. (Clinical co-director 20-PC, T1)

If I told you there isn't any real desire for co-management to work? (Medical director 18-PC, T1)

Co-leadership is on the organizational chart. End of the story. It's not just sending us a piece of paper and saying, "This is co-management." Our roles have to be explained. We have to develop an understanding of what co-management is together. What is my role? How far do I want to go? What is my co-leader's role? How far can she go? (Medical director 19-PC, T1)

Similar comments were made during the second round of interviews:

We had one or two training sessions, we were supposed to have coaching sessions as dyads to develop co-management, but it all stopped. There are no signs that it's going to be revived. To me we are regressing. (Medical director 19-PC, T2)

The director of finance was supposed to meet with every medical director to teach us how to read budgets, but it was never done. (Medical director 18, T2)

Administration decided to hire consultants to help us develop a shared understanding of co-management and make sure it is viable and optimal. We had one meeting and then it died. (…) It didn't go very far and it was clumsy. (…) Before, some strategies were thought of, but it never was actually done. It created more dissatisfaction instead of helping clarify things. (Clinical co-director 19-PC, T2)

Approximately a year after the announcement of the changes in the organizational chart, the director of medical teaching noted that declaring that a structure was transformed was insufficient to modify actors' behaviors and attempted to organize group discussions to clarify the organization's vision of co-management as well as actors' roles and responsibilities. His idea was hence to make space for the new role. However, a lack of participation contributed to delegitimating the new structure instead of legitimating it. Once again, organizational members' passiveness was an obstacle to establishing the new roles:

The director of professional services is also deputy CEO. His preoccupations are diluted a little bit. Implementing co-management is not his priority. When we started the project, I saw myself as a facilitator, but not the leader. (…) When you announce the implementation of co-management, you create expectations. A committee mandated to reflect on the implementation process was supposed to meet in June, but it didn't. I didn't hear about it. (…) The reflection committee's days are counted. It's not something we should continue. It could have been a lever, an opportunity for the co-leaders to discuss together. It was the only opportunity but it never took place. It never took place. (Director of medical teaching-PC, T2)

It stopped there. I think the adjunct to the director of professional services had good intentions, but people didn't participate. The response wasn't strong enough for him to keep investing… (…) I think no one answered. People did not manifest any interest. (Medical director 20-PC, T2)

Noting the failure of this first attempt, the director of medical teaching decided to meet all dyads to discuss the members' roles, responsibilities and vision (that is, make space). However, when meeting the dyads, the director of medical teaching quickly noticed that the members of the dyads had never discussed and hence possessed different and sometimes divergent ideas of their roles and vision. This legitimating attempt hence had delegitimating consequences caused by actors' passiveness:

> I tried to meet them, for them to tell me about their vision and plan of action for the coming year. But I saw that they hadn't discussed anything together. They were making two monologues. They had two months to prepare something for the meeting. Why didn't they prepare anything? Normally, they should have prepared something. I told them, "I want a position as a team leading a sector." I don't want two monologues anymore. (Director of medical teaching-PC, T2)

> We didn't want to impose a model on the dyads. We expected the co-leaders to sit down and divide their responsibilities among themselves. It hasn't been done. Maybe it's utopian to think that they are going to sit together and… we tried to encourage it. At one point I forced them – I scheduled meetings with them. It didn't work. I asked the co-leaders to invite me to two of their meetings every year. I imposed it. But they weren't meeting at all. (Director of medical teaching-PC, T2)

The lack of proactiveness in implementing and developing the new model was not restricted to the co-directors. Because the CEO and director of professional services believed changing the organization chart would be sufficient to implement the new co-management model, no leadership

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was exercised. Their passivity significantly contributed to delegitimise the new roles. In the following quotes, the director of medical teaching explains considering playing a more active role in the implementation process to compensate for the deputy CEO's passiveness, but not wanting to impose:

> I am supporting the implementation of the co-management model, but maybe I should discuss the leadership of the project with the deputy CEO. If I am the leader, I'll do it. Right now, my role is to facilitate. (…) Perhaps we should clarify the expectations. I am willing to go further, but I don't want to… (…) My role is clear: I support the process he is leading. Should I take the lead? (…) I am not taking the lead because I am not the deputy CEO and director of professional services. I am his adjunct. I am not taking the lead because I respect him. (Director of medical teaching-PC, T2)

> I could be mandated to implement the co-management model, instead of having an artificial role… (…) Maybe one mistake… maybe not a mistake but from the start we could have been more precise in defining what is a project leader. A leader responsible to implement the model… There is a breach… the project fell into the cracks. (Director of medical teaching-PC, T2)

This passiveness was highlighted by numerous actors throughout the 21 months of data collection. When reflecting back on the implementation process during the last interviews, participants saw this passiveness as the central reason for the failure of the change attempt:

> It's like co-management was a project that was weakly led. It's the fashionable things right now, other organizations have done it, it's well perceived. They implemented the model but didn't dare to push too much. They didn't want to offend anyone, didn't want to impose it to anyone. They didn't want to displease the physicians, didn't want to displease the directors… They are not pushing much… (…) The CEO should take a stance: do we implement co-management or not? And then define the model. If top management commits to the model,

they need to state it clearly and define the model, and the directors, we are going to conform to it. (Clinical co-director 18-PC, T2)

I don't think we were supported in developing the new model. (…) I didn't hear about it much. (…) I didn't see a movement toward co-management. (…) Have we given ourselves the means to succeed? I would say no. (…) Do we believe in co-management? Are the clinical co-directors ready to share their power? Was there a real consultation to see if we agreed the model should be implemented? I would tend to answer no. (…) Co-leadership needs to be a priority in the organization. Have we reviewed the priorities? No. It hasn't been mentioned anywhere in the strategic plans. (Clinical co-director 20-PC, T2)

My co-management role was thrown at me… At one point I heard they wanted to offer training, but I don't know if they offered it or not. I never heard about it. (…) We never sat down to reflect on what is co-management. They said: co-manage. I am a medical practitioner. Co-leadership – ok, but help me out. Tell me what it involves, what the objectives are… There was nothing except generalities during one or two meetings, and then "Lets' go!" (Medical co-director 19-PC, T2)

It's not real. There is nothing concrete. Administrators announced co-management, but nothing has been done. The strategies used were clumsy and unproductive. They announced something, but it wasn't serious. (Medical co-director 19-PC, T2)

This portray of the implementation process at the Primary Care HSSC, which is illustrated in figure 5.3., reveals how active delegitimating attempts are not necessary to impede a structural change. In this case, passivity, especially of the change agents and co-directors, prevented the establishment of the new roles. Some incidents suggesting misunderstanding and structural inertia were noted, but did not constitute the main obstacle to legitimating medical directors' influence in strategic decision processes.
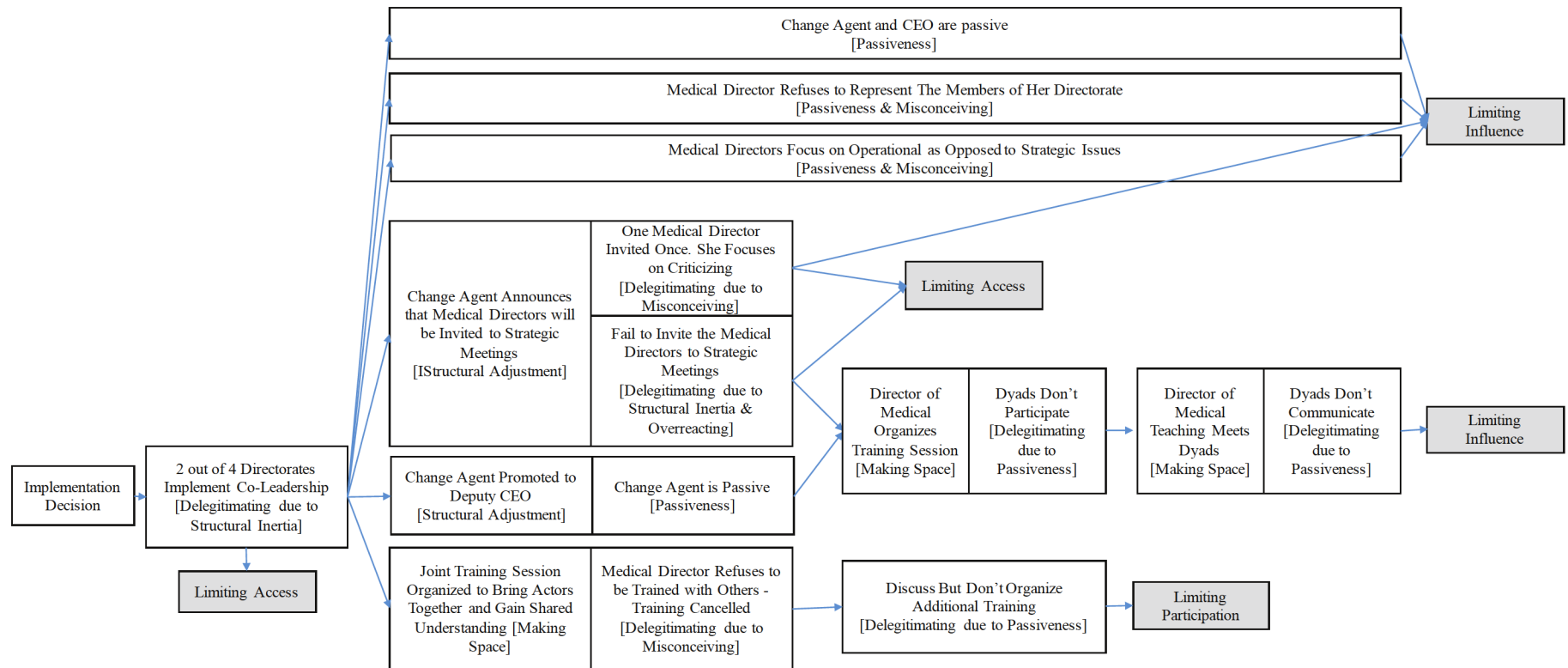
Figure 5.3. Illustration of the Implementation Process at the Primary Care Centre and Its Consequences on Strategic Decision Processes [8]

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[8] Note that these figures do not constitute an exhaustive list of all the practices I observed. Instead, it reflects the story of the implementation process told in the previous pages, which is meant to reflect typical practices.

At the Primary Care HSSC, access to strategic decision processes remained almost inexistent throughout the 21 months of the research project. Only one medical director was invited to one decision process at the end of the data collection period. Presence and participation were hence insignificant. Although I am aware that influence can be done behind the scene in day-to-day activities, no influence has been observed or reported by any participant.

The Semi-Rural Health and Social Services Centre

The Semi-Rural HSSC first implemented the co-management structure in 2008. The original model involved assigning the role of medical director to the existing chiefs of medical departments. However, this initial experience was difficult. The director of professional services, who was chief of a medical department during these early attempts, explained these difficulties:

> At first, they made errors, obstacles. They took the chiefs of medical departments and they catapulted us to the roles of medical directors. It might not necessarily be the right thing because they were focused on the hospital rather than the entire HSSC. They weren't linking the first and second lines. They focused on the second line. And the roles weren't defined as well as they currently are, so there were misunderstandings. So the implementation was lame. (…) To some medical directors, the clinical co-director was like a secretary and some clinical co-directors were afraid of meeting their medical counterpart. Some medical directors resigned. One clinical co-director also resigned. Then another medical director who didn't understand the difference between his co-management role and his role as chief of medical department resigned as well. A lot of misunderstandings on both the medical and administrative co-directors' sides. (Director of professional services-SR, T1)

These early unsuccessful attempts contributed to delegitimating the new roles. At the arrival of the new director of professional services, a more structured attempt to implement the co-management structure was made.

The Semi-Rural HSSC's second attempt at introducing medical director roles started with the creation of a committee responsible for the implementation of the co-management model. The committee was originally composed of the director of professional services, the director of human resources, a consultant as well as the first strategic dyad. Later on, a second tactic level dyad joined the committee, as well as the CEO. In itself, the committee constituted an attempt to legitimize the new roles by determining and creating space, as well as by demonstrating and developing their ability to empathize by encouraging an open exchange between medical directors and senior managers.

At first, the committee's efforts were focused on defining the roles and responsibilities of the medical directors, which the first strategic dyad experimented. After a few months, three additional dyads were created, making the co-management arrangement organization-wide. During the first months, the medical directors' time was mainly spent meeting with their co-leaders, allowing the dyads to bond and the medical directors to familiarize with the issues their clinical co-directorates were facing. These early efforts were focused on defining and making space for the new role in managing the directorates, structural adjustment as well as empathizing within the dyads.

Simultaneously, the co-management implementation committee was able to gain the financial support of a private foundation in the implementation of the co-management model. The foundation was supporting the structural change by paying for a change management consultant to accompany the HSSC through his change process, as well as to cover different fees related to the organization of coaching, co-development and training sessions. Gaining this external funding constituted a legitimating practice involving injecting resources to support the structural change.

Besides injecting resources, the co-management implementation committee attempted to make space for the new roles and develop their ability to empathize. These attempts to gain legitimacy however had unexpected delegitimating effects caused by organizational members' passiveness reflected in participation deficiencies and misconceiving suggested by the presentations' format

inadequacy. The implementation committee indeed deployed significant efforts to organize training sessions in which managers, physician-managers and physicians from all levels of the organization were invited to socialize and listen to presentations on the co-management model. However, the first session in March 2011 was cancelled as only one or two physician-managers accepted to attend the event (Notes taken during a co-management implementation committee-SR, 20131008). A second training session organized in the fall of 2011 attracted more people. However, the format of the training session made physicians and physician-managers uncomfortable, and the explanation of the co-management model created more confusion:

> I haven't been aware of that role for very long. Maybe one month. I learnt about it during a training session when they presented the model. Oh my god, it was complicated – it was like they were speaking Chinese – we didn't understand anything. At least I did not understand, and I know the chiefs of the medical department didn't either. They completely lost everyone. (Clinical Middle Manager -SR, T1)

> The physician behind me was saying, "What am I doing here?" He does some management, but going to training sessions like that – mommy meetings where we play little games with cardboard pieces. He was going crazy. (Clinical Middle Manager-SR, T1)

When the CEO joined the co-management implementation committee, the medical directors as well as the change agents responsible for the successful introduction of the medical co-director roles were hoping to gain access to the top management team meetings for the medical directors, another structural adjustment practice. In order to include medical directors in strategic decision processes but avoid overwhelming them with long and purely administrative discussions, the CEO created a new structure of committees in the fall of 2012 in which the strategic committee was split in two: the administrative and the clinical committees. The director of professional services describes the new structure as follows:

> The clinical strategic committee is decisional, and sometimes makes recommendations or requests opinions from the administrative committee. The goal is to divide what is clinical and

what is not, because at the administrative committee sometimes there are very administrative presentations or discussions about policies. (Director of professional services-SR, T1)

More specifically, the administrative committee was composed of the clinical and administrative directors, and focused on discussions related to administrative issues. The clinical committee was composed of the clinical and medical directors, and emphasized clinical issues. The creation of the clinical committee was intended to force some interaction between the medical directors and other members of the top management team, and make the presence of medical directors more mandatory and official during strategic discussions.

The new structure of committee however appears to have only marginally transformed the dynamics, as the three medical directors occupying a top management role at the time were relatively passive. Indeed, a medical director was increasingly withdrawing, first from his role as medical director and then from the HSSC altogether. The second medical director had little time or interest for the role, and was happy to let his clinical co-director lead the directorate single-handedly. The third medical director, the most active one, left on maternity leave, and was therefore absent for a year from the HSSC. When she returned, the medical director was often uncomfortable intervening in sensitive issues, and hence hid behind her clinical co-director, the director of professional services or the CEO:

> At a meeting, an important financial issue came up, a bomb, a surprise that came up at the end of the meeting. It is downright [my clinical co-director] who took the lead. She took the lead. I left that to her because, first, I was not aware of that interpretation of the project, and second, it exceeded me. I felt exceeded so I let her lead. (Medical Director 17-SR, T2)

This passiveness of the medical directors contributed to delegitimating the new roles. During the winter of 2013, the director of professional services who led the committee of chiefs of medical departments also attempted to make structural adjustments to legitimize the new roles in the medical community by systematically inviting them. However, the medical directors were present

only once, and mainly remained silent. Once again, a legitimating adjustment turned into a delegitimating incident because of the medical directors' passiveness.

In the fall of 2013, the structure of strategic committees was reviewed again in another attempt to legitimize the new roles through structural adjustment. A third strategic committee was created, the joint strategic committee, in which discussions concerning administrative, clinical and medical directors were taking place:

> Finally. I applaud. We are going to have a real vision of the whole organization with all stakeholders sitting at the table. Finally. And it is going to eliminate redundancy, when we had to explain in one meeting what we had discussed in another. To me, there should be no other strategic committee than the clinical one. (Medical Director 17-SR, T2)

The administrative and clinical strategic committees still remained, and focused respectively on purely administrative and clinical issues.

