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The Antecedents of Middle Managers' Strategic Contribution: The Case of a Professional Bureaucracy

Graeme Currie and Stephen J. Procter

Nottingham University Business School; University of Newcastle

ABSTRACT Our study contributes towards a burgeoning literature that argues organizational performance is heavily influenced by what happens in the middle of the organization, rather than at the top. Examining the UK National Health Service, our study develops the work of Floyd and Wooldridge (1992, 1994, 1997, 2000). It utilizes role theory to conceptualize changing experiences of middle managers in organizations as a role transition. Associated with this are problems of role conflict and role ambiguity (Biddle, 1979, 1986; Biddle and Thomas, 1966; Kahn et al., 1964, 1966). Our study illustrates that there are limiting factors to a more strategic role for middle managers associated with the professional bureaucracy context. However, role conflict and ambiguity can be mediated by a socialization process, which values incoming identity and personal characteristics (Van Maanen and Schein, 1979).

INTRODUCTION

Our study contributes to a burgeoning literature that argues organizational performance is heavily influenced by what happens in the middle of organizations, rather than at the top (Burgelman, 1983a, 1983b; Dopson and Stewart, 1990, 1993; Dutton and Ashford, 1993; Dutton et al., 1997, 2001; Floyd and Lane, 2000; Floyd and Wooldridge, 1992, 1994, 1997, 2000; Frohman and Johnson, 1993; Huy, 2001, 2002: Nonaka, 1988, 1991, 1994; Nonaka and Takeuchi 1995; Smith, 1997; Wooldridge and Floyd, 1990). Within this literature middle managers are positioned as key strategic actors. However, much of this literature has been developed through studies carried out in technologically intensive environments and in which

Address for reprints: Graeme Currie, Nottingham University Business School, Jubilee Campus, Nottingham University, Wollaton Road, Nottingham NG8 1BB, UK (graeme.currie@nottingham.ac.uk).

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organizations have more organic structures. This more enlightened view of middle managers' strategic contribution has not spread universally across organizations and there still remains a need for more context sensitive studies of middle managers' contribution to strategy (Dopson and Stewart, 1990, 1993; Smith, 1997). In response to this research gap, we adopt a case study approach to build theory regarding the role of middle managers in organizations (Eisenhardt, 1989). We focus upon middle managers in a large professional bureaucracy – the UK National Health Service (NHS) – an organization in which middle managers' strategic contribution is subject to influence from a powerful professional cadre of core employees within the organization – doctors (Mintzberg, 1979, 1995) – and is framed by the changing priorities of government policy.

The most systematic, comprehensive and widely cited attempt to explore middle managers' contribution to strategy has been made by Floyd and Wooldridge (Floyd and Wooldridge, 1992, 1994, 1997, 2000; Wooldridge and Floyd, 1990). Our research builds upon Floyd and Wooldridge's work and follows their call for more comparative, descriptive case studies that 'tell the story' behind the development of a particular initiative from the middle level perspective (Floyd and Wooldridge, 2000, p. 143). Specifically our study examines the expectations of executive managers, government policy-makers and doctors towards the middle manager's role, the response of middle managers towards these expectations and how organizations might intervene to develop the capability of middle managers to make a greater strategic contribution.

CONCEPTUAL FRAMEWORK

Floyd and Wooldridge's typology relies upon the idea that strategy encompasses both deliberate and emergent influences as a 'pattern in a stream of decisions' (Mintzberg and Waters, 1985, p. 257). This broadens strategy to encompass the influence of stakeholders beyond executive management including middle management. Floyd and Wooldridge (1992, 1994, 1997) argue that middle managers can and do actively participate in the 'thinking' as well as the 'doing' of strategy. They put forward a framework that allows for a consideration of their enhanced role (see Figure 1).

There are two dimensions to their framework. The first dimension is one that describes the direction of influence exerted by middle managers upon strategy – that is, upward or downward direction of influence. The second dimension is one that assesses the extent to which the influence of middle managers alters the organization's concept of strategy. For example, middle managers can take action or contribute ideas that co-ordinate dissimilar activity and support a coherent direction and thereby have an integrative influence upon the organization's strategy.