Despite the existence of this structure of committees, the medical directors reported having little influence on strategic decisions. Although they were invited to top management meetings, access to strategic decision processes remained problematic as decisions were not actually made during those meetings, suggesting structural inertia, "Some decisions debated in top management meetings, I realize that opinions have already emerged because the director of professional services talks more often than me with the CEO. So decisions have been made before I start working on it." (Medical director14-SR, T2) The tendency of the director of professional services and chiefs of medical departments to bypass the medical directors contributed to this situation, indicating further structural inertia:

> It's complicated. It is much more complex than what appears on the paper. My perception is that the reporting lines established, these communication paths are not always respected, and certain decisions bypass the required paths. Of course, I am new in the organization and some chiefs of medical departments and also the director of professional services perhaps are not

used to include me. The chiefs very very very often go straight to the director of professional services or even straight to the board. So I am curiously very often bypassed. (…) And sometimes decisions concerning us are made above us, and I am not even informed. (…) If time passes and many issues are dealt with this way, I am going to lose people's trust and be seen as an obstacle to be avoided rather than the path to be taken. And I do see that a little bit. (Medical director14-SR, T2)

Unintentionally, important structural legitimating efforts hence had delegitimating consequences caused by the medical directors' passiveness and structural inertia. At the Semi-Rural HSSC, one medical director did attempt to legitimize her own role by being proactive in shaping strategic decisions and making space for herself to exercise influence:

At first, my co-director was feeding me, and from time to time I would make a small contribution, give her a small information. Now we are more equals. Not perfectly equal, but more. Something happened in February. The director of professional services was absent, and my co-director needed to talk to the director of professional services of another organization to solve a problem. I said, "I am going to take the phone and make the call. We have to discuss that doctor to doctor. As medical director, I think this is my role. " I think it was a turning point. I think my co-director realized I could be useful, that I was not an ornament. That the CEO had not told him, "Here, we are going to put an ornament by your side, dust is going to accumulate but once in a while ask him what he thinks." No no no. I wasn't an ornament anymore. I had moved and shaken things up. (Medical director 17-SR, T1)

In sum, at the Semi-Rural HSSC, as shown on figure 5.4., structural legitimation strategies allowed medical directors to have a say in strategic decision processes, but the behaviour of individuals surrounding these processes limited their influence. The director of professional services' bypassing of the new role (that is, structural inertia) as well as the medical directors' passivity indeed countered the significant efforts to adjust the structure and make space for the new role.
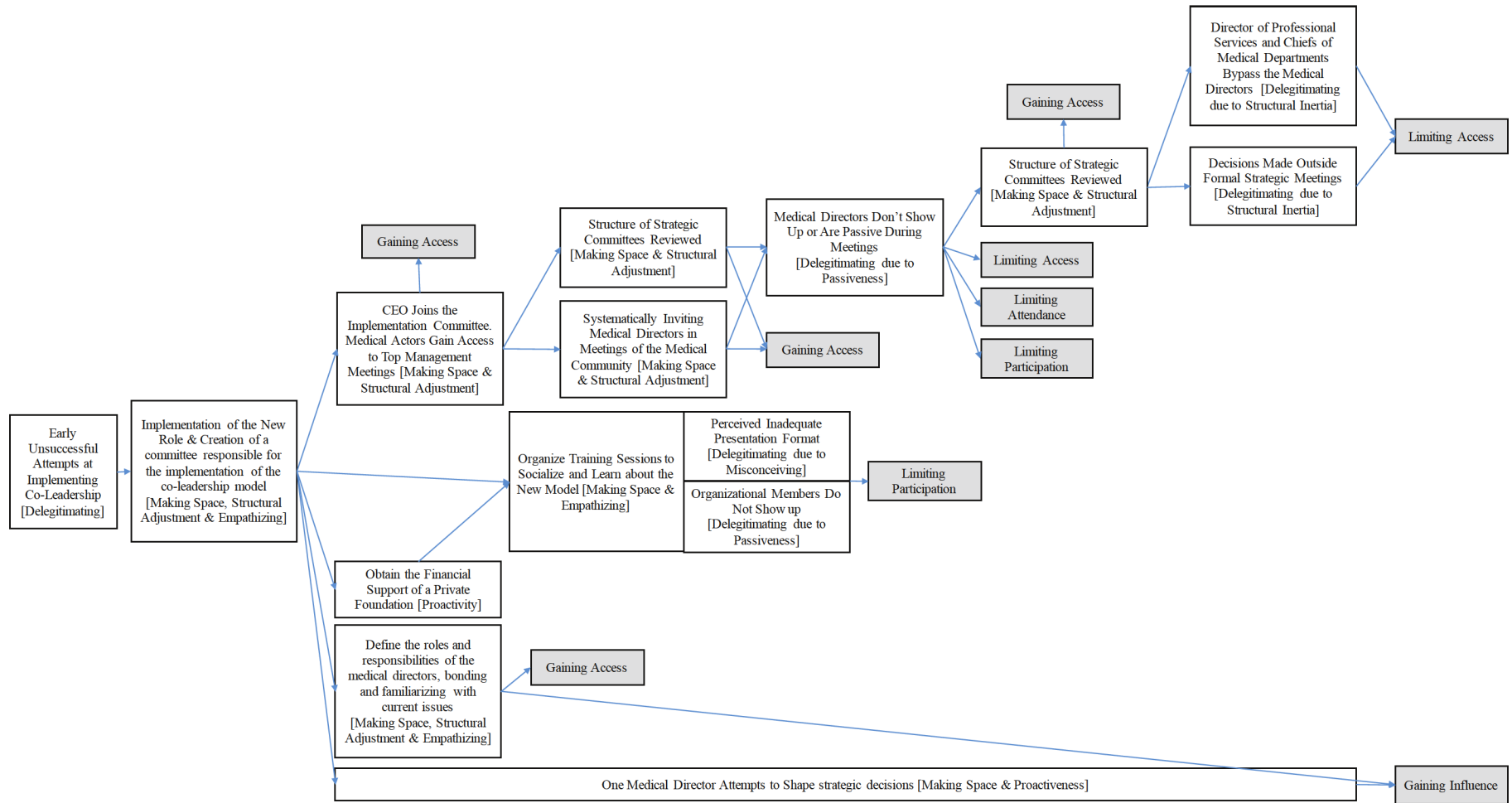
Figure 5.4. Illustration of the Implementation Process at the Semi-Rural HSSC and Its Consequences on Strategic Decision Processes

At the Semi-Rural HSSC, medical directors gained access to top management meetings, but not to strategic decision processes. Additionally, attendance (showing up at meetings) and participation (lack of time, willingness to risk isolation and interest to say something during meetings or regarding some decisions) in top management meetings emerged as problems. Nonetheless, some medical directors did have an influence on some strategic decisions. However, this influence was mainly within the dyads, when decisions were made collaboratively by the co-directors. Medical directors' perspective also appeared to be seriously taken into consideration within the top management team, but their contributions regarded mainly operational issues and related to their medical expertise (for instance, explaining to clinical co-directors that two groups of patients cannot be put side by side as one group risks being infected by the other) as opposed to their insights into strategic management.

The Regional Health and Social Services Centre

At the Regional HSSC, the project of implementing a co-management structure at the strategic level was initiated by the deputy CEO. After she and the CEO defined the model they were hoping to implement, she made presentations across the organization to explain the need for change as well as the principles behind the new structure, "The game plan is to get the organization's 5000 employees and physicians to adhere to a deep restructuring of the organization." (Assistant CEO-R, T1) These presentations, it was hoped, would contribute to legitimize the new roles by making space for the medical directors. Although it was intended to strengthen support for the new structure, the format of her presentation to the chiefs of medical departments created resistance and frustration:

> They are starting to talk about governance again. Last week, a guy presented. Again, they want to change the structure. He arrives, does his speech, and my first question is, "Exactly why are you here?" Because he is going to present the new structure to the board next week. What can I tell you? Whether I have a problem with the structure or not, I can't think about it, I can't study it. Once again, they decided something and then came to show us. There always is that lack of communication. I don't think it is intentional but it happens. (…) He wasn't consulting us– we have to be careful – he was presenting. He was warning us. He didn't ask,

"Can I present that structure to the board?" He wasn't there to ask for a permission to present the structure. He was there to tell us that he was going to present that. There is a huge difference. Consulting is done ahead of time. They did not wake up the day before thinking, "Ok, let's make a new structure." They thought about it all summer. But no one told us. (Chief of medical department-R, T1)

Misconceiving hence turned these practices hoped to legitimize the new structure into delegitimating actions. Indeed, the inadequate format of the presentation and the lack of involvement of actors in the early stages of the development of the new model made chiefs of medical departments reticent to adhere to the new model.

After becoming co-responsible for the implementation of the new structure and seeing this resistance, the director of professional services decided to organize a training session in which a presenter would explain the existing medical management roles (director of professional services, chief of medical department, and council of physicians, dentists and pharmacists). His hope was that such clarification of roles would minimize confusion at the arrival of the medical directors, and create a space in which they could play their roles without overlapping with other physician-managers' roles as defined by the law. In other words, the director of professional services was trying to legitimize the new roles by making space within the existing medical structure. However, instead of clarifying the roles, the presenter explained how the new role was illegal, threatening for other physician-managers and a betrayal to the medical profession:

A [consultant] came and scared everyone. He said he was against the new roles, that it was illegal and that we should not do that. He warned everyone that our loyalty had changed. Many things like that. That did not make much sense to me. What I do know is that I don't have a problem: I am loyal to my profession and to the population. Anyway, it is all taxpayers' money, whether it comes from the organization here, it does not change my loyalty and it does not change my ethical values. I thought the arguments were funny. I keep

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having a discourse of collaboration and wanting to move things forward when people are negative regarding the role. (Medical Director 10-R, T2)

Once again, an attempt to gain support and legitimize the new roles had unexpected delegitimating consequences. In this case, the attempt to make space contributed to restricting the space for the new roles.

After the introduction of the medical directors in their roles in September 2013, the director of professional services then attempted to include the medical directors in his regular meetings with the chiefs of departments. It was hoped that the presence of medical directors during chiefs' meetings would be a structural adjustment mechanism legitimating the new roles. However, the idea was loudly rejected by the chiefs, a loud rejection intended to restrict the space given to the new roles which resulted in a delegitimating of the new roles:

> The committee of chiefs of medical departments, I suggested that we have one meeting [with the medical directors] to get to know each other, and then that medical directors come to every other meeting, but it was refused. By all chiefs. All chiefs unanimously. They said, "We'll decide when they need to come and we'll invite them." (Director of professional services-R, T2)

Perceiving the resistance of different actors from the medical community as well as a lack of support from the CEO, a medical director volunteered to discuss his new role with the chiefs of medical departments. This practice, he hoped, would allow him to make space for his new role. His clinical co-director did not support this idea, which he perceived as being part of the CEO's role:

> Some chiefs of medical departments and members of the executive of the medical council question these roles. At one point, one of the new medical directors told me they wanted to sit down with them. I said, "It is not your job to do that. Don't go to the stake. It is not you, but the CEO who should defend the relevance of your role. It is an organizational decision adopted by the board. Don't go to the stake." (Clinical co-director 11-R, T2)

This passiveness and lack of support from the CEO was noticed by many actors, including all clinical co-directors, and contributed to delegitimating the role of medical directors:

> Are there precise objectives? Do we have specific mandates? Have the model or the new role been discussed? Are we talking about the challenges of the new structure? No. Have we even met the CEO? No. (Clinical co-director 12-R, T2)

> Clearly we have a long way to go to legitimize the new roles. It needs to be worked on, and it can't be done within directorates. Maybe once the orientations of the organization will be known, but first there needs to be planning at the organizational level. And believe me when I tell you, "Everything remains to be done." (Clinical co-director 11-R, T2)

All four medical directors working at the Regional HSSC also insisted on the challenges associated with the overlap between their role and the role of the director of professional services, which led to delegitimating the new role. The assistant CEO noticed this overlap as well, and commented on the resulting delegitimating structural inertia:

> [The clinical co-director of mental health services] was very close to the director of professional services. Their offices are almost side by side, and they have been making decisions together for a long time. So when [the medical director] arrived, he was the third wheel. And [the director of professional services and the clinical co-director] both have strong personalities, so - it is not dysfunctional, but it is not easy. (Assistant CEO-R, T2)

The Regional HSSC's decision making process was another instance of structural inertia. Indeed, although the medical directors were invited and attended most official strategic meetings, the existence of an inner circle in which strategic decisions were actually made prevented the role holders from gaining access and influence. The top management team meetings were indeed not moments of discussion or decision making, as reported by the assistant CEO:

Our top management meetings are very focused on administrative issues. Everything is decided before and we give the royal assent there. There is little space for discussions. The tactic committee, we have 25 people around the table, so the discussions are pretty limited too. (Assistant CEO-R, T2)

Instead, strategic discussions and decisions were made in an inner circle. The existence of this inner circle was revealed two months after the arrival of the medical directors. The following quotes respectively reflect the announcement of its existence by the CEO and the reaction of a clinical co-director:

CEO: During the meetings of the advisory committee, I bring up topics I need to discuss. I feel the need to discuss with others. Are present the director of professional services, the director of finance, the director of human resources and a consultant. If I need someone else, I'll invite him or her. We could have kept inviting insiders every Monday morning in my office, but we decided to make it official. (Notes taken by the observer during a discussion following the introduction of the new model-R, 20131023)

I didn't even know that this advisory committee existed. I am not on it. I am very close to the other clinical co-directors, so after the meeting where we learnt about that committee, we met. None of us knew about that advisory committee. Now we understand whose perspectives are shaping the CEO's decisions. (Clinical co-director 12-R, T2)

Medical directors' presence in official strategic meetings nonetheless permitted more empathizing. As highlighted by a clinical co-director, administrators previously tended to be hypersensitive:

It is true that sometimes we were going a little too fast in considering the medical perspective, so sometimes we did not give it enough weight. But on the contrary sometimes we gave it too much weight. The medical directors help us give it the right weight. (…) We were sometimes over cautious, "How are physicians going to react?" We were moving very

slowly, prudently. Now the medical directors can say, "No, this issue has to be resolved. It has been a problem for a long time, physicians want that to be resolved." (Clinical co-director 11-R, T2)

Although the decisions weren't made in the official strategic meetings, the medical directors were present and could participate in the discussions taking place. One of the medical directors contributed to delegitimating her role by behaving in a way administrators perceive as inappropriate, suggesting misconceiving:

> The medical director is very voluble, perceived as deranged by… Well, deranged… That's not the right term, but… by almost everyone. She is not politically clever. She takes the floor, she talks, she yells, she is very very very voluble. She is not incompetent. She has experience as chief of medical department. (…) Her credibility is already not very strong in the medical community. She has to learn to be silent and say what is essential in administrative meetings. She stands out right now. (Deputy CEO-R, T2)

On the other hand, another medical director contributed to legitimating her role both in the medical and administrative communities by concentrating her early efforts as medical director on applying the orientations jointly taken before her arrival in the role in a committee composed of managers, physicians and employees of the directorate:

> [Before becoming medical co-director], we worked six months on a strategic plan. I was part of the strategic committee. (…) I took the plan, and I am applying it. It's helpful because it wasn't just the doctors developing the plan, it wasn't just the administrators, the coordinators were involved, many people. Everyone was involved and we all wanted the same things. Applying the plan makes the organization move forward. And I think the physicians and employees are happy because they see that we are respecting what they wanted. (Medical director 11-R, T2)

By respecting orientations jointly set and keeping all parties involved in applying them, the medical director gained legitimacy by empathizing and using past collaborations as a stepping stone to make space for her new role.

In sum, my data suggest that the medical directors at the Regional HSSC were investing significant efforts to make the introduction of the new role a success. Figure 5.5. reveals these practices. However, these efforts were countered by the blunders and hesitations of some administrators as well as by the opposition of other physician managers who delegitimized the medical directors when trying to assert their own roles. The following quote of the director of professional services illustrates this dynamic: "My meetings with the chiefs of medical departments have never been as good as since the medical directors were introduced." (Notes taken by the observer during a discussion following the introduction of the new model-R, 20131023) These physician-managers' reaction was unexpected. Indeed it appears that the new role threatened these actors who were first expected to perceive the role positively and benefit from it. .
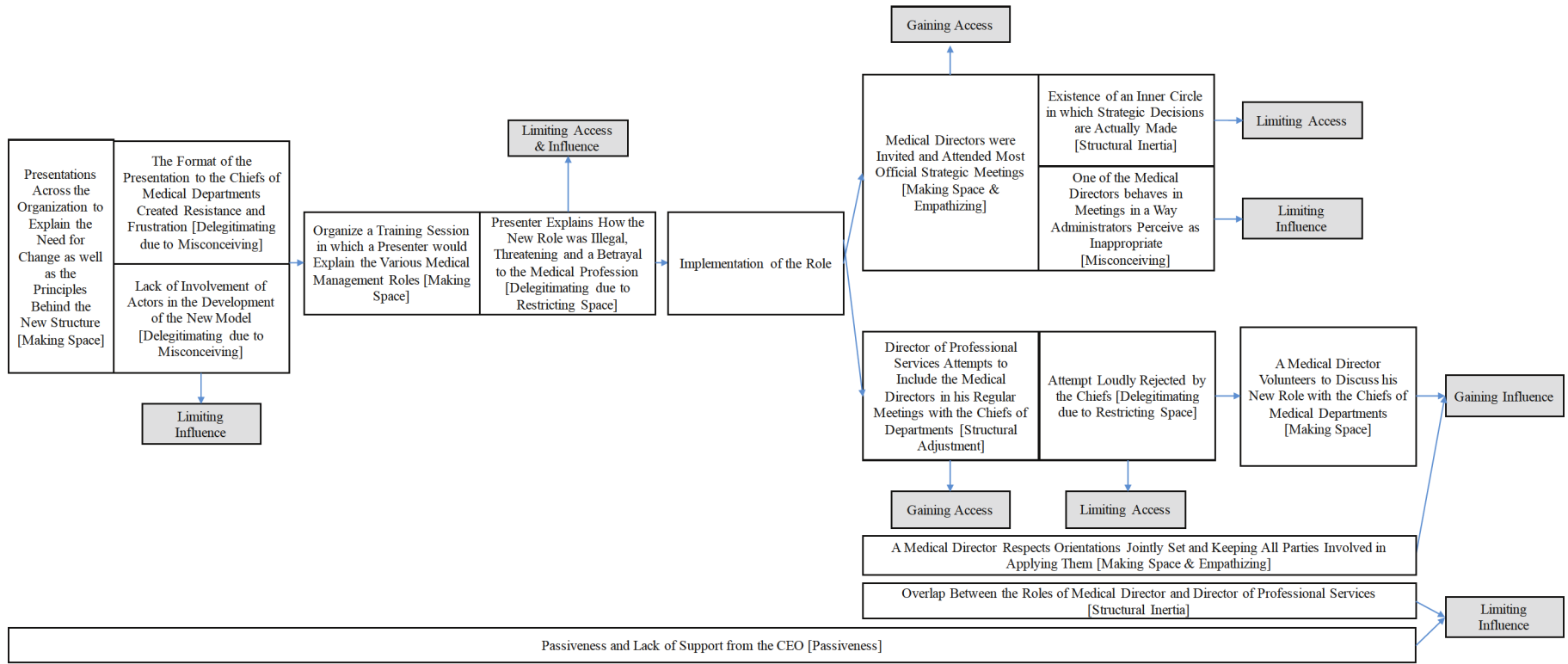
Figure 5.5. Illustration of the Implementation Process at the Regional HSSC and Its Consequences on Strategic Decision Processes

At the Regional HSSC, although medical directors were invited to official meetings, their access to strategic decision processes remained limited as decisions were in reality made in an inner circle excluding them as well as their clinical co-directors. Beside access to the decision processes, attendance and participation became problematic as medical directors lacked time to attend meetings and were concerned with the isolation from their medical colleagues that could result from taking an unpopular stance. The medical directors' influence on strategic decisions nonetheless seemed stronger at the Regional than the Semi-Rural and Primary Care HSSC. Indeed, with the exception of one individual, the medical directors' opinions were taken seriously into consideration within the dyads and did appear to shape strategic decisions within the directorates. This capacity to shape strategy seemed to contribute to legitimating the new roles and their holders. Although the existence of an inner circle impeded their influence, medical directors at the Regional HSSC were proactive in sharing their perspective and attempting to shape strategic decisions at the organizational level. Having been introduced into their roles only a few weeks before the end of the data collection, it is difficult to comment more extensively on the medical directors' influence.

The University Health Centre

At the University Health Centre, chiefs of medical departments were involved from the very beginning in shaping the organizational structure. Three chiefs indeed collaborated with the CEO, director of professional services and the top management team to elaborate the new model:

> What I am proud of, is having defined the new model with physicians. (…) I had a small advisory committee and we examined, based on our strategic plan, what kind of structure we needed to achieve our objectives. Three chiefs of medical departments and three key directors participated in defining the new structure. We presented what we could do, what other organizations were doing and what we wanted to improve based on our strategic plan. It was interesting and it guided me as CEO in defining the new organizational chart. (CEO-U, T1)

Such early involvement of physicians in the process suggests empathizing contributing to legitimating the new roles. Efforts to implement the co-management roles started with structural

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adjustments through the creation of a dyad including the director of professional services and director of nursing, which would be responsible to both manage all the services offered in the organization and ensure the success of the structural change undertaken:

> It is essential for us to support the dyads correctly. It wouldn't make sense for us to manage the other dyads if we weren't working in co-management ourselves. In our mind, we have a duty to support and accompany the dyads at the tactic level correctly. We are trying to do it, among other things, by being role models. (Director of professional services-U, T1)

> I think if we didn't have a strong director of professional services who believes in co-management and walks the talk, it wouldn't work. I wouldn't risk implementing the model. But co-management is his personal project, he wants co-management to be the legacy he leaves to the organization. (CEO-U, T1)

The tandem's proactivity and efficiency contributed to legitimating physicians' influence on strategic decision processes by testifying of the extent to which the partnership between doctors and managers can bring both groups much further than working separately:

> Being connected to the medical community is a little bit difficult for administrators, but dyads can go much further with both physicians and employees. When people see the dyad of the director of professional services and director of nursing, they see that they are working together… the dyad has a credibility that allows us to go further. (Clinical co-director 6-U, T1)

> We have the example of our superiors. No one can say, "They say things but don't walk the talk." No. It helps to change the culture. (Medical director 7-U, T2)

To coordinate the activities of the different clinical programs within their directorate, the dyad created a committee composed of all the dyads working at the tactic level to manage these clinical programs. The committee was originally used for the director of professional services and director

of nursing to transmit the strategic orientations set in top management meetings and coordinate projects spanning more than one clinical program. The strategic dyad's work to make the committee decisional constituted a legitimating structural adjustment practice aimed at increasing the tactic level dyads' influence on both tactic and strategic decisions:

> What we are trying to do is to bring the tactic level dyads at the heart of decision making. They are going to decide for us. Over time, our actions were intended to reinforce the committee. The committees' meetings are going to be more frequent in the future also. (Director of professional services-U, T1)

The dyad additionally attempted to give more autonomy and decision making power to the tactic dyads, supporting them whenever necessary:

> We have more and more responsibilities, we have the budgets. They give us the budget saying, "Play with it." Earlier today my co-manager was asking the director of professional services if we should hire an additional nurse. He said, "You decide. It's your sector, and you know what we want: we want things to work and the objectives to be met. (Medical director 1-U, T1)

> The director of professional services and the director of nursing are giving us back the power to manage our sectors and to negotiate between us. (Clinical co-director 1-U, T2)

The dyad also contributed to legitimating the medical directors' influence by deploying significant efforts to support their work and develop them as individuals and as co-leaders:

> We have a serious challenge because we are supporting 21 individuals. We have to support them when they have to manage crises. We have to support them when they are developing action plans. It requires a lot of energy. (Director of nursing-U, t1)

> We are trying to identify what we are looking for in co-leaders as transformational leaders, and then we are going to look at the co-leaders we have after. In four to eight years, how are

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we going to fill the void between what we have and what we want, and how can we

accompany the dyads. First, I would say individual development plans for the medical co-

leaders, because clinical co-leaders already have training in management. Second, supporting

the dyads in becoming transformational leaders. For instance, in communicating. Evaluating

how the dyads talk to their teams: you said it that way, but you should have said it that way.

We don't constantly coach them, and sometimes we have to pick up the pieces. (Director of

professional services-U, t1)

These efforts to support, develop and clarify the roles of the dyads and medical co-leaders could be

seen as efforts of the strategic dyad to make space for the new roles. Beyond the director of

professional services and director of nursing, the CEO attempted to make space and legitimize the

physician managers' influence on strategic decision processes by assigning the responsibility of co-

leading every strategic project, or at least supporting the project manager, "A chief of medical

department is associated to every transformation project in the organization." (CEO-U, T1) This

practice of the CEO constituted another effort to make space for the medical managers in strategic

management.

Through their involvement in decision processes, some physician managers nonetheless

delegitimized their own influence by letting the interests of their medical department and colleagues

guide their decisions as opposed to the organization or clinical programs' best interests, suggesting

misconceiving:

The chiefs defend their own point of view. In other words, the chief of surgery will defend

the department of surgery. The chief of anaesthesia will defend his department. (…) They all

want their department to develop. (President of the council of physicians, dentists and

pharmacists-U, T1)

Others delegitimized their influence by unwillingly showing their lack of understanding of

organizational issues when debating strategic decisions:

They make decisions, but they don't necessarily understand the whole process. (…)

Sometimes my medical co-manager tells me a decision the medical managers made, and I

think, "I don't understand where this is going." I am not sure that they were aware of all the

implications of their decision and of everything at stake. (Clinical co-director 7-U, T2)

Despite the intention of the director of professional services and director of nursing to decentralize decision making, participants reported how the centralization of power around the strategic dyad contributed to delegitimating the medical directors through structural inertia:

I don't think co-management improved things because the sectors don't have enough power.

Dyads have a limited power. For resources, you can't go beyond a relatively tight limit – so

all the time you have to ask permissions to develop the services. Actually, developments, you

don't even have to ask, you know the answer will be no. But when you want to make changes

you have to ask. And because we don't meet our superiors very often and you can't write an

e-mail, you are always relatively blocked. (Medical director 9-U, T2)

I don't feel more autonomous than I was before. I don't have more decision making power.

The co-directors, the strategic dyad, keep most decision making power. It's okay, they are

directors. We have to negotiate with them. But I didn't feel like I had more power or

leeway… on the contrary. (Clinical co-director 3-U, T2)

Nonetheless, the medical co-leaders' sustained presence at strategic and tactic meetings continued to strengthen their influence on strategic decisions over time:

The director of professional services and the director of nursing, they walk the talk. (…) At

the tactic meeting, the medical managers are present and the quality of their practices

changed significantly, it's really an exchange, an organizational and administrative discussion

on orientations. It's more strategic instead of being operational. The quality of the discussions

evolved. (Clinical co-director 7-U, T2)

With the structural change, the changes made to the committees, the new role of the tactic committee, the role is more strategic than before. More decisional as well. It wasn't necessarily before. We are not there yet, but we are moving forward. (Clinical co-director 2-U, T2)

The director of professional services explains that "real clinical decisions" are going to be made by the tactic committee, but that we have to develop a shared vision of the organization's strengths first. This statement seems to indicate the power they are hoping to give to the tactic committee in making strategic decisions. (Notes taken during the tactic committee-U, February 15, 2012)

While their increasing participation to strategic decisions in the tactic committee constituted legitimating structural adjustment and proactiveness practices, the centralization of decision making around the strategic dyad could be seen both as delegitimation through structural inertia and restricting space. With two exceptions, the medical directors' inability to develop a vision of the whole organization nonetheless weakened their legitimacy to influence strategic decisions (that is, misconceiving):

Some of them are able to rise to the organizational level and go beyond what they are experiencing in their clinical program. Not a lot of them. Of the 11 medical co-leaders, maybe 2 are able to really position themselves at the organizational level. The majority stays at the clinical program level and we need to work a lot to make them see the whole organization. It's not instinctive, they don't have that understanding or that competency yet. (Director of professional services-U, T2)

When we face important problems or decisions are contested, the medical co-leaders' first reflex is to go back to being chiefs of medical departments and protect their department. It's

their first reflex. It's instinctive. The director of nursing and I are trying to help them take a stance, and that the physicians of their department accept it. (Director of professional services-U, T2)

It's a paradox, because the individuals driving the strategic committee are the medical co-leaders, but they don't necessarily understand an organization's life, the human resources. (Clinical co-director 7-U, T2)

In 2012, the strategic dyad and CEO further solidified the dyads' position in the organization by creating two new roles in the human resources directorate dedicated to manage, support and develop the physician-managers, thus sending a clear message of the top managers' dedication to making the new co-management model work and physicians effective medical managers. The director of professional services and director of human resources commented on these structural adjustments:

When you have a human resource director who assigns the responsibility to support managers' development, including medical managers… (Director of professional services-U, T2)

We are going to offer training sessions, and we are going to have two individuals responsible for accompanying the dyads. (Director of human resources-U, T2)

A project was also started in collaboration with a local university to develop a list of competencies needed for physicians to be successful tactic and strategic level co-leaders. Training sessions guided by the model of competencies developed were then offered. The opportunity was also used to discuss and clarify the roles and responsibilities of the different medical, clinical and administrative co-leaders. Thereby, space was made for the medical co-leaders to play their role, and structural adjustments were attempted through the clarification of roles:

[The researcher] met every dyad to make a diagnosis of the situation and identify the competencies and behaviors that contribute to the success of the dyad, those not contributing,

and what is the maturity level of our dyads. In the short term, the human resource directorate

will help reach the objective of creating effective dyads. We are going to help develop co-

management between the clinical and medical co-leaders. (Director of human resources-U,

T2)

At the University Health Centre, seven of the 20[9] physician-managers represented the medical

component of the organization during strategic management meetings throughout the project.

During observations of the meetings, three to four of these physician-managers actually attended the

meetings. Among the medical managers present, two played active roles, while a third one

contributed to some debates occasionally. During some discussions touching the organization's

vision and values, all physician-managers remained silent:

> Observer's comments: Physicians intervene less on the vision. The debate is between
>
> administrators. The interest is even lower during the discussion about values. No physician
>
> intervenes. I can feel their lack of interest. (Notes taken during a meeting of the top
>
> management team-U, 2012-03-13)

When they contributed, the physicians' positions nonetheless appeared to be seriously taken into

consideration. One medical manager's proactivity in shaping strategy contributed to legitimating the

new roles:

> [That medical manager] wants to understand the process, he is extremely involved. (…) His
>
> understanding of the organization is at another level, discussing with him is at another level.
>
> He really enters the model. He is an extremely significant element. When he is with us and
>
> participates, he asks real questions. He says, "I want to contribute, but I have to understand.
>
> What does this thing mean?" (…) When he is around the table, we don't need to coach him.
>
> He is at the same level as we are. He leads us. (Clinical co-director 7-U, T2)

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[9] Regardless of organizational level.

As portrayed on Figure 5.6., the process of implementation of the new roles is characterized by the significant legitimating efforts deployed by different actors, especially the two change agents. All four types of legitimating practices were used, while only minor incidents of structural inertia, restriction of space and misconceiving were observed. In this case, the easier implementation of the new roles may be partly due to the research and teaching orientation of the Health Centre, making the medical community a historically powerful component of the organization. Beyond the higher status of physicians as compared to the other cases, the dynamics at the University Health Centre may have been significantly shaped by the organizational structure assigning the medical co-management roles to the chiefs of medical departments. These dual roles limited the potential resistance in the medical community as the new co-management roles were simply expanding the scope and power of the medical representatives, giving them influence and responsibilities within administration. Overall, access, presence, participation and influence appeared to remain relatively constant over the 21 months of data collection or with the implementation of the new co-management structure.
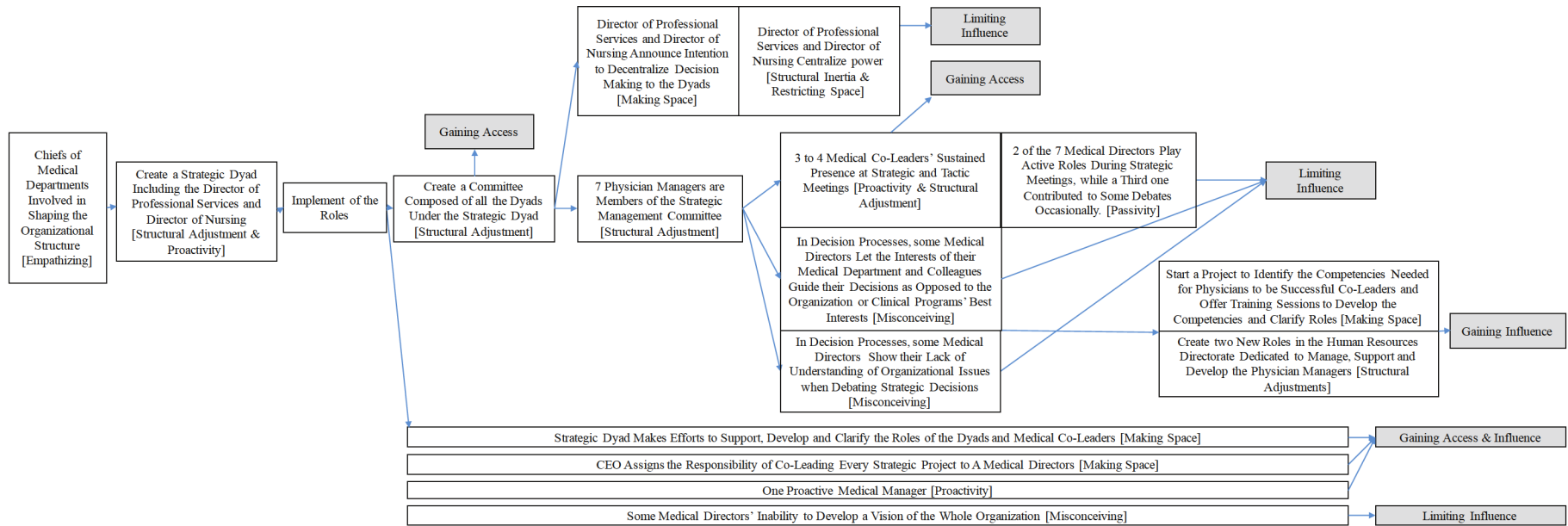
Figure 5.6. Illustration of the Implementation Process at the University Health Centre and Its Consequences on Strategic Decision Processes

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5.5. Discussion

The story of the implementation of new medical co-management roles in the four organizations revealed different implementation processes and takeaways. The implementation story at the Primary Care HSSC shows how changing an organizational chart is not sufficient to change organizational members' behaviors. The story also shows that the passivity of change agents resulting from assuming that changing the organizational chart would be sufficient delegitimized the new roles, making them empty shells. The Semi-Rural HSSC shows how despite creating a space for exercising influence, the passivity of role holders can impede the establishment of this influence. The Regional HSSC differently is an example of how administrators' hesitations and blunders can make the legitimation of the new medical director role difficult, despite active role holders committed to successfully integrate themselves in the top management team and gain influence. The case of the University Health Centre was characterized by significant legitimating efforts outweighing some delegitimating practices or incidents. The case also reveals how a history of collaboration can facilitate the implementation of medical co-management roles, and how using the new roles to expand the roles of chiefs of medical departments to include administrative duties can limit the potential of resistance to the new structure.

Interestingly, the Semi-Rural HSSC also attempted assigning the role of medical director to chiefs of medical departments three years before participating in the pilot projects. However, the chiefs of medical departments restricted themselves to representing and protecting their medical departments. Believing the role of medical director should entail joint management of a directorate based on the organizations' strategic orientations, change agents at the Semi-Rural HSSC considered this first attempt unsuccessful and in a second attempt to introduce the new roles, selected physicians specifically to play these new roles. In sum, while assigning dual roles was unsuccessful at the Semi-Rural HSSC, the strategy limited potential resistance and eased the implementation of the new roles at the University Health Centre where chiefs of medical departments were already performing more extensive management tasks as researchers and university professors, and were already

contributing to strategic decision making. The efforts deployed to clarify the roles also appeared much greater at the University Health Centre than during the Semi-Rural HSSC's first attempt.

From a process perspective, although the four implementation processes were very different, the stories reveal a pattern reflecting the legitimacy work practices and their effect. Figure 5.7. illustrates this process. The arrows show the possible paths and consequences that may result from different practices.
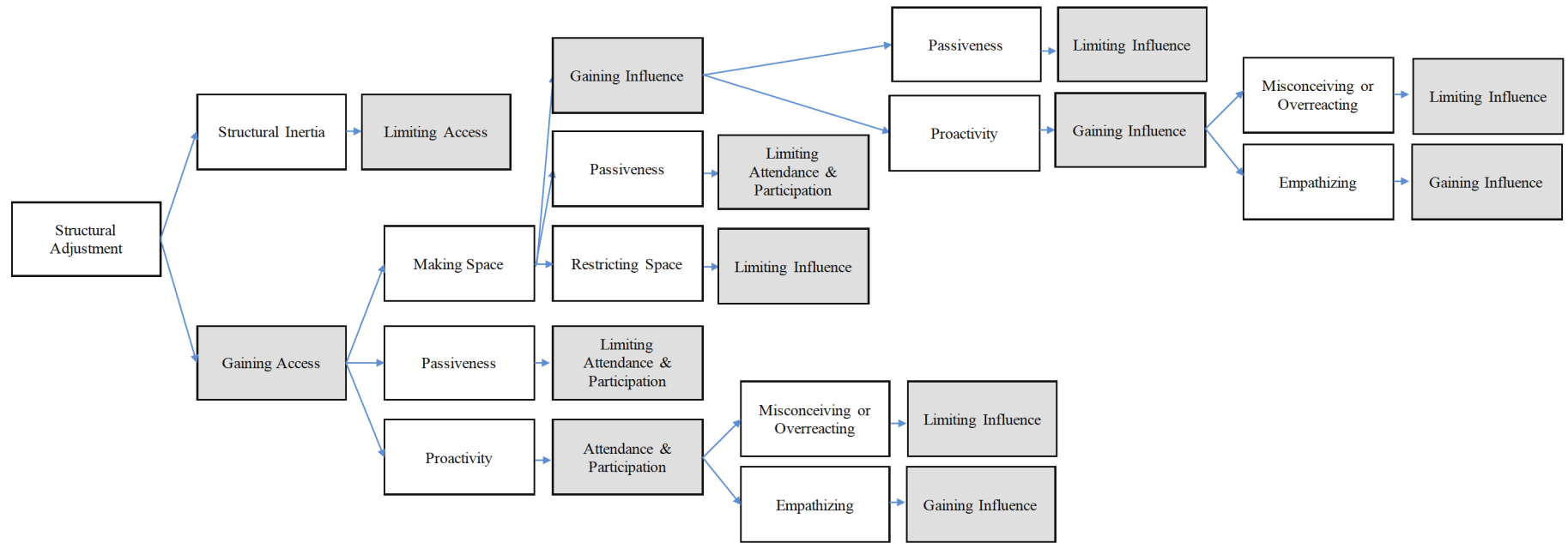
Figure 5.7. Process of Legitimacy Work and Consequences

Overall, as shown in the figure, the results show that structural adjustment practices are generally first used to implement new roles. These practices may lead to structural inertia and limit the role holders' access to decision processes. On the other hand, when access is gained, different actors' passiveness or proactivity determines whether roles holders will attend and participate in decision forums. If proactivity brings attendance and participation, practices of empathizing or misconceiving dictate whether influence is built or reduced. After structural adjustment allowed to gain access, common practices involve attempts at making space for the new role. Counter efforts to restrict space may result, leading to limited influence. Passiveness may also be the response, most likely leading to limited attendance and participation in decision forums. If these attempts are successful, once again, passiveness or proactivity modulates influence. Proactive practices of empathizing contribute to further building legitimacy and influence, while misconceiving would delegitimate influence. Contrary to Vaara and Tienari (2011) who believe that legitimation efforts precede delegitimation work, my study shows that the patterns of legitimacy work do not follow a linear process in which one type of work follows the other. Instead, legitimation and delegitimation practices may be simultaneous or alternate, and may influence one another.