This gives rise to four possible types of involvement of middle managers in strategy. First, in Figure 1, under 'synthesizing information', middle managers can

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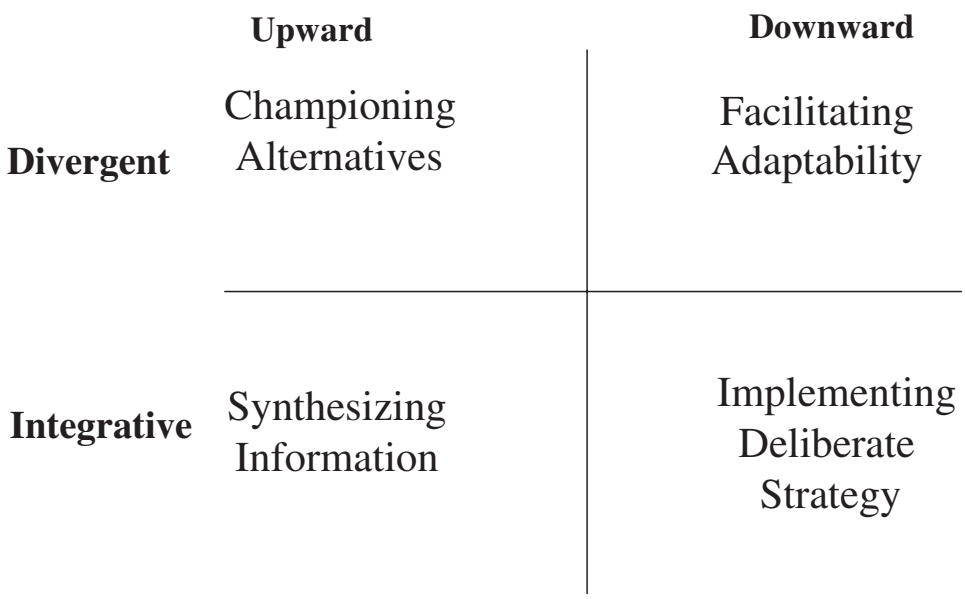

Figure 1. Typology of middle manager influence (Floyd and Wooldridge, 1992)

interpret information and channel it upwards to executive management. This may affect executive management's view of organizational circumstances and the information synthesized by middle managers may then become the primary basis for deciding how executive management will allocate limited attention and resources amongst an array of issues (Dutton and Ashford, 1993). Second, under 'championing alternatives', middle managers have the potential to reshape the strategic thinking of executive management by selling to them strategic initiatives that diverge from their current conception of strategy. Third, middle managers can exert a downward influence through 'facilitating adaptability' where they support more radical activities within the areas they manage that lie outside executive management's official expectations.

The fourth type of involvement of middle managers in strategy identified by Floyd and Wooldridge in Figure 1 – 'implementing deliberate strategy' – is one that they report as most evident in their study. This they define as managerial interventions that align organizational action with the strategic intentions of executive management. Middle managers implement strategy by translating corporate strategy into action plans and individual objectives. Floyd and Wooldridge highlight its importance, arguing that a certain degree of uniformity is required from middle managers in this role to achieve horizontal consistency at operating levels of the organization. Such consistency is associated with improved organizational performance. Without consistency of middle managers' influence in this role, 'coordination breaks down among the various elements of strategic change. Inconsistent levels of downward influence among an organization's middle managers is

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likely, therefore to hamper the overall realization of strategy' (Floyd and Wooldridge, 1997, p. 472).

Others also suggest that middle managers make a significant contribution through implementing deliberate strategy, by translating broad strategic objectives into shorter-term operational foci of behaviour (Hrebiniak and Joyce, 1984) or mediating between operational 'reality' and executive management's vision (Nonaka and Takeuchi, 1995). As Quinn (1980) notes, there may be significant discretion for middle manager influence in implementing strategy since strategy is likely to be modified to incorporate new information as it presents itself. Our study seeks to build theory, focused upon the role of middle managers in implementing deliberate strategy.