Figure 5.8., which constitutes a schematic theoretical synthesis of the contribution of the article, reflects this idea. The arrows joining legitimation to delegitimation practices illustrate this dynamic of mutual influence. The schema also shows that the responses to these practices may shape the nature of their impact by either building or weakening legitimacy. This impact then both modulates and is shaped by access, attendance, participation and influence in strategic decision processes.
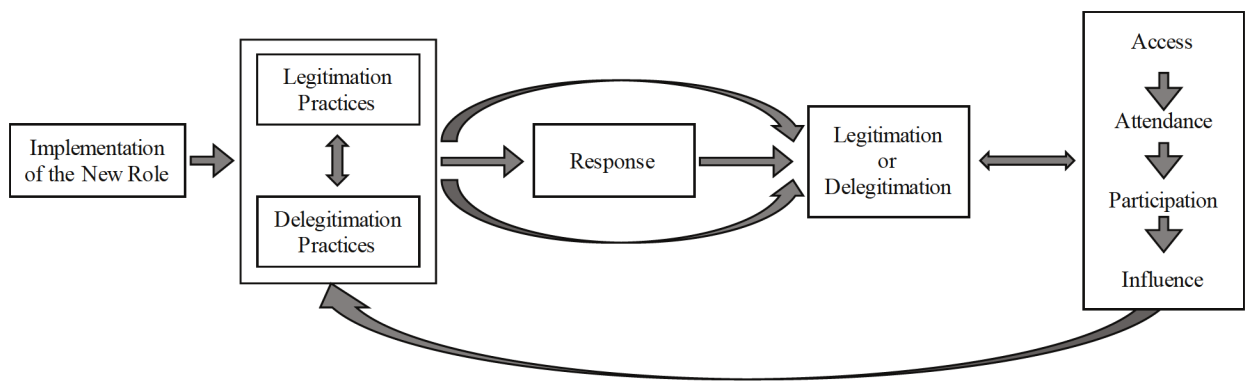
Figure 5.8. Schematic Theoretical Synthesis of the Contribution

Comparing the four cases deciphered, my results suggest that practices to adjust the structure and make space are generally used by change agents during the first phases of the implementation of senior management roles for medical professionals. While some delegitimating practices were used by the chiefs of medical departments, the delegitimation of medical directors' influence on strategic decision processes mainly appears to derive from change agents' legitimating practices having unintended consequences, or seems to unintentionally result from change agents' actions later in the process. Unintentionally delegitimating practices seem to result from change agents' deep-rooted habits reinforcing the old structure or simply from forgetting to reinforce the new role. While Burns and Baldvinsdottir (2005) highlighted that the credibility of the change agents responsible for implementing new roles contributes to establishing the role, my study reveals that change agents can also significantly contribute to weakening a new role. Administrators' blunders and hesitations seem to further contribute to the preservation of the old structure. These patterns are not surprizing in healthcare organizations in which large-scale changes are continuous, succeed each other before being completely implemented, and are layered over existing structures and practices without substituting them (Evans, Baker, Berta, & Barnsley, 2015).

Results also indicate that medical directors contribute to turning practices intended to legitimize their influence into delegitimating actions. More concretely, it appears that even when change agents succeed at creating a space for medical directors to play their roles, the latter's passiveness

prevents gaining, and sometimes even reduces legitimacy. It seems that some medical directors'
lack of awareness of the importance of establishing the new role causes them to act in ways that
counter other actors' efforts to legitimize their roles. More active medical directors mostly seem to
demonstrate more empathizing, make efforts to impose themselves directly or through their co-
director, build relationships and make explicit their influence on the strategy to legitimize
themselves in later phases of decision processes. When loudly rejected, attempts at building
relationships can weaken the medical directors' influence. For the literature on legitimacy work,
these findings reveal the importance of not only looking at the practices used to legitimize or
delegitimize influence, but also at other individuals' response to these practices. These responses
and reactions may significantly shape the impact of the practice and lead to unintended
repercussions.

Hence, I support Vaara and Monin (2010)'s claim that the legitimation practices of proponents of a
change may be turned into delegitimation arguments by its opponents. I, however, go further by
showing that such reversal can result from the legitimation practice (discursive or action) itself or
from any actor's response (that is, even fellow proponents). My results also show that doing nothing
(that is, passiveness) can sometimes be the strongest cause of reversal. In this vein, the results show
that assigning polarized and stable positions to actors can be dangerous (for instance, opponent and
proponent as in Suddaby and Greenwood (2005)). Actors may for instance have an official position
but perform actions having the opposite effect willingly or not.

My results also indicate that the nature of the relationship between the medical directors and their
co-leaders has a significant impact on the role holders' ability to legitimize their role. A clinical co-
director who ignores or rejects the medical directors' input or does not support the medical
director's attempts to legitimize himself can indeed significantly contribute to delegitimating the
new role. These results also support the importance, as pointed out by Vaara and Monin (2010), of
investigating delegitimation practices beyond the typically studied legitimation practices
(Daudigeos, 2013; Goodrick & Reay, 2010; Reay, Golden-Biddle, & Germann, 2006; Sherman,

2010; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014) which offer only a partial portrait of the situation. The practices of all actors should also be taken into account. Solely exploring the legitimation practices of the role holders or change agents as most authors do (Burns & Baldvinsdottir, 2005; George, 2008, 2013; Reay et al., 2013) seems to provide an incomplete understanding of the dynamics.

Two types of practices I uncovered reflect Treviño et al. (2014), Daudigeos (2013), and Burns and Baldvinsdottir (2005)'s findings. Indeed, these three studies discuss role holders' attempts at making space for their roles in different contexts by building relationships. Treviño et al. (2014) and Daudigeos (2013) also address the issue of empathizing when discussing role holders' efforts to adapt the way they frame issues to their audience. Contrary to these two studies, I however go beyond selecting arguments depending on the actor they are attempting to influence and using a language fitting the audience to discuss an issue. To me, empathizing also encompasses practices such as selecting when and where meetings are held, determining the format of training sessions as well as deciding when professionals in management roles should take a stance and when to remain silent. Besides involving a lack of understanding of the other's culture, one of the legitimating equivalent of empathizing, overreacting, reflects an understudied phenomenon observable when some actors may be aware but overly concerned about the other group's concerns and reality. *Proactivity* also partly echoes Reay et al. (2006)'s conclusions. Like the authors' nurse practitioners, the medical directors tried to build a history continuous small 'wins' demonstrating the value of the new role. In the existing literature, delegitimation practices (passiveness, structural inertia, restricting space and misunderstanding) as well as the unintended consequences of legitimating practices are however not discussed.

Taken together, the three last cases show how significant efforts deployed to implement and legitimize new roles can have relatively limited repercussions. In the first three cases, the impact of the introduction of physicians in management roles seemed to be relatively limited over the 21 months of this study. Physicians at the University Health Centre benefited from a greater influence

on strategic decisions before the pilot projects, but my results suggest that this influence did not increase with the implementation of the new roles. These findings are coherent with previous research examining the influence of professionals in management roles at the strategic level. Harrison and Miller (1999) found that few clinical co-directors had influence on strategic decision processes, while MacIntosh et al. (2012) reported the limited power perceived by physician managers as well as their inability to access real decision forums. Like Kippist and Fitzgerald (2009), I found that even as insiders of decision circles, professionals can be prevented by time constraints and limited understanding of management philosophies from attending decision forums or participating. I also support the authors' conclusions that professionals in management roles may perceive a lack of autonomy in making decisions, causing frustration and disengagement.

5.6. Conclusion

To conclude, four types of practices (proactivity/passiveness, structural adjustment/inertia, making/restricting space and empathizing/misunderstanding) can be used to legitimize and delegitimize medical directors' influence on strategic decision processes. Even when intended to legitimize, practices can have delegitimating consequences. In some cases, these unintended consequences are the result of different actors' response to a legitimation or delegitimation attempt. Alternatively, delegitimating influence can be done accidently, especially as time goes by and the establishment of the new role becomes less salient in actors' minds. As discussed earlier, although they initiate most legitimating practices, change agents and the holders of the new roles simultaneously contribute significantly to limiting influence on strategic decision processes. The professional and managerial communities do contribute to both legitimize and delegitimize influence, but do not appear to be central in shaping influence.

In sum, my study shows how, despite investing significant resources and deploying important efforts, an organizational culture is not easy to change. Implementing new roles involves changes well beyond the new role itself. The entire structure has to adapt. Even with the best intentions, such adaptation is not easy and the system might reject the new role. Not rejecting or confirming other

actors' rejection of the new role appears difficult. As a consequence, professionals entering senior management roles are seen as having little influence on strategic decisions. Difficulties accessing inner decision making circles, as well as attendance and participation deficiencies also prevent role holders from making a significant contribution and the role from being established.

Beyond considering how a change transforms an organization, this study took into account how the organization and its actors modify the change itself as well as its impacts. I hence contributed to understanding how actors respond to and shape events, which derive from the attention given to efforts aimed at legitimating or delegitimating the change by various actors. Indeed, contrary to previous studies in which attention is given only to attempts at establishing influence (creating change), I also explored efforts to counter the change and preserve or recreate the status quo. Efforts for change and stability, whether conducted by different individuals or in a contradicting manner by the same person in different situations, were explored simultaneously. The consideration of a variety of actors, from top management to front-line physicians, filled an additional gap in literature.

My conclusions have important implications for practitioners. First, beyond changing organizational charts, change agents should invest in legitimating efforts, especially at early stages in the structural change process. Change leaders responsible for adding a new role to an organizational structure would benefit from carefully ensuring the coherence of their actions with the change they are trying to implement, especially as months go by and old habits come back. Professionals entering management roles should be individuals committed to the new role. My results indeed show that when organizations struggle to find professionals interested in management role and resort to arm twisting, the role holders might be more passive in playing their roles, often discrediting themselves and the new role involuntarily. The experiences of assigning medical director roles to chiefs of medical departments at the Semi-Rural and University Health Centres also reveals that for such dual

roles to be played successfully, role holders must understand the difference between their two roles. Otherwise, the role of chief of department might be predominant, thus delegitimating the role of medical director.

Of course, these conclusions are based on the analysis of the implementation process in four organizations. More research is hence needed to confirm the results. This study revealed that 21 months of data collection might not be enough to evaluate the influence on strategic decisions of holders of newly created management roles. Future research could avoid this limit by collecting data over a longer period of time. In future research, specific strategic decision processes could also be followed over time to identify both the unfolding of legitimating and delegitimating practices as well as the changes in different actors' perception of influence on the decision process. With such design, the connections between the practices and the influence on decision processes could be enriched.

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CHAPITRE 6 : Conclusion

Indépendamment, les trois articles composant cette thèse explorent la rencontre des logiques institutionnelles à trois niveaux : l'individu, la dyade et l'organisation. Globalement, l'ouvrage peint le portrait du processus d'implantation de rôles de cogestion pour les professionnels visant à faire le pont entre les logiques managériale et professionnelle tout en augmentant l'influence des professionnels dans la prise de décision stratégique. Dans ce contexte, j'ai cherché à savoir *quel est l'impact à travers le temps de l'intégration de professionnels dans des rôles de gestion dans les organisations professionnelles au niveau des individus, des dyades et de l'organisation?* Pour répondre à cette question, une étude longitudinale se déroulant sur 21 mois, soit de février 2012 à octobre 2013 au sein de quatre organisations de santé et services sociaux canadiennes a été menée. La collecte de données incluait 167 entrevues, l'observation non participante de 102 rencontres ainsi qu'une analyse documentaire.

L'étude montre que si l'intégration de professionnels en gestion peut avoir pour objectif de lier des logiques et enrichir la prise de décision, les pratiques quotidiennes des acteurs peuvent en réalité renforcer l'ancienne structure de différentiation des logiques, témoignant de la résilience de ces organisations. Cette résilience est particulièrement apparente à mesure que le temps passe et qu'un ralentissement des efforts de changement se conjugue avec un retour aux anciennes pratiques. Au niveau individuel, l'étude montre que l'identité des professionnels en gestion sera modelée par la régulation identitaire à laquelle ils seront soumis et évoluera à travers le temps. Au niveau de la dyade, il ressort que le modèle de co-leadership peut permettre de lier deux logiques lorsque certaines configurations existent, mais permet souvent de renforcer la dominance d'une logique ou de coopter des membres adhérant à une autre logique. Au niveau organisationnel, on peut conclure que l'influence des professionnels en gestion sur la prise de décision stratégique sera affermie si, à long terme, les efforts de délégitimation et les retombées en ce sens des pratiques de légitimation ne contrebalancent pas le travail réalisé pour établir la légitimité de l'influence associée aux nouveaux

rôles. En d'autres mots, le rôle ne doit pas être délégitimé davantage qu'il n'est légitimé pour que ses détenteurs puissent posséder une certaine influence.

Pour conclure l'ouvrage, dans les prochaines sections s'enchaîneront les contributions à la littérature propres à chaque article et une discussion de la contribution plus générale aux débats portant sur l'introduction de professionnels en gestion. Les limites de l'étude et avenues de recherche seront ensuite abordées.

6.1. Discussion

Les trois articles qui composent cette thèse apportent des contributions aux débats sur le travail identitaire, les logiques institutionnelles et la légitimité. Celles-ci sont discutées dans les pages qui suivent, puis suivies d'une discussion portant sur la contribution de la thèse à la littérature portant sur l'intégration de rôles de gestion par des professionnels.

6.1.1.   Niveau individuel : le travail identitaire

Dans le premier article situé au niveau individuel, j'ai exploré comment l'identité des professionnels évolue à travers le temps lorsqu'ils intègrent des rôles de gestion. Globalement, le premier article met en lumière que des professionnels qui entrent dans des rôles de gestion s'efforcent de construire un narratif de continuité plutôt que de rupture. Contrairement aux études antérieures sur le travail identitaire (Clarke et al., 2009; Croft et al., 2015; McGivern et al., 2015; Watson, 2009), l'article explore des transitions dans le cadre desquelles des professionnels intègrent des rôles de *cogestion*. Dans ce contexte particulier, l'étude montre que la relation avec le cogestionnaire est un facteur déterminant qui modèle la nature et la rapidité de la transition identitaire. L'article met également en lumière cinq formes de travail identitaire pour répondre aux régulations : construire la continuité, se distancier de la gestion, réinventer la gestion, se positionner au-dessus de la mêlée et définir la relation avec le co-leader. Les trois premières formes rejoignent les conclusions de plusieurs auteurs sur le travail identitaire (Croft et al., 2015; Kreiner et al., 2006;

Llewellyn, 2001; Pratt et al., 2006; Thomas & Davies, 2005), mais les deux dernières contribuent en enrichissant notre compréhension du spectre des pratiques mises de l'avant par les individus (c'est-à-dire se positionner au-dessus de la mêlée et définir la relation avec le co-leader).

L'étude apporte également un éclairage différent sur les pratiques. Contrairement à McGivern et al. (2015) qui identifient les efforts de construction d'un nouveau professionnalisme, les résultats de cette étude montrent plutôt une réinvention de la gestion. De plus, contrairement à ces auteurs, aucun effort pour réguler le professionnalisme à l'aide de processus organisationnels n'a été observé. Nos données suggèrent plutôt que les professionnels évitent activement de réguler leurs collègues, laissant généralement le soin d'accomplir toute action qui pourrait s'approcher d'une telle régulation aux gestionnaires ou aux professionnels plus expérimentés occupant des postes de gestion de manière plus permanente ou à des niveaux plus élevés dans la hiérarchie. La position charnière des professionnels en gestion et la nouveauté du rôle intégré peuvent quant à eux contribuer à expliquer pourquoi nos résultats diffèrent de ceux de Ibarra (1999), les professionnels évoluant dans le contexte que j'ai étudié étant souvent isolés les uns des autres avec peu de modèles de rôle et risquant de s'isoler davantage ou perdre le support d'autres acteurs s'ils optaient pour une expérimentation d'attitudes et comportements inappropriés.

Nos résultats mettent également en relief l'importance de tenir compte de l'évolution de l'identité et du travail identitaire à travers le temps. Contrairement à Pratt et al. (2006) et Kreiner et al. (2006) qui proposent des modèles séquentiels dans lesquels les différentes formes de travail identitaire sont mobilisées de manière linéaire, cette étude suggère que les formes sont mises de l'avant alternativement et simultanément, interagissant les unes avec les autres. L'article montre que le recours à ces formes de travail identitaire suit un processus général typique, bien que les professionnels à différentes étapes de leur mandat et soumis à des régulations identitaires de nature différente insistent particulièrement sur certaines formes plutôt que d'autres lorsqu'ils construisent leurs narratifs.

De plus, le contexte (tel que le degré et la nature de la régulation identitaire) semble influencer le processus de transition identitaire. Il est donc peu probable qu'une seule séquence linéaire de mobilisation des formes de travail identitaire soit applicable à tous, la transition étant probablement beaucoup plus contextualisée. En ce sens, l'étude amène aussi à penser que les catégorisations dichotomiques de l'identité que proposent plusieurs auteurs (Forbes et al., 2004; Hoff, 1999; McGivern et al., 2015; Spyridonidis et al., 2014) devraient être nuancées. Comme l'argumentent P. Thomas et Hewitt (2011), notre étude montre que l'hétérogénéité au sein d'une profession ne devrait pas être sous-estimée, une analyse fine des professionnels pouvant enrichir et nuancer les conclusions basées sur une catégorisation plus large.

6.1.2. Niveau de la dyade : les logiques institutionnelles

Dans le second article au niveau dyadique, j'ai tenté de clarifier si et comment un modèle de co-leadership permet de faire le pont entre deux logiques institutionnelles. Les implications théoriques du second article touchent la littérature sur les réponses à la complexité institutionnelle (Battilana & Lee, 2014; Fossestol et al., 2015; Greenwood et al., 2011; Reay & Hinings, 2009). De manière générale, on constate que l'équilibre entre les logiques n'est pas facile à établir et maintenir dans les dyades de co-leaders, la séparation, soumission ou cooptation résultant fréquemment. L'article explique six configurations de co-leadership : la dyade d'un, la consultation professionnelle, le duo de liaison, le duo de gestion, l'unité de gestion et l'unité de mission.

De manière plus pointue, il ressort de l'étude que c'est lorsque l'un des co-leaders adhère aux deux logiques à la fois que le modèle semble posséder le plus grand potentiel de contribuer à faire face à la complexité institutionnelle, à condition que celui-ci soit actif et coordonne ses activités avec son vis-à-vis. Sauf dans le cas de ces duos, la plupart des tandems sont dominés par une seule logique, soit parce que le membre adhérant à une logique contribue peu ou pas (comme dans les dyades d'un) ou parce que les deux membres mettent l'emphase sur la même logique (comme dans les duos de gestion et l'unité de gestion). Il semble que le modèle de co-leadership peut aider à lier deux logiques lorsque les deux membres des dyades acceptent d'amortir leur logique originale dans le

cadre de leur travail de cogestionnaire et se concentrent sur des principes supérieurs les unissant. Alternativement, un modèle de co-leadership peut également renforcer la dominance d'une logique en contribuant à coopter des représentants d'une autre logique.

Contrairement à Fjellvaer (2010) qui identifie différentes configurations enracinées dans l'adhésion des membres des dyades aux logiques, nos résultats montrent que les patterns individuels de mobilisation des logiques ne se traduisent pas nécessairement au niveau dyadique. Nos résultats enrichissent par ailleurs la typologie des configurations de Gibeau et al. (2015) en montrant que la configuration se rapprochant du modèle idéal de distribution, le duo de liaison, semble rare et fragile en plus de résulter en des activités de liaison plutôt limitées au niveau individuel, la liaison étant principalement exercée au niveau dyadique par une division des rôles basée sur l'expertise. Nos résultats suggèrent également que les configurations que les auteurs qualifient de « duplication » peuvent provoquer une synergie supérieure aux autres, au-delà des possibles rivalités et conflits soulevés par les auteurs. Finalement, l'article suggère que la configuration « consultation professionnelle » peut offrir un potentiel intéressant car elle permet à des professionnels de contribuer sans toutefois être contraints d'investir un temps significatif dans l'exécution du rôle ou l'apprentissage de la gestion. Leurs expertise et capacité d'influence propres sont donc exploitées sans que le rôle ne devienne trop lourd pour être accepté.

De manière générale, ces conclusions indiquent que les tensions existantes au niveau organisationnel ne sont donc pas résolues par le modèle de co-leadership mais plutôt reflétées au sein des dyades. D'un point de vue processuel, l'article montre que les configurations des dyades semblent relativement stables. Dans les cas où celles-ci évoluent, le changement peut se faire dans le sens d'une plus grande intégration ou de la désintégration.

6.1.3. Niveau organisationnel : la légitimation

Au niveau organisationnel, la question suivante a été investiguée : *comment et pourquoi l'intégration de professionnels dans des rôles de gestion affecte (ou non) leur influence sur la prise*

de décision stratégique à travers le temps? Ce troisième article contribue à la littérature portant sur le travail de légitimation en identifiant quatre types de pratiques symétriques qui peuvent légitimer ou délégitimer l'influence : proactivité/ passivité, ajustement/inertie structurelle, créer/restreindre l'espace et sensibilité/incompréhension interculturelle. Alors que certaines pratiques de légitimation énumérées reflètent les stratégies identifiées dans des travaux antérieurs (Burns & Baldvinsdottir, 2005; Daudigeos, 2013; Reay et al., 2006; Treviño et al., 2014), cette étude contribue en mettant en lumière des pratiques de délégitimation (en plus des pratiques de légitimation) effectuées par une variété d'acteurs (au-delà du détenteur du rôle et des agents de changement) ainsi que leurs répercussions réelles (plutôt qu'attendues) et les réponses qu'elles engendrent.

Une contribution découle par ailleurs de la démonstration faite que la plus grande menace à la légitimité de l'influence des professionnels en gestion découle des pratiques des agents de changement et des détenteurs des nouveaux rôles. Alors que les études antérieures positionnent d'emblée les agents de changement et détenteurs du rôle comme acteurs contribuant à l'établissement des nouveaux rôles (par exemple, Burns et Baldvinsdottir (2005)), l'article trois montre que ces acteurs peuvent en fait affaiblir significativement le rôle à travers les conséquences inattendues de leurs pratiques de légitimation ou par le biais de leurs réponses à ces pratiques. Conséquemment, il semble dangereux d'assigner d'entrée de jeu des positions aux acteurs entourant les nouveaux rôles implantés, celles-ci pouvant être en réalité fluides et les pratiques de ceux-ci pouvant être incohérentes avec leurs positions formelles ou avoir des conséquences non planifiées.

Les résultats mettent également en lumière l'importance de s'attarder aux stratégies de délégitimation, au-delà des stratégies de légitimation, les premières pouvant contrebalancer les dernières. L'article indique par ailleurs que des pratiques de légitimation peuvent en fait délégitimer, soit directement ou en raison de la réponse des autres acteurs à ces pratiques. La délégitimation de l'influence peut survenir accidentellement, et ce particulièrement avec le temps, à mesure que le besoin d'établir l'influence de nouveaux acteurs devient moins prépondérant dans l'esprit des gens.

En somme, comme l'avançaient Baker et Denis (2011), l'étude contribue en faisant la démonstration que l'implantation de nouveaux rôles demande des changements au-delà du rôle lui-même. La structure entière doit s'adapter. Le changement structurel que constitue l'implantation de nouveaux rôles représente une première étape qui peut être limitée par l'inertie structurelle. Dans un second temps, des lacunes liées à des pratiques plus participatives peuvent nuire à l'établissement du rôle dont le manque d'espace au quotidien pour permettre aux détenteurs de jouer ces nouveaux rôles, la passivité de différents acteurs et l'incompréhension culturelle. Néanmoins, les données supportent les conclusions de Ham (2008) selon lesquelles un historique et une culture de collaboration peuvent favoriser le leadership professionnel.

Par rapport aux débats entourant la prise de décision, les résultats nuancent l'idée de Llewellyn (2001) selon laquelle les professionnels en gestion peuvent questionner de l'intérieur le contrôle (quasi-) exclusif des gestionnaires non-professionnels de contrôler la prise de décision stratégique et y prendre davantage d'espace. En effet, malgré leur position charnière, l'étude montre que dans plusieurs cas, même lorsqu'ils occupent un poste de gestion et ont accès aux forums de prise de décision, plusieurs professionnels sont passifs, peu présents ou participent peu lors des discussions. Les résultats confirment plutôt les conclusions d'études antérieures selon lesquelles les professionnels en gestion sont souvent exclus de la prise de décision (Neogy & Kirkpatrick, 2009), ne sont pas nécessairement présents lorsqu'ils y sont invités (Kippist et Fitzgerald (2009), ne participent pas forcément quand ils sont présents (Burns et al. (1989) et ont généralement peu d'influence sur les décisions prises (Harrison & Miller, 1999b; MacIntosh et al., 2012; Neogy & Kirkpatrick, 2009). L'un des cas étudiés montre par ailleurs que l'implantation d'un modèle de cogestion ne modifiera pas automatiquement l'influence sur la prise de décision stratégique dans les organisations dans lesquelles les professionnels jouissent déjà d'une influence plus importante.

Au-delà des trois articles, la thèse apporte des contributions aux débats entourant l'intégration de professionnels en gestion. La prochaine section discute de ces contributions.

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6.1.4. Discussion générale : l'intégration de professionnels en gestion

La contribution des trois articles est intégrée dans la figure 6.1. ci-dessous qui montre les liens entre les différentes facettes de l'intégration des professionnels en gestion abordées dans les trois articles composant cette thèse.

Le schéma montre que l'identité du professionnel en gestion est modelée par la régulation identitaire des professionnels et gestionnaires ainsi que du cogestionnaire à travers le temps. Cette relation est réciproque puisque la nature de l'identité affecte la régulation qui est exercée. L'identité du professionnel en gestion façonne également la manière dont celui-ci mobilise les différentes logiques ainsi que sa façon de jouer son rôle. En d'autres mots, l'identité du professionnel en cogestion contribue à définir la configuration de la dyade dans une relation d'influence réciproque. La configuration dépend également de la mobilisation des logiques par le second cogestionnaire, et façonne à son tour si et comment les cogestionnaires font conjointement le pont entre les logiques ainsi que la légitimité du professionnel en gestion. Cette légitimité est aussi modelée par le travail de (dé)légitimation de différents acteurs des communautés professionnelle et administrative à travers le temps. Encore une fois, cette influence est réciproque, le degré de légitimité affectant le travail de (dé)légitimation mis en œuvre. La légitimité et l'influence sur la prise de décision se modulent à leur tour l'un l'autre : une plus grande légitimité solidifie l'influence, alors que jouir d'une influence importante peut aider à construire la légitimité. De manière similaire, l'influence et les configurations des dyades se définissent réciproquement, la manière de conjointement jouer le rôle déterminant en partie l'influence dont jouira le professionnel et gestion, tandis que l'influence de celui-ci contribue à modeler le rôle joué au sein de la dyade. Finalement, l'influence sur la prise de décision stratégique impacte l'identité des professionnels en gestion, ceux-ci pouvant se définir partiellement en fonction de l'influence dont ils jouissent.
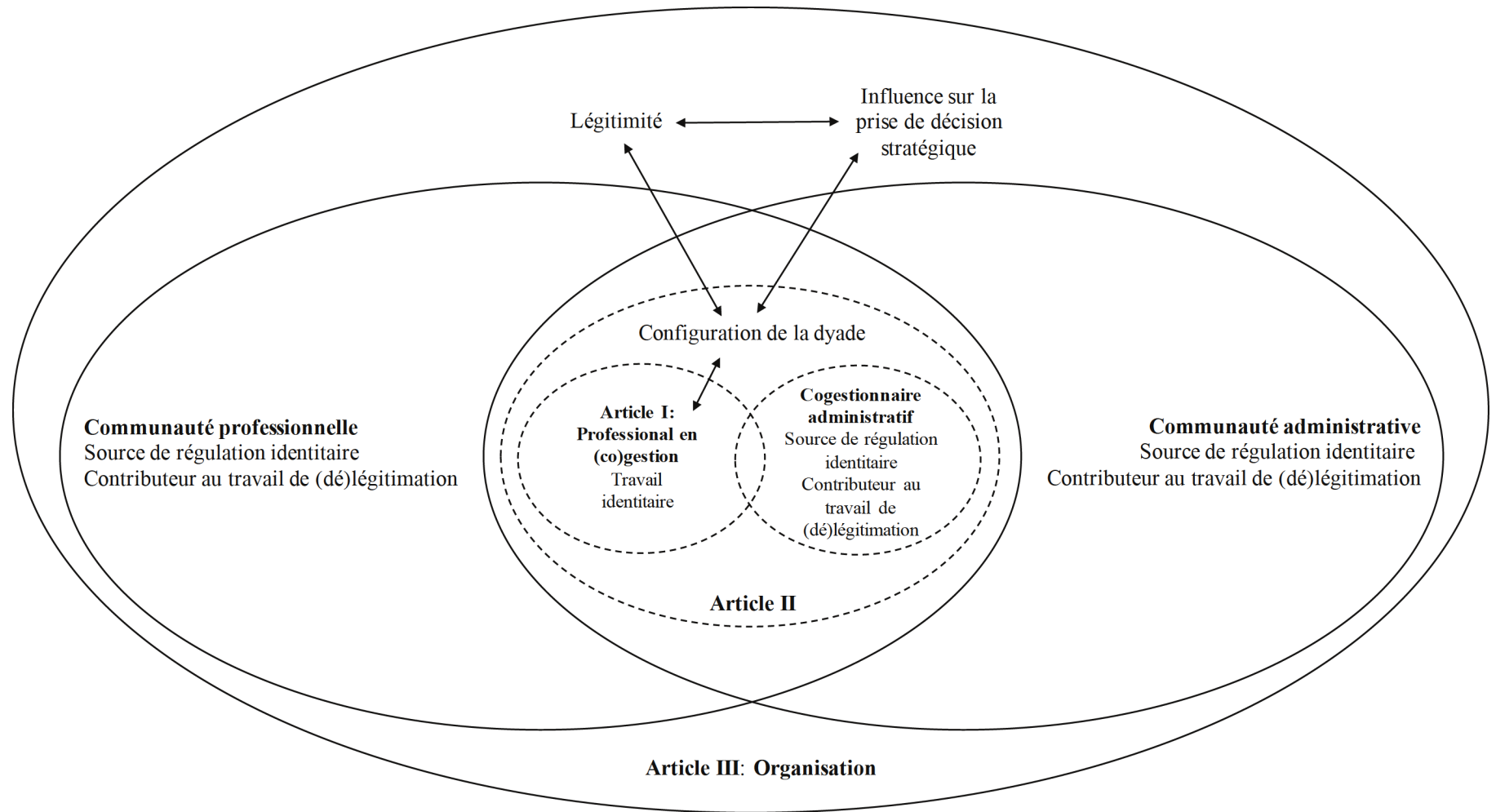
Légitimité ←→ Influence sur la prise de décision stratégique

Configuration de la dyade

Communauté professionnelle
Source de régulation identitaire
Contributeur au travail de (dé)légitimation

Article I:
Professional en (co)gestion
Travail identitaire

Cogestionnaire administratif
Source de régulation identitaire
Contributeur au travail de (dé)légitimation

Communauté administrative
Source de régulation identitaire
Contributeur au travail de (dé)légitimation

Article II

Article III: Organisation

Figure 6.1. Schéma intégrateur des contributions des trois articles

Prise globalement, cette étude vient enrichir la littérature portant sur l'intégration de professionnels dans des nouveaux rôles de gestion visant à lier deux logiques. Nos résultats montrent que si ce changement peut être vu comme une réponse à la complexité organisationnelle visant à passer d'un modèle de différentiation structurelle à une structure hybride (Greenwood et al., 2011), perçu comme de l'hybridité positive (Fossestol et al., 2015) ou conçu comme constituant une réponse créative à la pluralité (Battilana & Lee, 2014; Kraatz & Block, 2008), l'étude des implications et impacts du changement suggère une tout autre interprétation. En effet, les trois articles portent plutôt à croire que des situations de non-hybridité et d'hybridité négative (Fossestol et al., 2015) ont été générées par le changement, l'hybridité ad hoc et positive étant plutôt marginale. Des réponses à la complexité institutionnelle identifiées par Battilana et Lee (2014), l'ignorance des demandes venant d'une source et la séparation des demandes semblent en effet plus fréquentes que l'intégration, supportant les conclusions de Pache et Santos (2010a) selon lesquels des combinaisons de pratiques intactes venant de différentes logiques sont plus probables que l'hybridation.

Comme le soupçonnaient Correia et Denis (2016), il serait donc inadéquat de tenir pour acquis qu'une convergence des logiques résulterait de l'introduction de rôles de gestion pour professionnels. Au sein des dyades et dans les forums de prise de décision, les deux derniers articles de cette thèse suggèrent qu'une logique devient ou demeure dominante tandis que l'autre s'efface avec le temps. Dans notre cas, la logique managériale a pris préséance. Notons tout de même que la logique professionnelle, qui a historiquement occupé une place importante dans les organisations professionnelles, est demeurée très forte. En effet, si quelques professionnels ont été cooptés, le modèle de cogestion a tout de même laissé intact un corps médical très influent dans les décisions stratégiques. L'influence de la logique professionnelle ne se manifeste cependant pas nécessairement à travers les voies formelles de la gestion. Cette influence passe plutôt par différentes stratégies de résistance et de véto. En d'autres mots, la tension entre les logiques ne s'estompe pas, mais se poursuit via des mécanismes informels et politiques autour et en parallèle à la délibération collective.

D'ailleurs, bien que j'ai noté certains mouvements en ce sens, le modèle implanté ne semble pas avoir significativement contribué à une réconciliation des attentes divergentes associées aux logiques, avoir augmenté l'influence des médecins dans la prise de décision ou avoir provoqué une mobilisation des membres de la communauté professionnelle vers des objectifs communs. Ces constatations semblent cohérentes avec l'idée maintenant soutenue par plusieurs auteurs de l'incohérence relativement stable des logiques à travers le temps (Fossestol et al., 2015; Greenwood et al., 2011; Oliver, 1991; Pache & Santos, 2010a), une coexistence qui peut évoluer suite aux réponses organisationnelles à la complexité mais demeure sous une forme ou une autre. Au-delà du niveau organisationnel, le second article permet de constater comment les dynamiques et enjeux liés à la coexistence des logiques au niveau de la dyade semblent refléter celles observées au niveau organisationnel.

Par ailleurs, il ressort de notre étude qu'un tel changement structurel n'engendre généralement pas de transformation significative dans la manière dont des logiques coexistent, sinon la cooptation de certains individus appartenant à une logique vers une autre. Cette cooptation semble particulièrement forte au sein des dyades plus intégrées discutées dans le second article, le cogestionnaire pouvant constituer un ancrage important pour les professionnels en gestion dans le monde administratif. L'étude confirme donc que les changements structurels sont insuffisants (Baker & Denis, 2011), l'ambiguïté et l'inertie structurelle, la passivité de différents acteurs, les efforts pour restreindre l'espace du détenteur pour jouer son rôle, le manque de sensibilité interculturelle, les pressions des professionnels pour le respect de leur logique et la désintégration des dyades renforçant plutôt le *statu quo*. Plutôt que le simple ajout d'une position dans une structure, l'implantation de rôles de gestion pour professionnels nécessite l'adaptation de la structure entière pour laisser une place aux nouveaux détenteurs des rôles.

Plus spécifiquement, l'étude montre qu'en plus des changements structurels et des mécanismes économiques discutés dans la littérature (Alexander et al., 2001; Burns & Muller, 2008; Robinson,

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1997; Shortell et al., 2000), le potentiel d'harmoniser les logiques à travers l'introduction de professionnels en gestion peut être renforcé à travers des formations adaptées à la culture des participants, contextualisées et ancrées dans les besoins immédiats des professionnels et gestionnaires. Peuvent aussi contribuer des efforts pour assurer la clarté des rôles, la proactivité constante à travers le temps des différents acteurs dont les actions doivent être cohérentes avec l'objectif visé, le renforcement du respect de la structure mise en place en refusant le contournement des professionnels en gestion, l'accès et la prise en compte de la contribution dans les forums de prise de décision, le développement de la relation entre des cogestionnaires par différentes activités communes, le développement d'une compréhension et sensibilité à la culture et aux normes associées à l'autre logique ainsi que la sélection de cogestionnaires compatibles. Comme le soutenait Berry (2004), la sélection de cogestionnaires compatibles ayant une relation constructive peut contribuer significativement au succès de l'implantation d'un modèle de cogestion à différents niveaux. La sélection de professionnels possédant une expérience et un intérêt pour la gestion mais une identité professionnelle forte renforcissent les probabilités que l'individu saura se positionner habilement entre les logiques à travers le temps. En utilisant les termes de l'article un, on parlera d'un professionnel incorporant dans son narratif certains aspects de la gestion ou y construisant des liens avec certains acteurs de ce domaine.

Correia et Denis (2016) appelaient à des travaux qui permettraient de mieux comprendre le rôle des professionnels dans la définition du changement au cœur duquel ils se trouvent. Le troisième article de cette étude constitue une réponse à cette demande et montre que les professionnels introduits dans des nouveaux rôles de gestion façonnent significativement ce changement qu'ils incarnent. Par différentes pratiques de légitimation et délégitimation volontaires ou non, les professionnels établissent ou affaiblissent l'influence qui constitue la raison centrale de leur rôle. La passivité de certains professionnels en gestion ressort d'ailleurs dans les deuxième et troisième articles de l'ouvrage, et contribue à modeler le processus de changement, à renforcer une certaine dominance de la logique managériale sur la logique professionnelle ainsi qu'à limiter leur influence sur la prise de décision. La manière dont ils mobilisent les logiques dans leur discours et jouent leur rôle de

gestion en collaboration avec un administrateur discutés dans le second article semblent par ailleurs grandement marquer la nature et l'impact du changement au centre duquel ils se trouvent.