Effect of Contingent Factors upon the Strategic Contribution of Middle Managers

The typology of middle manager involvement in strategy developed by Floyd and Wooldridge (1992, 1994, 1997) is set against changing expectations regarding the role of middle managers in organizations. This consists of two distinct phases. The first phase from the start of the twentieth century to the end of the 1970s is one that, in retrospect, can be viewed as a 'golden age' for middle managers since they appeared to be 'riding high' (Frohman and Johnson, 1993) with significant increases in their numbers and elaboration of the middle manager hierarchy within organizations in the USA and Europe (Bendix, 1956; Chandler, 1977; Frohman and Johnson, 1993; Melman, 1983; Wheatley, 1992). The second phase, evident from the 1980s onwards, is one in which the forces of deregulation, global competition and pressure for short term results created a 'new competitive reality' (Frohman and Johnson, 1993; Hirst and Thompson, 1995; Robertson, 1992). Exhortations to downsize, by 'cutting out the fat' and getting 'lean and mean' (Peters, 1987; Peters and Waterman, 1982), were found to be irresistible by senior executives in the USA and Europe. Predicated upon their view that middle managers enacted a task orientated role in which they merely implemented deliberate strategy determined by executive managers above them (Andrews, 1971; Chandler, 1962; Nutt, 1987), executive management focused upon de-layering middle managers (Cascio, 1993; Smith, 1997; Staehle and Schirmer, 1992; Wheatley, 1992).

There may be a distinct third phase emerging because the anticipated cost reduction and improved organizational performance have not been forthcoming from de-layering. Instead de-layering has 'inevitably destroy[ed] part of an organization's social network, and this may explain why firms have experienced negative results from the restructuring process' (Floyd and Wooldridge, 1997, p. 481). From this viewpoint, organizational goals, innovation and creativity depend heavily upon an enlightened or empowered middle manager (Dopson and Stewart 1990; Floyd and Wooldridge, 2000; Frohman and Johnson, 1993; Millman and

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Hartwick, 1987; Nonaka, 1988; Nonaka et al., 1992; Smith, 1997). Yet the effects of job insecurity from a previous phase of de-layering in organizations are likely to remain for middle managers and this may inhibit any role transition that requires them to make a greater strategic contribution (Goffee and Scase, 1992; Johnson and Frohman, 1989; Scase and Goffee, 1989; Westley, 1990).

Floyd and Wooldridge (1992, 1994, 1997) identify contingent factors that potentially mediate any unwillingness or inability on the part of middle managers to make a greater strategic contribution. First, they argue that middle managers in boundary spanning positions between the organization and customers, suppliers or professional associations are 'better positioned than others to comprehend the strategic problem or propose an initiative and exert upward influence' (Floyd and Wooldridge, 1997, p. 471). They conclude, therefore, that middle managers should be put in regular contact with the environment if an organization wants them to make a greater contribution to strategy.

Second, Floyd and Wooldridge (1992) provide evidence that upward influence behaviours of 'synthesizing information' and 'championing alternatives' were less common at lower levels of middle management. Rather than consider middle managers as a single group, the relationship between their contribution to strategy and their hierarchical position in the organization needs to be broken down in finer detail.

Third, beside the position of middle managers in the organizational hierarchy, Floyd and Wooldridge highlight a trend in which organizations have replaced traditional hierarchies in favour of flatter, more process-orientated structures. On the one hand, as earlier identified, this may have negative consequences for middle managers because it may be associated with de-layering. On the other, they argue that moving away from hierarchical toward more horizontal business structures increases the importance of the contribution that middle managers can make towards achieving competitive advantage (Floyd and Wooldridge, 1994) This view is supported by others (Frohman and Johnson, 1993; Kanter, 1982, 1983; Nonaka and Takeuchi, 1995).

Fourth, Floyd and Wooldridge found a greater effect upon organizational performance where middle managers were involved in setting goals and generating alternatives than when they were involved purely in the implementation side of the process (Wooldridge and Floyd, 1990). Support for this view is found in studies of the UK NHS (Pettigrew et al., 1992).

Fifth, Floyd and Wooldridge (1994) call for investment in management and organization development to support an enhanced contribution to strategy from middle managers (Floyd and Wooldridge, 1994). Again, others note this as important in the private sector (Frohman and Johnson, 1993) and the UK NHS (Pettigrew et al., 1992).