L'insuffisance de l'aspect structurel dans l'implantation d'un nouveau rôle de gestion pour professionnels soulevé plus tôt permet également de mettre en perspective l'idée que les gestionnaires, adhérant à la logique managériale, devraient accorder une influence aux professionnels en gestion basée sur leur position hiérarchique et considérer celle-ci comme légitime (Fjellvaer, 2010). Or, l'étude montre que des efforts de délégitimation peuvent surpasser le poids de la position structurelle pour établir un rôle, et ce même au sein de la communauté administrative. La possible délégitimation du nouveau rôle par les acteurs responsables de son implantation risque de nuire particulièrement au changement, ceux-ci devant idéalement être des interlocuteurs crédibles auprès des acteurs touchés (Rondeau & Bareil, 2010). Du côté professionnel, les efforts pour établir les nouveaux rôles sont entre autres modelés par la cooptation de certains individus résultant de leur entrée dans les rôles de gestion. En effet, tel que discuté dans le premier article, se rapprocher de la gestion a été perçue négativement par les autres professionnels dans plusieurs cas (Spyridonidis et al., 2014), limitant ensuite la capacité des détenteurs des nouveaux rôles à influencer leurs pairs. Comme Ham (2008) le soulignait, une culture organisationnelle propice semble contribuer à éviter l'isolement des professionnels en gestion, à permettre au professionnel en gestion d'apprivoiser une certaine hybridité et à conférer (ou du moins ne pas nuire à) une légitimité au rôle comme à son détenteur.

Sur les questions d'identité et d'hybridité, les résultats indiquent que si certains professionnels deviennent des hybrides capables d'incarner à la fois les logiques managériale et professionnelle (Champagne et al., 1998; Lega & Sartirana, 2016), la majorité adhère de manière prédominante à l'une des logique. Bien qu'une certaine hybridité peut être atteinte, l'équilibre parfait semble toutefois rare, l'hybridité comportant plutôt un spectre de combinaisons des logiques qui évolue à travers le temps. L'étude montre par ailleurs que même s'ils occupent un poste charnière, l'hybridité est un stade temporaire qui semble généralement se conclure par un mouvement vers

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l'une ou l'autre des logiques. Il semble que le maintien de l'équilibre minimal à travers le temps peut être ardu, nécessitant un travail constant de positionnement à la jonction de logiques. Comme il ressort de la littérature, l'aspect professionnel semble tendre à demeurer prédominant chez plusieurs (LeTourneau & Curry, 1997; Llewellyn, 2001; Quinn & Perelli, 2016). Aux débats touchant l'identité et l'hybridité, l'étude contribue en montrant que pour les professionnels œuvrant en cogestion, la relation avec le cogestionnaire constitue un aspect déterminant de la transition qui s'entamera (ou non). L'importance de la compatibilité et d'une relation constructive est donc centrale si le souhait est d'encourager les professionnels à adhérer davantage à la logique managériale.

Outre les contributions à la littérature, il est possible de dégager des implications pratiques des trois articles possédant le potentiel d'éclairer les praticiens professionnels et gestionnaires impliqués dans un processus d'introduction de professionnels dans des rôles de gestion.

6.2. Les implications pratiques

Au-delà des contributions à la littérature, les résultats de cette étude peuvent guider les gestionnaires souhaitant introduire de nouveaux rôles de gestion pour professionnels. Les prochaines pages contiennent donc les implications managériales dégagées de nos efforts de recherche. Notons d'entrée de jeu que la nature et les objectifs du premier article permettent de guider une réflexion sur l'identité des professionnels entrant dans des rôles de cogestion. Toutefois, tenter d'en tirer des recommandations visant à forger l'identité d'un individu ou à créer le « parfait directeur médical d'un point de vue administratif » constituerait un détournement de l'étude et irait à l'opposé de son intention première, soit de comprendre le parcours de ces individus vivant une expérience potentiellement drastique de transition identitaire. Les articles suivants portant sur les dyades de co-leaders et la légitimation de nouveaux rôles se prêtent mieux à l'exercice

6.2.1. Niveau individuel : la transition identitaire de professionnels entrant dans des rôles de gestion

Le premier article portant sur la transition identitaire des professionnels entrant dans des postes de gestion montre bien que l'entrée dans de tels rôles ne signifie pas que le détenteur du poste développera une identité cohérente avec son rôle administratif. Conséquemment, il est possible que le professionnel en gestion agisse et prenne des décisions de manière plus cohérente avec la pensée professionnelle qu'administrative. De plus, une identification grandissante à la gestion ne signifie pas que le détenteur du rôle se percevra comme un gestionnaire (celui-ci pouvant s'identifier uniquement à certaines composantes de la gestion) ou que cette identification subsistera à travers le temps.

Sans surprise, notre analyse de la régulation identitaire suggère qu'une régulation forte et constante à travers le temps peut encourager une plus grande identification à la gestion. Dans les cas étudiés, des efforts de régulation identitaires prenant la forme de formations, coaching et discussions permettant la clarification des attentes semblent avoir été efficaces.

Dans le contexte de l'entrée dans un rôle de *cogestion*, les résultats obtenus suggèrent qu'une attention particulière devrait être portée à la composition des dyades. Une identification plus grande à la gestion est plus probable lorsque le professionnel nouvellement en gestion entretient une relation forte et constructive avec son co-leader.

Les résultats obtenus mettent également en lumière l'importance de laisser assez d'espace aux professionnels entrant dans des rôles de gestion pour se positionner, ceux-ci étant sujets à des pressions non seulement de la part des administrateurs mais également des autres professionnels. S'ils sont incapables de se positionner de manière confortable, il est possible que les professionnels opteront pour un départ du rôle.

6.2.2. Niveau de la dyade : le co-leadership pour lier des logiques institutionnelles

Pour les praticiens, le second article peut guider le choix d'une stratégie pour faire face à la complexité organisationnelle. L'étude apporte également des pistes quant au type de configuration qui semble le plus approprié pour lier des logiques institutionnelles ainsi que quant à la manière d'évoluer vers une telle configuration. Tout d'abord, l'étude montre qu'un modèle de co-leadership permet de lier des logiques institutionnelles différentes lorsque des « duos de liaison » (*boundary duos*) sont créés, ou lorsqu'un principe supérieur mobilise les co-leaders vers un objectif commun au-delà des logiques présentes (c'est-à-dire l'unité de mission). La configuration de la consultation professionnelle peut également constituer une option intéressante puisqu'elles permettent de profiter de l'expertise et de l'influence des professionnels sans toutefois les surcharger. Les co-leaders doivent donc coordonner leur travail à différents niveaux d'intensité mais représenter conjointement les différentes logiques à lier. Le risque demeure cependant grand qu'une seule logique domine.

Si les deux logiques doivent être représentées, il semble préférable d'éviter que les co-leaders incarnent de manière prépondérante une seule logique chacun. Si les co-leaders représentent la même logique, l'autre logique n'est évidemment pas représentée dans la dyade. Si les co-leaders incarnent des logiques différentes, le principal risque serait le retrait partiel ou complet d'un co-leader, laissant sa logique sous ou non représentée. Un des co-leaders devrait plutôt être un « hybride », c'est-à-dire qu'il comprend et peut représenter les deux logiques présentes. Ce cogestionnaire hybride doit cependant être actif et se coordonner avec son vis-à-vis.

D'un point de vue processuel, le second article indique qu'il ne serait pas réaliste de s'attendre à une évolution naturelle de la configuration des dyades créées. En effet, celles-ci semblent relativement stables. De plus, les configurations qui évoluent peuvent progressivement devenir plus intégrées ou désintégrées. Conséquemment, des actions concrètes sont nécessaires pour modeler la nature des configurations des dyades. Ces actions pourraient prendre la forme de formations, de démarche de clarification des rôles, d'efforts de définition de critères de décision appartenant aux deux logiques ou d'entretien des liens entre les co-leaders et les groupes aux logiques distinctes

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qu'ils représentent. Ainsi, la collaboration pourrait être encouragée et la mobilisation des deux logiques cultivée.

L'étude indique également qu'il est plus probable que les relations au sein des duos soient constructives quand les co-leaders se sélectionnent mutuellement, plutôt que d'être imposés l'un à l'autre. Finalement, un équilibre entre la spécificité et l'ambiguïté des rôles des co-leaders devrait être recherché. Une trop grande spécificité aurait pour effet de réduire la marge de manœuvre des co-leaders tandis qu'une trop grande ambiguïté peut engendrer confusion, frustration et conflits.

6.2.3. Niveau organisationnel : la légitimation de l'influence

Le troisième article portant sur la légitimation des nouveaux rôles peut aussi guider les praticiens. Tout d'abord, nos résultats démontrent que changer un organigramme n'est pas suffisant pour établir l'influence de détenteurs de nouveaux rôles de gestion. Des efforts de légitimation tout au long du processus d'implantation sont importants. Les résultats suggèrent également que la passivité des agents de changement et détenteurs du nouveau rôle peut nuire significativement à la légitimation de l'influence en neutralisant les efforts en ce sens. Les hésitations d'administrateurs à soutenir le nouveau rôle peuvent avoir des répercussions similaires. Les agents de changement - mais également les détenteurs du rôle et administrateurs souhaitant le succès d'un tel changement structurel - bénéficieraient de s'assurer de la cohérence entre leurs actions et le changement qu'ils souhaitent implanter, et ce particulièrement à mesure que le temps passe et les anciennes habitudes reprennent le dessus. En somme, des efforts de légitimation constants et actifs de tous les acteurs impliqués contribuent à établir le nouveau rôle.

Les résultats suggèrent également que les professionnels entrant dans des rôles de gestion devraient être des individus engagés au nouveau rôle. Lorsque des professionnels peu intéressés par l'administration sont poussés à occuper des rôles de gestion, ceux-ci risquent d'être passifs dans leur rôle, se discréditant et délégitimant ainsi le nouveau rôle. Les professionnels ayant une expérience antérieure en recherche, enseignement ou gestion (c'est-à-dire autre que professionnelle

ou de représentation de la profession) semblent souvent être plus sensibles au besoin d'établir leur influence. Quoi qu'il en soit, les détenteurs de tels rôles devraient être sensibilisés dès leur entrée en poste à la nécessité de déployer des efforts pour légitimer leurs position et influence. Nos résultats montrent par ailleurs que les différents acteurs impliqués dans l'implantation de tels rôles doivent développer une plus grande compréhension de la culture et de la pensée de l'autre groupe puisqu'un manque de sensibilité à la réalité de l'autre peut contribuer à délégitimer le nouveau rôle. À travers entre autres différentes formations, la socialisation, le coaching et le codéveloppement, les agents de changement et administrateurs collaborant étroitement avec les détenteurs des nouveaux rôles peuvent améliorer leur connaissance des préoccupations et contraintes professionnelles tandis que les professionnels peuvent enrichir leur compréhension du monde de la gestion.

Les résultats indiquent également que la légitimation de l'influence des professionnels en gestion passe par l'autonomie de ces derniers dans la prise de décision ainsi que par l'accès, la présence et la participation aux forums de prise de décision. Un manque d'influence semble avoir pour effet de démotiver les détenteurs du rôle et de réduire la légitimité du nouveau rôle de gestion. Dans des structures en co-leadership, le cogestionnaire doit idéalement laisser de l'espace au professionnel en gestion afin de lui permettre d'exercer une certaine influence. L'impact des comportements du cogestionnaire sur la légitimité du nouveau rôle va cependant bien au-delà de l'influence sur la prise de décision. Par exemple, des efforts de développements d'une relation de collaboration entre les deux membres du tandem peuvent contribuer significativement à démontrer le sérieux de l'initiative de partenariat et à construire la légitimité du nouveau rôle.

Finalement, dans le contexte spécifique des organisations en santé, il semble que l'assignation de rôles de cadres supérieurs aux chefs de départements médicaux peut limiter la résistance de plusieurs acteurs si les deux rôles sont bien définis et compris. Dans le cas contraire, le rôle de représentation semble prendre le dessus, contribuant ainsi à délégitimer le rôle de gestion.

6.3. Les limites de la recherche

Si elle a contribué à faire avancer les connaissances, cette recherche comporte tout de même certaines limites qu'il est primordial de mettre en lumière. Ces limites peuvent être regroupées en trois catégories : les organisations participantes, le profil des chercheurs et les sujets traités.

La première limite de la présente recherche concerne la possibilité de généraliser les résultats obtenus par l'étude des quatre organisations participantes. En effet, les organisations participantes se situent toutes au Québec, dans un système de santé possédant des caractéristiques et une culture propre. De plus, seule la profession médicale a été au cœur de l'étude. Le profil des organisations étudiées constitue à la fois une limite et une force de la présente recherche. En effet, réunies, les quatre organisations couvrent la gamme des profils des organisations en santé. Toutefois, leurs différences significatives de structures, cultures, processus de changement et contextes les rendent difficiles à comparer. De plus, le centre de santé et services sociaux régional a retardé d'un an l'implantation des changements structurels requis en raison de contraintes budgétaires. Bien que nous ayons tout de même pu y collecter des données d'une grande richesse, celles-ci s'étendent sur une plus courte période de temps, limitant ainsi notre compréhension du processus de changement dans cette organisation. La possibilité de généraliser les dynamiques observées peut également être affectée par la nature des changements structurels apportés par les organisations dans le cadre du projet pilote. En effet, les organisations devaient intégrer des professionnels de la médecine dans des rôles de cadres supérieurs travaillant en cogestion avec un administrateur. Ce modèle de cogestion semble avoir coloré l'introduction des médecins dans leurs nouveaux rôles de gestion et pourrait rendre nos conclusions moins applicables aux contextes dans lesquels les professionnels occupent des rôles de gestion en solo. Finalement, soulignons que les organisations participantes implantaient un modèle de cogestion au niveau stratégique dans le cadre du projet pilote de l'AQESSS. Certaines d'entre elles ont tout de même opté pour aussi expérimenter le modèle aux niveaux tactique et stratégique. Or, en raison des objectifs du projet pilote, des objectifs de recherche et de la difficulté de comparer le processus d'implantation aux autres niveaux dans les différentes organisations (en raison de la très grande variabilité des expérimentations à ces niveaux),

l'accent a été mis sur le niveau stratégique. Notons tout de même que malgré les spécificités du contexte empirique, le potentiel de transférabilité de l'étude découle principalement de la théorie et de la conceptualisation.

La seconde limite de l'étude découle de la division du travail de collecte de données entre deux chercheurs (l'auteur de la présente thèse et un professionnel de recherche). Les deux chercheurs possédaient des profils, champs d'expertises et intérêts différents, ce qui a pu affecter la nature des données collectées dans les différents sites. Afin de limiter cette possibilité, les guides d'entretiens et d'observations ont été développés en collaboration et les chercheurs se sont assurés de discuter de leurs données tout au long de l'étude. Néanmoins, les entrevues et observations étaient de nature semi-dirigées afin de permettre aux chercheurs d'adapter leurs questions et notes aux participants rencontrés et à leur contexte. Si cette flexibilité à permis aux chercheurs de bien comprendre et de s'adapter aux différents contextes étudiés, elle a néanmoins eu un certain effet au niveau de la comparabilité des données. Chaque chercheur a en effet pris des directions un peu différentes et mis l'accent sur des aspects différents en cours de route. Par conséquent, nous possédons des données d'une richesse variable pour certains sujets selon le site. Cette variabilité est plus forte pour les questions ayant émergé dans les différents sites au cours de la collecte de données. Bien qu'il se puisse que le fait d'avoir été deux chercheurs ait entraîné certaines variations dans l'approche des entrevues et observations, cela ne semble pas avoir limité notre capacité à documenter empiriquement les processus et pratiques d'intérêts dans les différents cas à l'étude.

Les sujets traités ont engendré certaines limites additionnelles de cette étude. Notons tout d'abord que l'étendue des sujets à couvrir dans le cadre du projet peut avoir limité la richesse des données sur certains sujets. Le temps d'entrevue et la capacité d'un observateur à noter étant limités, il peut avoir été difficile d'explorer en profondeur tous les sujets souhaités. Par ailleurs, si 21 mois de collecte de données permettent de suivre le processus d'implantation d'un changement structurel sur une période importante, j'ai pu constater que 21 mois est relativement peu de temps pour constater des changements dans l'influence sur la prise de décision stratégique. Dans cette veine, bien que le

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projet de recherche ait originellement été conçu de manière à suivre différents dossiers de prise de décision stratégique à travers le temps dans les différents sites, des changements au sein des différents sites (rotation des acteurs clefs, contraintes financières, crises, etc.) ont influencé ces processus de décision et limité notre capacité à suivre étroitement leur évolution.

6.4. Les avenues de recherches futures

De ces limites découlent différentes avenues de recherche futures. D'abord, la réalisation d'études similaires dans des contextes différents pourrait permettre de mieux évaluer l'applicabilité des résultats à d'autres contextes. Par exemple, des organisations professionnelles œuvrant dans les domaines du droit, de l'éducation et des arts constitueraient des sites de recherche révélateurs. Considérant le modèle de cogestion implanté dans les quatre organisations étudiées, des recherches futures examinant l'applicabilité de nos conclusions dans des contextes de gestion en solo pourraient enrichir les connaissances actuelles. La collaboration très rapprochée des professionnels nouvellement en gestion avec des cadres supérieurs expérimentés semble en effet avoir influencé significativement les dynamiques observées. Par ailleurs, puisque notre projet mettait l'emphase sur le niveau stratégique, il serait intéressant d'étudier la cogestion et son implantation à des niveaux plus opérationnels.

Par ailleurs, puisque les changements dans l'influence sur la prise de décision stratégique semblent se réaliser lentement, une étude s'étendant sur une plus longue période pourrait permettre de mieux comprendre l'évolution (ou absence d'évolution) à travers le temps. Dans une étude future des relations entre différents groupes aux logiques différentes ou au sein de dyades, il serait intéressant de pousser l'idée de demander aux participants d'illustrer ces relations tout en expliquant verbalement leur dessin. Bien que cette technique n'ait pas été exploitée de manière systématique dans la présente recherche, les illustrations et explications obtenues montrent le potentiel de la technique.

Finalement, une démarche de recherche ultérieure pourrait se concentrer sur la formation offerte aux médecins, gestionnaires et médecins-gestionnaires dans le cadre de telles initiatives de partenariats médico-administratifs. En effet, j'ai pu constater que différents types de formations (théorique, simulations, coaching, codéveloppement, etc.) ont été offerts dans les différents sites étudiés, amenant des répercussions variant significativement. Nos participants ont exprimé une préoccupation importante pour comprendre comment développer des formations efficaces et mieux évaluer les retombées des formations offertes. De plus, la question des formations offertes par les différents sites revient invariablement lorsque les résultats de la présente recherche sont présentés dans le milieu académique ou auprès de praticiens. Des efforts de recherche visant à mieux comprendre les formations offertes ainsi que leurs répercussions pour différents acteurs sembleraient donc pertinents.