Finally, we should note that Floyd and Wooldridge, in more recent work, examine the strategic contribution of employees positioned in the middle level of

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the organization more generally, rather than middle managers specifically (Floyd and Wooldridge, 2000). Within a professional bureaucracy a key group of employees with whom middle managers need to interact are the professional operating core of the organization – for example, within a hospital, doctors (Mintzberg, 1979, 1995; Rouleau, 2005). Doctors are able to define the purpose of health services and control the actual delivery and general development of services (Ham, 1981; Hunter, 1979) and to resist, subvert and modify any proposed change that threatens their interest within the organization (Ackroyd, 1996; Dopson, 1996; Ferlie et al., 1996; Harrison et al., 1992; Mintzberg, 1979, 1995). Consequently middle managers in the NHS serve as 'diplomats' (Harrison et al., 1992) and only maintain power as long as the professional operating core perceives him or her to be serving their interests effectively (Mintzberg, 1995).

In sum, Floyd and Wooldridge (1992, 1994, 1997) identify strategic roles for middle managers and contingent factors that support enactment of a more strategic role. They appear relatively optimistic that, given a supportive organizational context, middle managers can undertake the necessary role transition to make a greater strategic contribution. However, within a professional bureaucracy the situation is rendered more complex – for example, the presence of a powerful professional group limits the potential for middle managers to move from a 'diplomat' role to a more autonomous strategic role. Our study builds upon Floyd and Wooldridge's work to take account of the complexities of role transition within a professional bureaucracy, focusing upon aspects of context that both inhibit and support role transition.

THE CONTEXT OF THE UK NHS

The empirical site for our theory building study was the UK NHS. The policy backdrop to our study was one of New Public Management (NPM). This consisted of four elements: an efficiency drive; cultural change; downsizing and decentralization; and a public sector orientation (Ferlie et al., 1996). The emphasis upon each element varied across the period over which our research took place (1996–99). Relatedly, the interaction of the elements of NPM provided inconsistent cues for the role that middle managers were expected to enact.

On the one hand, the drive for efficiency has combined with cultural change to promote a general management ethos. The general management ethos was reinforced by the implementation of an 'internal' or 'quasi-market'. This separated purchasers and providers of healthcare, with providers of healthcare expected to compete with each other to some degree (DoH, 1989a, 1989b).[1] Within this context, positioned as 'change agents', from the mid-1980s to mid-1990s, middle managers were in the ascendancy (Ferlie et al., 1996; Harrison et al., 1992; Pollitt et al., 1991; Stewart and Walsh, 1992).

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On the other hand, the drive for efficiency has combined with downsizing and decentralization to the disadvantage of middle managers because they have been de-layered. Prompted by concern about increasing management costs, government ministers criticized the number of 'men in grey suits' and asked for a reduction in their numbers (Ham, 1997). From 1997 onwards, with the election of the new Labour Government, increasingly prescriptive advice has been given to healthcare organizations that management costs should be cut, specifically middle management costs (*Health Service Journal*, 11 December, 1998; Industrial Relations Services, 1997; Pettinger, 1998; Wall, 1999). All three of our empirical cases felt the impact of this, as revealed below.

METHODOLOGY

Selection of Cases

The aim of our study was to generalize theoretically with data gathered through multiple case studies (Yin, 1994). We selected cases so that individual cases could be used for corroboration of specific propositions, patterns could be perceived more easily and chance associations eliminated. By piecing together the individual patterns, the researcher can thus build a more complete theoretical picture (Eisenhardt, 1989, 1991; Yin, 1994). Specifically drawing upon those contingent factors identified by Floyd and Wooldridge (Floyd and Wooldridge, 1992, 1994, 1997, 2000; Wooldridge and Floyd, 1990), including consideration of the impact of other professional employees within the middle of the organization, three cases were selected for study (see Table I). Each case was carefully chosen to serve a specific purpose within the overall scope of inquiry[2] so that a theoretical sampling logic was followed. In short, cases were selected to show sufficient variation in both the contingencies of middle managers' behaviour and the behaviour itself. To ensure appropriate case selection, before data gathering commenced, the researchers carried out exploratory interviews with two key organizational members in each case.

In each case the strategic intervention under examination was high priority in the strategic agenda of the organization in the face of the problem it was designed to address. In CCHT, recruitment and retention difficulties for key professional staff meant innovative ways had to be found to maintain existing levels of healthcare services and vertical and horizontal skill mixing was meant to address this. In Florence Hospital, there was debate about rationalization of healthcare services across the two hospitals in the city as a result of a huge budget deficit locally. In developing services in a 'business-like' way through a formal business planning process, Florence Hospital hoped to stave off potential closure of services. In Edwards Hospital, performance indicators imposed by government dictated that

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Table I. The case studies

Case study	*Description*	*Strategic intervention under examination*	*Middle managers*
CCHT	Employs 1150 with budget £30 million. Provides primary healthcare through multi-disciplinary teams in community health centres	'Skill mixing' – change in vertical skill mix (e.g. training less qualified healthcare assistants through competence based approach to take up nursing roles) and horizontal skill mix (e.g. blurring boundary between health visitors and district nurses).	Locality managers that manage one community centre-based multi-disciplinary team (see Figure 2)
Florence Hospital	Teaching hospital that employs 3000 staff with budget £70 million	'Service Development' – service development in which middle managers produce a business plan as a precursor to marketing service	Service managers and general managers that manage specialist clinical departments (see Figure 3)
Edwards Hospital	Teaching hospital that employs 5000 staff with an annual budget of £114 million	'Theatres Pay Project' – a local pay project to overcome inefficient utilization of theatres through harmonizing pay and conditions of two key groups of theatres staff	Specialty managers and senior nurse managers that manage specialist clinical departments (see Figure 4)

waiting lists be cut and increasing throughput in theatres was key to this. Harmonization of pay and conditions across key groups of workers would facilitate increase in throughput.

Identification of Middle Management

Given inconsistency in definition of middle managers that has muddied the debate about their experiences in organizations (Dopson and Stewart, 1990, 1993; Pinsonneault and Kraemer, 1993), we asked executive management to identify middle managers in each of the cases. Accompanying this request, we emphasized that middle managers be identified within operational core of the organization, rather than the corporate centre functions such as human resources or business development and that they were positioned in the organizational hierarchy so at least two levels of staff were below them (Pugh et al., 1968; Smith, 1997; Staehle and Schirmer, 1992).

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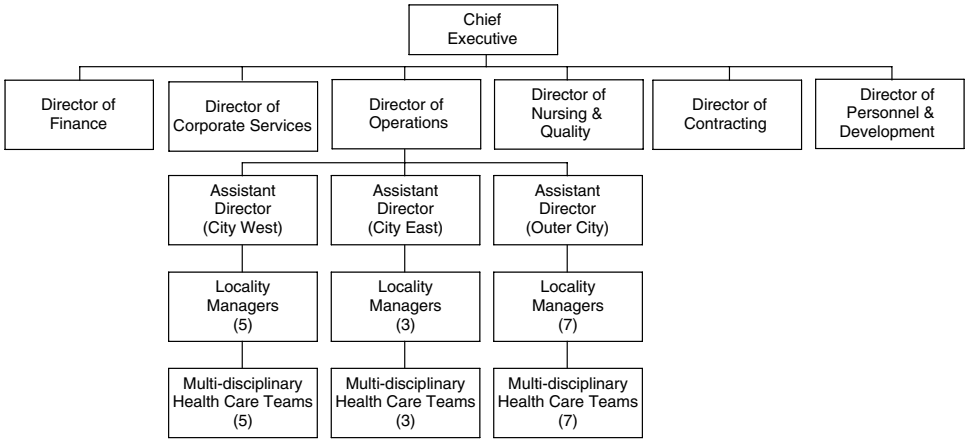