L'objectif de cette thèse était de mieux comprendre le processus d'implantation de rôles de cogestion pour professionnels dans les organisations professionnelles. Abordant ce changement structurel à trois niveaux, j'ai réussi à contribuer à clarifier le processus de transition identitaire de ces professionnels, la manière dont les dyades permettent (ou non) de faire le pont entre les mondes administratif et professionnel ainsi que le processus d'établissement (ou non) de l'influence de ces nouveaux médecins gestionnaires sur la prise de décision stratégique. À travers les contributions à la littérature et implications pratiques dégagées, j'espère que cette étude alimente les réflexions.

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ANNEXE 1: Entente entre l'AQESSS, les organisations participantes et l'équipe de recherche

|aqesss|

Entente de commandite – **Projet de recherche portant sur les pistes de partenariat médico-administratif**

Entre :   **L'Association québécoise d'établissements de santé et de services sociaux,** personne morale légalement constituée, ayant son siège au 505, boulevard de Maisonneuve Ouest, bureau 400, Montréal, province de Québec, H3A 3C2, dûment représentée par madame Lise Denis, directrice générale,

<p align="center">ci-après appelée « l'Association »</p>

Et :   **Centre de santé et services sociaux** ▬▬▬▬ personne morale légalement constitué, ayant son siège au ▬▬▬▬▬▬▬▬▬▬▬▬▬▬, province de Québec, dûment représentée par monsieur ▬▬▬▬, directeur général,

<p align="center">ci-après appelé « l'Établissement »</p>

A) Obligations de l'Établissement

Dans le cadre du projet de recherche mis en place par l'Association quant à l'analyse de pistes de partenariat médico-administratif, l'Établissement, à titre de site pour le projet pilote, s'engage à :

1. Mettre en œuvre les dispositifs prévus dans les pistes proposées au point 3 de l'annexe A, laquelle fait partie intégrante de la présente entente de commandite. Ces dispositifs doivent être mis en place d'ici le 31 décembre 2011.

2. Respecter les échéanciers pour la mise en œuvre et la réalisation du projet pilote, soit de mai 2011 à décembre 2013.

3. Déterminer, en collaboration avec l'équipe de recherche mandatée par l'AQESSS[1], l'objectif quant aux résultats escomptés qui feront l'objet d'analyse de la mise en place des pistes de partenariat (associé à la mission de l'établissement en termes de performance).

4. Identifier, en collaboration avec l'équipe de recherche mandatée par l'AQESSS, trois dossiers représentant de bons traceurs du fonctionnement de la gouvernance médico-administrative pour l'analyse des projets pilotes.

5. Assurer la gestion du changement requise au cours du déroulement du projet pilote.

6. Accepter l'observation non participante de l'équipe de recherche au sein des différents comités de l'Établissement.

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[1] Les cochercheurs principaux sont madame Ann Langley de HEC et monsieur Jean-Louis Denis de l'ÉNAP.

7. Fournir les informations requises pour l'analyse des résultats selon les objectifs retenus (statistiques, etc.).

8. Compléter, pour l'ensemble des parties prenantes au projet pilote, les formulaires de consentement requis à l'utilisation des instruments de recherche.

9. Désigner une personne qui assurera le lien avec l'équipe de recherche et l'Association en termes de logistique et d'arrimage dans le déroulement du projet pilote.

10. Communiquer à l'Association les enjeux et les ajustements requis, le cas échéant.

11. Participer à un groupe de suivi des projets pilotes à raison d'une rencontre par année pour les trois années que dureront les projets pilotes.

12. Accepter la publication des résultats associés au Projet de recherche après avoir été consulté par l'équipe de recherche.

13. Commanditer le projet de recherche à raison de cinq mille dollars (5 000 $) par année et ce, pour une période de trois (3) ans. Ce montant annuel est payable sur réception de la facture pour chacune des années 2011, 2012 et 2013.

14. Maintenir son engagement malgré d'éventuels changements des acteurs clés au sein de l'Établissement. Des modalités de retrait du projet pourront être discutées avec l'Association en fonction de situations exceptionnelles. Toutefois, l'Établissement devra quand même payer les frais exigés annuellement à l'Association, conformément à la clause 13 de la présente entente de commandite.

B) Obligations de l'Association

L'Association s'engage à :

1. Mandater l'équipe de recherche, avec comme cochercheurs principaux, madame Ann Langley de HEC et monsieur Jean-Louis Denis de l'ÉNAP, pour la réalisation de l'analyse des expériences au sein des sites pilotes identifiés au point 2 de l'annexe A de la présente entente de commandite.

2. Conclure des ententes avec les commanditaires du projet de recherche pour s'assurer du bon déroulement de ce projet de recherche.

3. Assurer la coordination de la démarche entre les différentes parties prenantes : les différents sites pilotes identifiés au point 2 de l'annexe A de la présente entente de commandite, l'équipe de recherche et le groupe de réflexion.

4. S'assurer de la participation des fédérations médicales (FMOQ et FMSQ) au projet afin de favoriser la collaboration et l'implication de leurs membres au déroulement des projets pilotes.
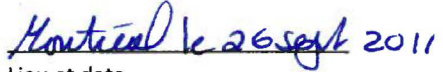
5. Coordonner et animer les rencontres annuelles du groupe de suivi des projets pilotes.

6. Agir comme un facilitateur entre les différentes parties prenantes : les différents sites pilotes identifiés au point 2 de l'annexe A de la présente entente de commandite, l'équipe de recherche et le groupe de réflexion.

7. Rendre disponible à l'Établissement toute information ou documentation pertinente qui pourrait être utile au déroulement du projet pilote.

8. Faire connaître l'évolution du projet pilote, avec le consentement de l'Établissement, auprès de ses membres.

9. Accompagner l'Établissement dans l'identification de moyens visant à le soutenir dans le déroulement du projet pilote.

10. Faire connaître la participation de l'Établissement dans toutes les communications (revues, publications, site internet et tout autre document) en lien avec le projet de recherche et lors de la diffusion des résultats.

La présente entente de commandite le 1er juin 2011 et se termine le 31 décembre 2013.

EN FOI DE QUOI, LES PARTIES À LA PRÉSENTE ENTENTE DE COMMANDITE ONT APPOSÉ LEUR SIGNATURE :

Lise Denis   _Montréal le 26 sept 2011_

Lise Denis   Lieu et date
Directrice générale
Association québécoise d'établissements
de santé et de services sociaux

Annexe A

Démarche d'implantation des projets pilotes
Analyse de pistes de partenariat médico-administratif

1 Contexte

L'Association québécoise d'établissements de santé et de services sociaux (AQESSS), consciente des enjeux actuels des établissements du réseau et des défis d'optimisation des services qui exigent une collaboration soutenue de la part des directions d'établissements et des équipes médicales, a initié une démarche afin d'identifier des pistes renouvelées de partenariat médico-administratif. Elle a mis en place un groupe de réflexion sur la gouvernance médico-administrative dont le mandat était de diagnostiquer la situation actuelle en ce qui concerne la gouvernance médico-administrative dans les établissements de santé et de services sociaux et de proposer des pistes de partenariat médico-administratif qui répondraient aux aspirations professionnelles des médecins et qui assureraient une meilleure collaboration des médecins à la réalisation des objectifs des établissements.

L'AQESSS souhaite mettre en place à court terme des projets pilotes pour expérimenter et évaluer ces pistes en collaboration avec les établissements intéressés. Les projets pilotes viendront documenter ces pistes, permettront de les bonifier, le cas échéant, afin d'évaluer l'intérêt d'élargir leur mise en place au sein des établissements du réseau et leur valeur ajoutée à la gestion des établissements dans le contexte actuel.

2 Nombre de sites et caractéristiques

- Quatre sites au total qui se répartissent comme suit :
  - Une organisation qui serait déjà avancée dans la mise en place d'un modèle intégrant des éléments proches des pistes proposées : ███████████████████████████ ██████.
  - Trois organisations de taille et de complexité différentes (pour lesquels les pistes sont à mettre en place) en assurant une représentativité de réalités et de régions différentes :
    - un grand CSSS avec un hôpital régional : █████████████ ;
    - un CSSS de taille moyenne avec un hôpital de courte durée : █████████████ ;
    - un CSSS sans hôpital de courte durée : █████████████.

3 Pistes de partenariat à mettre en place faisant l'objet de l'analyse

- Tenir des rencontres biannuelles entre le conseil d'administration (CA) et l'exécutif du conseil des médecins dentistes et pharmaciens (CMDP) afin de favoriser une collaboration entre ces deux instances.
- Confier à un comité du conseil d'administration la responsabilité des affaires cliniques et assurer une présentation annuelle au CA par les cogestionnaires des programmes-clientèles pour une compréhension juste des enjeux cliniques.
- Constituer une cellule de réflexion et d'orientation stratégique qui comprendrait minimalement le DG, le président du CA, le président du CMDP et le DSP.

- Intégrer les cogestionnaires médicaux de programmes au comité de direction.
- Prévoir la cogestion de l'ensemble des programmes par le directeur responsable et le DSP.
- Mettre en place un comité de coordination des programmes sous leur responsabilité.

4 Conditions préalables

- Rémunération des fonctions médico-administratives pour les médecins.

5 Critères organisationnels requis pour la mise en place des projets pilotes

- Engagement formel de tous les partenaires concernés : Direction générale, Conseil d'administration, CMDP, Comité de direction, chefs de département.
- Approche par programmes-clientèles en place.
- Cogestion médico-administrative des programmes-clientèles en place.
- Absence de conflit majeur au niveau de la gouvernance médico-administrative.

ANNEXE 2 : Lettre d'introduction du projet de recherche dans les organisations participantes

En 2011, l'Association québécoise d'établissements de santé et de services sociaux (AQESSS) a identifié des pistes de partenariats médico-administratifs qui répondraient aux aspirations professionnelles des médecins et qui assureraient une meilleure collaboration des médecins à la réalisation des objectifs des établissements. Le CSSSX s'est engagé à implanter ces pistes dans le cadre d'un projet pilote.

Des chercheurs du Pôle Santé des HEC Montréal ont été mandatés pour analyser le processus de mise en œuvre et les effets de ces nouvelles formes de collaboration dans les quatre organisations participant au projet pilote, dont la nôtre.

La cueillette de données du projet de recherche *Vers de nouvelles pistes de partenariat médico-administratif* se déroulera sur deux ans et comprendra des entretiens, des questionnaires et des observations. Les membres de l'équipe de direction ainsi que des membres du corps médical (exécutif du CMDP, directeurs médicaux de programmes-clientèles, chefs de département clinique, etc.) seront sollicités pour participer à l'étude.

Les renseignements que vous confierez aux membres de l'équipe de recherche seront utilisés pour la préparation de deux rapports de recherche destinés à l'AQESSS et aux établissements participants. Ils pourront également être utilisés subséquemment pour préparer une thèse de doctorat ou des publications académiques.

Vous êtes libre de refuser de participer à cette étude. Les membres de l'équipe de recherche s'engagent à protéger les renseignements personnels obtenus en assurant la protection et la sécurité des données recueilles, en conservant les informations recueillies dans un lieu sécuritaire, en ne

discutant des renseignements confidentiels qu'avec les membres de l'équipe de recherche et en n'utilisant pas les données qu'un participant aura explicitement demandé d'exclure de la recherche.

Le comité d'éthique de la recherche de HEC Montréal a statué que la collecte de données liée à la présente étude satisfait aux normes éthiques en recherche auprès des êtres humains. Pour toute question en matière d'éthique, vous pouvez communiquer avec le secrétariat de ce comité au 514-340-7182 ou au cer@hec.ca

Si vous avez des questions concernant cette recherche, vous pouvez contacter les chercheurs Ann Langley, Jean-Louis Denis et Marie-Pascale Pomey aux numéros de téléphone ou adresses de courriel suivants.

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marie-pascale.pomey@umontreal.ca

Merci de votre précieuse collaboration!

_____   _____

Directeur général   Président du Conseil d'administration

_____   _____

Directeur des services professionnels   Président du CMDP

1. Profils des répondants

1.1. **Parcours académique et professionnel :**

- Formation académique (médecine, administration, etc.)

- Poste actuel : depuis combien de temps l'occupez-vous? Quelles sont les circonstances qui vous ont amené à l'occuper?

- Postes occupés antérieurement, au sein de l'organisation et ailleurs

1.2. **Liens à la profession, perception du rôle et identification :**

- Si on vous demande que faites-vous dans la vie, lors d'une situation externe (dans un party, etc.), que répondez-vous?

- Comment décririez-vous votre rôle actuel au sein de l'organisation?

- *[Questions pour directeurs médicaux seulement]*

  Qu'est-ce qui vous distingue des autres membres dans l'équipe de direction? Comment votre façon d'aborder les dossiers diffère-t-elle des autres membres?

- Les individus peuvent s'identifier avec des groupes différents comme leur direction, leur organisation, leur profession, ou autres groupes. Vous, avec quel groupe vous identifiez-vous le plus? Pourquoi?

2. Les pistes ou les initiatives de partenariat médico-administratif

2.1. *Relations médico-administratives : situation générale actuelle*

- Avant la participation de votre établissement au projet de l'AQESSS, quelle était la situation du point de vue des relations entre le corps médical et le corps administratif ? Comment caractériseriez-vous cette situation? [Éléments clés, absence ou quasi inexistence, impacts sur certains dossiers, etc.]

2.2. *Mise en œuvre des pistes ou des initiatives de partenariat*

- Quelles sont les pistes de partenariat de l'AQESSS que vous avez entrepris de mettre en place jusqu'à présent? [Pour repères: 1) cogestion médico-administrative de programmes-

clientèles; 2) comité de coordination pour l'ensemble des programmes; 3) la participation de co-leaders médicaux de programmes au Comité de direction; 4) renforcement des liens entre le CA et le CMDP; 5) création d'un comité du CA sur les affaires cliniques; 6) création d'une cellule de réflexion et d'orientation stratégique qui comprendrait le DG, le Président du CA, le Président du CMDP et le DSP.]

- Quels ont été les défis rencontrés jusqu'à présent? Y aurait-il eu par ailleurs des éléments facilitateurs ? Si oui, lesquels? Quelles sont en définitive les conditions du succès d'une pareille mise en place?

- La mise en place d'autres pistes est-elle envisagée à plus ou moins court terme? Si oui, lesquelles? Et pourquoi?

2.3. **Le sens de la gouvernance médico-administrative**

- De manière générale, à quel besoin ou à quel objectif la gouvernance médico-administrative répond-elle [ou a-t-elle répondu par le passé] au sein votre établissement? [Sonder la pertinence des pistes de partenariat ou des initiatives de gouvernance médico-administrative en regard des orientations stratégiques]

- Comment voyez-vous votre propre implication dans ce projet de développement d'une gouvernance médico-administrative au sein de votre établissement? Qu'est-ce qui vous incite personnellement à y participer?

- Comment percevez-vous votre rôle de [gestionnaire/ médecin] en lien avec celui du [gestionnaire / médecin]? [Pour les médecins gestionnaires, sonder la question de la double allégeance professionnelle et son impact sur la perception de l'influence, de manière générale.]

- *Pour les médecins n'occupant pas une position formelle de cogestionnaire :* vous percevez-vous comme un co-leader?

3. **Relations médico-administratives**

3.1. *La cogestion (pour co-leaders seulement)*

- Depuis quand êtes-vous impliqué dans la cogestion?

- Pouvez-vous me décrire comment vous travaillez ensemble, comment vous coordonnez vos efforts? Quels sont les rôles de chacun? Comment vous partagez-vous les rôles?
- Qu'est-ce que la cogestion vous permet de faire? Pouvez-vous me donner un exemple de situation ou dossier où ce mode a été particulièrement utile ou efficace?
- Quels sont les défis de ce mode de gestion?
- Est-ce que votre façon de pratiquer votre rôle (comme gestionnaire ou médecin-gestionnaire) s'est modifiée depuis que vous travaillez en cogestion? Si oui, comment?

3.2. *L'harmonisation des logiques médicale et managériale*

- Selon vous, comment la logique médicale s'intègre-t-elle à la logique managériale et vice versa? Quelle est la place de la logique managériale/médicale dans les discussions? *[Peut s'appliquer aux dyades ou à l'équipe de direction]*
- Pouvez-vous me décrire une situation où la réconciliation des perspectives [dans la dyade ou l'équipe de direction] a bien fonctionné.
- À l'inverse, pouvez-vous me décrire une situation où la réconciliation des perspectives [dans la dyade ou l'équipe de direction] n'a pas très bien fonctionné.
  Quelle situation arrive le plus souvent?

4. Les dossiers traceurs

4.1. Impacts attendus

- Selon vous, quels sont les impacts attendus des pistes de partenariat à mettre en place sur les dossiers traceurs identifiés pour votre établissement ? [valider les impacts déjà répertoriés + voir s'il n'y en a pas d'autres → exemples concrets de dossiers]
- Selon vous, par quelles étapes le processus de mise en œuvre des pistes/initiatives de partenariat devra-t-il encore passer pour parvenir à des résultats satisfaisants concernant chacun des dossiers ?
- Quels sont les acteurs qui seront impliqués tout au long du processus? Quelles actions devront-ils poser, selon vous, et comment seront-ils appelés à interagir?

ANNEXE 4: Guide d'entretien de phase 2

1. **Profils des répondants**

1.1. ***Poste occupé :*** Description du poste tel qu'occupé lors de la première rencontre VS aujourd'hui : évolution?

2. **Liens à la profession, perception du rôle et autres identifications :**

2.1 ***Lien à la profession :*** Réponse au temps 1 à la question « Que faites-vous dans la vie, lors d'une situation externe (dans un party, etc.)? » Nuances à apporter aujourd'hui à cette réponse? Si oui, pourquoi?

2.2 ***Perception du rôle :*** Réponse au temps 1 à la question sur le rôle actuel au sein de l'organisation (en général). Comment voyez-vous ce rôle actuellement? Qu'est-ce qui a changé? De quelle façon cela s'est-il produit?

2.3 ***Identifications :*** Réponse au temps 1 à la question sur les appartenances à des groupes ou à des catégories particulières autres que la professionnelle. Identifications sont-elles les mêmes? Si changement, qu'est-ce qui peut l'expliquer?

Si, au Temps 1, aucune réponse n'a été donnée à l'une ou l'autre de ces questions [1.2.1., 1.2.2. et 1.2.3.] – ou si le répondant est rencontré pour la première fois au Temps 2, poser ces questions de la manière suivante :

- Que répondez-vous lorsqu'on vous demande ce que vous faites dans la vie? (Dans une situation extérieure au travail - party, etc.)? Auriez-vous donné la même réponse il y a un an? Si non, laquelle et pourquoi?

- Comment voyez-vous ce rôle actuellement au sein de l'organisation? Qu'est-ce qui a changé depuis un an? De quelle façon cela s'est-il produit?

- Y'a-t-il des groupes ou secteurs particuliers auxquels vous vous identifiez ? Si oui, lesquels? Y'a-t-il eu des changements depuis un an? Pourquoi?

3. **Traceurs généraux**

3.1 *Qualité des relations médico-administrative* Réponse au temps 1 à la question sur la situation des relations entre le corps médical et le corps administratif. Comment caractériseriez-vous l'état actuel de ces relations en comparaison d'il y a plus d'un an? S'il y a une différence, comment l'expliquez-vous? Qu'est-ce qui a changé et pourquoi? Que s'est-il passé?