Figure 2. Organization chart: City Community Healthcare Trust

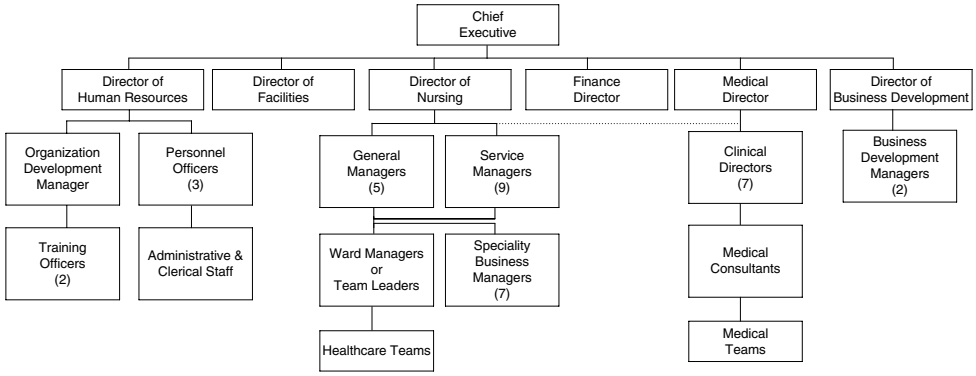

Figure 3. Organization chart: Florence Hospital

The resultant group upon whom the paper focuses are middle managers who manage departments ('directorates') that are organized around a clinical specialty – for example, Surgical Services, Trauma and Orthopaedics, Accident and Emergency, Radiology in the two hospital cases. These were Service Managers and General Managers in Florence Hospital and Specialty Managers and Senior Nurse Managers in Edwards Hospital (see Figures 3 and 4). In CCHT, Locality Managers were responsible for healthcare teams that served specific geographical areas of a city and surrounding districts (see Figure 2).

In all three cases, prior to taking up their present posts, middle managers had managed healthcare teams, composed of their own profession, commonly nursing. It was a role, framed by the expectations of their professional peer group, in which they deferred to the wishes of doctors (Harrison et al., 1992). Now, in all three cases middle managers were asked to manage a multi-disciplinary team consisting of their own and other professions.

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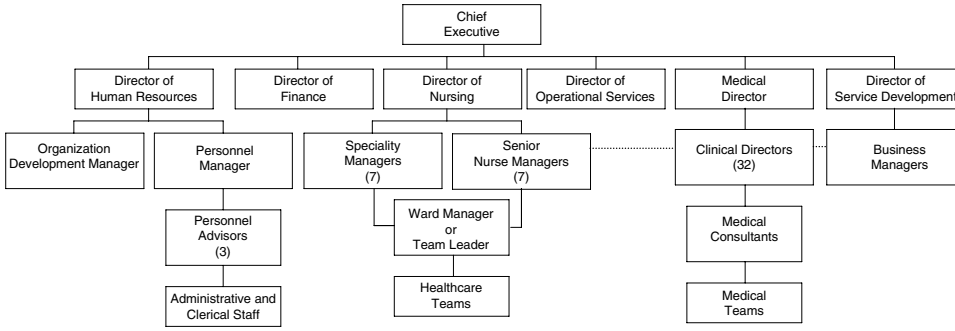

Figure 4. Organization chart: Edwards Hospital

A doctor formally heads up hospital departments as a 'Clinical Director'. Attempts by policy makers to draw doctors into the management process through positioning them as clinical directors have been the subject of extensive study since their introduction in the 1990s. Taking account of definitional problems of middle managers that beset research conclusions about their role (Dopson and Stewart, 1990), we feel the complexity of the hybrid role of clinical directors is best analysed separately. We do however note that clinical directors exert considerable influence upon strategy in their managerial role (Buchanan et al., 1998; Ferlie et al., 1996; Fitzgerald, 1994; Fitzgerald and Dufour, 1996; McKee et al., 1999; Thorne, 2000).

Within Table I, we should highlight that Locality Managers in CCHT are lower down the organizational hierarchy than those in the Florence and Edwards Hospitals. They had only one level of staff below them and did not interact directly with executive directors. As a result, in terms of their position in the organizational hierarchy, Locality Managers might be regarded as significantly different from middle managers in the two hospital cases. Yet we regard them as middle managers because, first, executive managers identified them as such. Second, Assistant Directors, into which they report, are positioned at corporate headquarters and removed from the operational core of the organization. Instead, Locality Managers managed the operations of the organization through leadership of multi-disciplinary neighbourhood teams that were organized on a geographical basis across the city and surrounding areas (see Figure 2). Third, the organization structure within CCHT is less elaborated in management terms, particularly beyond the corporate centre. This, in particular, illustrated the need to be sensitive to context when enacting any definition of middle managers (Dopson and Stewart, 1990).