Si, au Temps 1, aucune réponse n'a été donnée à cette question – ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante : Comment caractériseriez-vous l'état actuel des relations entre le corps médical et le corps administratif ? Qu'est-ce qui a changé et pourquoi? Que s'est-il passé?

a. Pour co-leaders seulement

- L'an dernier, vous aviez défini la relation avec votre cogestionnaire de la manière suivante. [Qualification (bonne ou mauvaise) et caractérisation (le pourquoi) de la relation] Qu'est-ce qui a changé depuis un an? Que s'est-il passé qui ?

- Pouvez-vous me décrire brièvement, en un mot ou deux, le fonctionnement de votre tandem (par rapport aux modes de coordination, de communication)?
  Pouvez-vous m'expliquer le choix de ce(s) qualificatif(s)?

  Si, au Temps 1, aucune réponse n'a été donnée à cette question – ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante :
  -Comment définissez-vous actuellement votre relation avec votre co-leader? Qu'est-ce qui a changé depuis un an? Comment l'expliquez-vous?
  -Pouvez-vous me décrire brièvement, en un mot ou deux, le fonctionnement de votre tandem (par rapport aux modes de coordination, de communication)? Pouvez-vous m'expliquer le choix de ce(s) qualificatif(s)?

b. Questions aux autres répondants : Point de vue extérieur

- Comment percevez-vous actuellement l'état des relations entre médecins et gestionnaires au sein de chacun des programmes ou secteurs de service?
  Qu'est-ce qui a changé depuis un an? Comment l'expliquez-vous?

- Pouvez-vous me décrire brièvement, en un mot ou deux, le fonctionnement de chacun d'entre eux (par rapport aux modes de coordination, de communication)? Pouvez-vous m'expliquer le choix de ce(s) qualificatif(s)?

3.2 Perception des rôles, responsabilités et compétences

a. Pour co-leaders seulement

1) **Perception des rôles et responsabilités au sein des tandems (propres à chacun et/ou partagés)** *[les rôles clés ou génériques + rôles et responsabilités spécifiques liés aux fonctions]* : L'an dernier, vous aviez décrit de la manière suivante vos rôles et responsabilités au sein du tandem. Qu'est-ce qui a changé depuis un an par rapport à cette manière de percevoir vos rôles et responsabilités, et aussi dans la manière de les exercer? Que s'est-il passé? Y'a-t-il eu une clarification qui a été apportée dans la définition de ces rôles et responsabilités? Si oui, comment cela s'est-il produit?

[Lorsque le cogestionnaire est un directeur médical] Comment décrivez-vous votre cogestionnaire médical dans sa manière d'exercer ses rôles et responsabilités? Pouvez-vous m'expliquer le choix de ces qualificatifs?

> Si, au Temps 1, aucune réponse n'a été donnée à l'une ou l'autre de ces questions ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante :
>
> - Comment décririez-vous vos rôles et responsabilités au sein du tandem? Qu'est-ce qui a changé depuis un an? Que s'est-il passé? Y'a-t-il eu une clarification qui a été apportée dans la définition de ces rôles et responsabilités? Si oui, comment cela s'est-il produit?
>
> - [Lorsque le cogestionnaire est un directeur médical] Comment décrivez-vous votre cogestionnaire médical dans sa manière d'exercer ses rôles et responsabilités? Pouvez-vous m'expliquer le choix de ces qualificatifs? Qu'est-ce qui a changé par rapport à l'an dernier?

2) **Asymétrie des rôles au sein des tandems en lien avec la prise de décision** L'an dernier, vous aviez décrit comme suit vos rôles et responsabilités en lien avec la prise de décision au

sein de votre tandem. La situation a-t-elle évolué depuis et si oui dans quel sens? [Évolution positive ou négative] Qu'est-ce qui fait que les choses ont changé ou non? [Obstacles, facilitateurs]

Considérez-vous que votre cogestionnaire et vous-même êtes appelés, depuis le début, à remplir vos rôles respectifs en toute égalité de statut [en regard de la prise de décision]? Si non, comment l'expliquez-vous ? Qu'est-ce qui a changé depuis un an? Que s'est-il passé?

Même question relativement à l'ensemble des tandems de l'organisation : Considérez-vous que les co-leaders de programmes dans leur ensemble sont appelés, depuis le début, à remplir leurs rôles respectifs en toute égalité de statut [en regard de la prise de décision]? Si non, comment l'expliquez-vous ?

Qu'est-ce qui a changé depuis un an? Que s'est-il passé?

Si, au Temps 1, aucune réponse n'a été donnée à l'une ou l'autre de ces questions ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante :

- Comment décririez-vous vos rôles et responsabilités, ainsi que ceux de votre co-leader, en lien avec la prise de décision? La situation a-t-elle évolué depuis un peu plus d'un an? Si oui, dans quel sens [positif ou négatif]? Que s'est-il passé?

- Considérez-vous que votre cogestionnaire et vous-même êtes appelés, depuis le début, à remplir vos rôles respectifs en toute égalité de statut [en regard de la prise de décision]? Si non, comment l'expliquez-vous ? Qu'est-ce qui a changé depuis un an? Que s'est-il passé?

- Même question relativement à l'ensemble des tandems de l'organisation : Con sidérez-vous que les co-leaders de programmes dans leur ensemble sont appelés, depuis le début, à remplir leurs rôles respectifs en toute égalité de statut [en regard de la prise de décision]? Si non, comment l'expliquez-vous ? Qu'est-ce qui a changé depuis un an? Que s'est-il passé?

3) Les types de compétences L'an dernier, vous aviez décrit comme suit les compétences nécessaires à la réalisation de la cogestion, dans votre tandem et/ou en général. Y'a-t-il eu

des améliorations depuis selon vous? Si oui, dans quel sens [positif ou négatif? Que s'est-il passé? [Formation? Si oui, quelle forme cela a-t-il pris?]Si aucune évolution, pourquoi? D'autres compétences se sont-elles rajoutées depuis?

> Si, au Temps 1, aucune réponse n'a été donnée à cette question – ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante : Comment décririez-vous les compétences nécessaires à la réalisation de la cogestion, dans votre tandem et/ou en général?

b. Questions aux autres répondants

1) Perception des rôles et responsabilités au sein des tandems (propres à chacun et/ou partagés) *[les rôles clés ou génériques + rôles et responsabilités spécifiques liés aux fonctions] :*

- L'an dernier, vous aviez défini de la manière suivante les rôles et responsabilités des co-leaders de programmes au sein de votre organisation. Qu'est-ce qui a changé depuis un an? Y a-t-il un effort de clarification qui a été proposé en termes de définition et de répartition de ces rôles et responsabilités? Si oui, comment cela s'est-il produit?

- Comment décririez-vous, en un ou deux mots, chacun des directeurs médicaux de programme dans leur manière d'exercer leur rôle? Pouvez-vous m'expliquer le choix de ces qualificatifs? Qu'est-ce qui a changé par rapport à l'an dernier?

> Si, au Temps 1, aucune réponse n'a été donnée à cette question ou si le répondant est rencontré pour la première fois au Temps 2, poser la question de la manière suivante :
>
> - Comment définiriez-vous la répartition des rôles et responsabilités actuelles des co-leaders de programmes ou secteurs de service au sein de votre organisation? En d'autres termes, qui fait quoi?
>
> - Qu'est-ce qui a changé depuis un an? Y a-t-il un effort de clarification qui a été proposé en termes de définition et de répartition de ces rôles et responsabilités? Si oui, comment cela s'est-il produit?

- Comment décririez-vous, en un ou deux mots, chacun des directeurs médicaux de programme dans leur manière d'exercer leur rôle? Pouvez-vous m'expliquer le choix de ces qualificatifs? Qu'est-ce qui a changé par rapport à l'an dernier?

2) Asymétrie des rôles au sein des tandems en lien avec la prise de décision Considérez-vous que les co-leaders de programmes dans leur ensemble sont appelés, depuis le début, à remplir leurs rôles respectifs en toute égalité de statut [en regard de la prise de décision]? Si non, comment l'expliquez-vous ? Qu'est-ce qui a changé depuis un an? Que s'est-il passé?

3) Les types de compétences Comment décririez-vous les compétences nécessaires à la réalisation de la cogestion?

3.3 Fonctionnement des programmes ou secteurs de services

a. Questions aux co-leaders

- Comparativement à il y a un an, quelle évaluation faites-vous maintenant du fonctionnement de votre programmes ou secteur de service dans son ensemble? Comment s'y est-on pris pour le ***faire vivre*** ? *[Exécutif de programme, fonctionnement des équipes en place, statutaires à différents niveaux, etc.]* Qu'est-ce qui a changé ou s'est ajouté depuis un an? Que s'est-il passé? Qu'est-ce qui n'a pas fonctionné et pourquoi? La cogestion a-t-elle eu un impact sur ce fonctionnement? Si oui, de quelle façon?

- Actuellement, comment les activités, interventions ou actions que vous réalisez quotidiennement à titre de [directeur clinique ou directeur médical] sont-elles perçues par les autres médecins, administrateurs et membres du personnel au sein du programme ou secteur? Quels sont leurs effets selon vous? Qu'est-ce qui a changé depuis un an? Comment l'expliquez-vous?

b. Questions aux autres répondants Comparativement à il y a un peu plus d'un an, quelle évaluation faites-vous maintenant du fonctionnement des programmes ou secteurs de service dans leur ensemble? Comment s'y est-on pris pour les ***faire vivre*** ? *[Exécutif de programme, fonctionnement des équipes en place, statutaires à différents niveaux, etc.]* Qu'est-ce qui a

changé ou s'est ajouté depuis un an? Qu'est-ce qui n'a pas fonctionné et pourquoi? La cogestion a-t-elle eu un impact sur ce fonctionnement? Si oui, de quelle façon?

3.4   Intégration verticale et horizontale : Liens entre équipes du terrain et direction de l'établissement

1) **Intégration de la présence médicale au niveau stratégique** Peut-on dire qu'il y a eu depuis un an un renforcement de l'influence médicale au niveau de la prise de décision stratégique? Si oui, qu'est-ce qui l'explique? [Forme de la participation, autres facteurs?] Si non, pourquoi? [Obstacles, inertie?]

2) **Rôle des médecins et du tandem dans le rapprochement entre administration de l'établissement et équipe sur le terrain** Valider la portée de cette observation : dans quelle mesure ce rapprochement s'est-il avéré? Et, le cas échéant, comment cela s'est-il produit? Quels changements la cogestion médicale a-t-elle apportés du point de vue de la communication en général entre l'administration et le terrain?

4   Traceurs spécifiques aux établissements

Pour chaque dossier : Évolution du dossier : que s'est-il passé en un an? Les médecins ont-ils été impliqués? Si oui comment? Perspectives en termes de développement de la gouvernance médico-administrative?

5   État de la gouvernance médico-administrative

5.1   La participation des médecins

Formes de la participation

- Présence paritaire ou majoritaire-minoritaire sur des comités statutaires ou ad hoc; participation d'office ou sur invitation. Évolution des formes de la participation à des comités depuis un an?

- Formes de la participation au sein des programmes? Évolution depuis plus d'un an?

Intérêt ou motivation à participer

- *La motivation des médecins à participer a-t-elle été encouragée depuis un an? Si oui, comment?*

- Sentiment d'être étranger par rapport à tout ce qui est d'ordre purement administratif. Subsiste encore? Si oui, pourquoi?

5.2   Bilan de la cogestion médicale des programmes ou secteurs de service

Évaluation des stratégies d'implantation

- Avec le recul, quelle évaluation faites-vous des stratégies qui ont été mises en place pour l'implantation de la cogestion médicale [lire: la participation des médecins à la gestion des programmes]?

- Quel regard portez-vous actuellement sur les conditions préexistantes à une telle implantation (culture favorable ou défavorable, facilitateurs et obstacles structurels)?

Impacts sur l'organisation

- De manière générale, quelle contribution la cogestion médicale a-t-elle apportée à l'organisation depuis son implantation? Pouvez-vous donner des exemples?

- À l'inverse, peut-on parler de situations problématiques qui auraient été engendrées par la cogestion médicale?

5.3   Réaménagement de la gouvernance ?

Place de la cogestion médico-administrative dans le système de gouvernance

- Au final, le bilan que vous faites du fonctionnement de la cogestion médico-administrative depuis son implantation/ formalisation vous amène-t-il à penser que sa structure actuelle devrait être modifiée? Si oui, pourquoi? De quelle façon?

- La cogestion médico-administrative va-t-elle finir par favoriser une plus grande autonomie des programmes clientèles?

Recomposition des comités, repositionnement de leurs rôles Quel est le rôle du CMDP dans les démarches d'implantation de la cogestion?

5.4 Défis pour l'avenir et retombées perçues de la participation au projet de l'AQESSS

- Entrevoyez-vous encore des défis à relever en ce qui concerne le développement de la gouvernance médico-administrative au sein de votre établissement ? Si oui, lesquels? Y a-t-il une différence avec les défis qui se sont posés dès le départ?

- Selon vous, quelles seront les retombées pour votre établissement de votre participation au projet de l'AQESSS? Est-ce que ça a valu la peine?

Comité d'éthique
de la recherche

HEC MONTRÉAL

AVIS DE CONFORMITÉ À LA POLITIQUE EN MATIÈRE D'ÉTHIQUE
DE LA RECHERCHE AVEC DES ÊTRES HUMAINS DE HEC MONTRÉAL

La présente atteste que le projet de recherche décrit ci-dessous a fait l'objet d'une évaluation en matière d'éthique de la recherche avec des êtres humains et qu'il satisfait les exigences de notre politique en cette matière.

Titre du projet de recherche :
Autonomie et collaboration : Construire un partenariat médico-administratif gagnant-gagnant

Chercheur principal :
Chercheur : Émilie Gibeau
  Titre :   Étudiant(e) Doctorat
  Service/Option :   Management

Co-chercheur : Marie-Pascale Pomey
  Titre :   Professeur(e) autre
  Service/Option :   (Université de Montréal)

Co-directeur : Jean-Louis Denis
  Titre :   Professeur(e) autre
  Service/Option :   (ENAP)

Co-directeur : Ann Langley
  Titre :   Professeur(e) titulaire
  Service/Option :   Management

Date de déclaration du projet au Comité d'éthique de la recherche :
15 juin 2011

Date d'approbation du projet :
07 septembre 2011

Date de publication de l'avis :
07 septembre 2011

Jonathan Deschênes
Comité d'éthique de la recherche

ANNEXE 7: Attestation d'approbation éthique complétée

HEC MONTRÉAL

Comité d'éthique de la recherche

ATTESTATION D'APPROBATION ÉTHIQUE COMPLÉTÉE

La présente atteste que le projet de recherche décrit ci-dessous a fait l'objet des approbations en matière d'éthique de la recherche avec des êtres humains nécessaires selon les exigences de HEC Montréal.

La période de validité du certificat d'approbation éthique émis pour ce projet est maintenant terminée. Si vous devez reprendre contact avec les participants ou reprendre une collecte de données pour ce projet, la certification éthique doit être réactivée préalablement. Vous devez alors prendre contact avec le secrétariat du CER de HEC Montréal.

Projet # : 2012-1167, 1156 - 1156

Titre du projet de recherche : L'intégration de professionnels dans des rôles de gestion : Identité, co-leadership et légitimité

Chercheur principal :
Emilie Gibeau, étudiante Ph. D.
HEC Montréal

Directeur/codirecteurs :
Jean-Louis Denis; Ann Langley

Date d'approbation initiale du projet : 07 septembre 2011

Date de fermeture de l'approbation éthique : 17 août 2016

Maurice Lemelin
Président du CER de HEC Montréal

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Attestation d'approbation éthique complétée - Fermeture de projet
Comité d'éthique de la recherche - HEC Montréal
1 / 1

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ANNEXE 8: Accord des coauteurs d'un article inclus dans une thèse de doctorat

Accord des coauteurs d'un article inclus dans un mémoire de Maîtrise ou une thèse de Doctorat

Registrariat

3000, chemin de la Côte-Sainte-Catherine
Montréal (Québec) Canada H3T 2A7

HEC MONTRÉAL

Lorsqu'un étudiant n'est pas le seul auteur d'un article qu'il veut inclure dans son mémoire ou dans sa thèse, il doit obtenir l'accord de tous les coauteurs à cet effet et joindre la déclaration signée à l'article en question. **Une déclaration distincte doit accompagner chacun des articles inclus dans le mémoire ou la thèse.**

1. Identification de l'étudiant

Emilie
_____
Nom, Prénom

Gibeau
_____
Matricule HEC

| Doctorat en administration |
Programme d'études

| Management |
Spécialisation

2. Description de l'article

Auteur(s): Emilie Gibeau, Nicolas Van Schendel, Ann Langley, Jean-Louis Denis

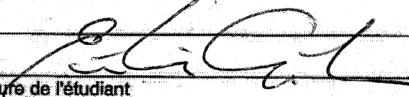Titre : Co-Leadership dyads in professional organizations: Bridging professional and managerial Logics?

Publication :

État actuel de l'article : ☐ publié   ☐ soumis pour publication   ☒ en préparation

3. Déclaration de l'étudiant

Pour chaque article publié ou soumis pour publication, l'étudiant doit indiquer brièvement la nature de sa participation aux travaux de recherche et, s'il y a lieu, l'importance de sa contribution à l'article par rapport à celle des coauteurs. Dans le cas d'un article en préparation, il indiquera sa contribution actuelle ou prévisible aux travaux de recherche et à l'article.

J'ai effectué 50% de la collecte de données, l'analyse et ai rédigé l'article. Nicolas Van Schendel a réalisé 50% de la collecte de données et a participé à l'analyse des données. Ann Langley et Jean-Louis Denis ont offert leurs conseils et facilités le processus de collecte, analyse et rédaction.
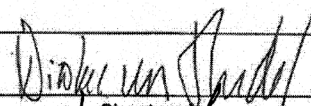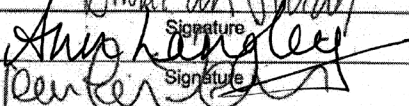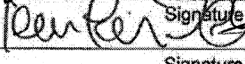
_____
Signature de l'étudiant

2 sept 2016
_____
Date

4. Déclaration de tous les coauteurs autres que l'étudiant

À titre de coauteur de l'article identifié ci-dessus, je suis d'accord pour que Emilie Gibeau inclue cet article dans ☐ son mémoire de maîtrise / ☒ sa thèse de doctorat qui a pour titre :

| L'intégration de professionnels dans des rôles de gestion : Identité, co-leadership et légitimité |

(titre du mémoire ou de la thèse)

Nicolas Van Schendel
_____
Coauteur

_____
Signature

25 Juin 2016
_____
Date

Ann Langley
_____
Coauteur

_____
Signature

29/6/2016
_____
Date

Jean-Louis Denis
_____
Coauteur

_____
Signature

27 Juin 2016
_____
Date

_____
Coauteur

_____
Signature

_____
Date