We also highlight variation in management education that middle managers participated in prior to the period of our study. Again, there is significant difference between CCHT and the two hospital cases. In Florence and Edwards Hospitals, middle managers had undertaken a formal management education

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programme, such as the Institute of Health Services Management Certificate. Additionally, at Edwards Hospital many of the current middle managers, including those involved in the Theatres Pay Project, had participated in an MBA (Health Services Management) programme set up by the Organization Development Manager in conjunction with a local university. In contrast, in CCHT, middle managers had little experience of formal management education, this being mainly limited to a small number of one-day, in-house training around people and budget management issues. With respect to these, middle managers adopted a 'pick and mix' approach with some attending all and some attending none of the workshops.

Data Gathering and Analysis

Data gathering techniques (see Table II) incorporated 100 taped and transcribed, semi-structured interviews, between 50 and 80 minutes long, with middle managers and executive managers across all three cases, the collection of a wealth of documentation across all three cases and in the case of service development at Florence Hospital only, this was supplemented by observation, recorded in the

Table II. Data gathering techniques

Time period	*Case*	*Interviews*	*Observation*	*Documentation*
1996–98	Skill Mixing at CCHT	Total 30: 14 middle managers 9 executive managers 2 personnel officers 1 non-executive director		Competence-based frameworks, job advertisements
1995–96	Phase one: Service Development at Florence Hospital	Total 25: 2 clinical directors 1 medical director 8 executive managers 12 middle managers	16 management development workshops 2 marketing workshops	Business plans, management development materials
1997–98	Phase two: Service Development at Florence Hospital	Total 25: 2 clinical directors 1 medical director 8 executive managers 12 middle managers	8 management development workshops	Business plans, management development materials
1997–99	Local Pay at Edwards Hospital	Total 20: 10 middle managers 1 medical director 2 clinical directors 7 executive managers		Human resource strategy, minutes of project group meetings, pay and conditions frameworks

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form of hand written notes. Interviews were conducted with executive managers and doctors in managerial positions (Medical or Clinical Directors) as well as middle managers. In line with the research questions, interviews were designed to elicit detailed description of middle managers' contribution to the strategic initiatives under study and the contingent factors that facilitated or inhibited a more effective contribution.

Data gathering and data analysis were not clearly distinct phases but instead were intertwined (Bechhofer, 1974; Bryman and Burgess, 1993; Burgess, 1984). To analyse the data, the authors read and re-read transcripts of interviews, observational notes and documentary evidence, as data was collected, in the course of which they discussed and refined emerging themes. The empirical case thus represents a second-order interpretation of perceptions of interviewees, supplemented by observational and documentary evidence (Bryman and Burgess, 1993; Taylor and Bogdan, 1984).

FINDINGS

We represent our findings case by case. We consider skill mixing at CCHT first. Second, we consider service development at Florence Hospital. Third, we consider the 'Theatres Pay Project' at Edwards Hospital.

Skill Mixing at CCHT

In the case of skill mixing at CCHT, the approach taken by the Director of Human Resources (HR) towards realizing strategic change, was one where he adopted best practice as represented in the generic human resource management practitioner literature. The change in skill mix was one that directly affected the professional and non-professional employees that delivered healthcare for whom the middle managers were responsible. However, middle managers were not involved in the formulation of the content of change. Instead, the Director of HR employed a management consultancy firm to implement a competence-based job progression scheme similar to that successfully implemented in private sector organizations and then imposed this upon middle managers without their contribution towards its formulation.

The resultant intended strategy was one that, for the middle managers, appeared insensitive to context. In response, they ignored it by 'carrying on as normal' [Locality Manager 5] and not changing the skill mix of their healthcare teams. Alternatively, they paid 'lip service to it' [Locality Manager 1] by advertising a vacancy with reference to the new competence-based framework, but when discussing the post with candidates, describing it in terms of responsibilities and pay related to the national grading structure. In one case, rather than cut costs through employment of less skilled, cheaper healthcare employees in place of

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more highly qualified and costly staff, a middle manager presented a case for changes in skill mix that meant the employment of more of the latter. Ironically, whereas the Director of HR had chosen to ignore the knowledge of middle managers in formulating the content of strategic change, middle managers utilized their knowledge to 'pull the wool over HR's eyes so they think things have changed but they haven't' [Locality Manager 4]. The Director of HR, meanwhile, admitted he found it difficult to assess what was going on because he lacked the requisite clinical and operational knowledge.

Yet when asked, middle managers were not against skill mix changes in principle, since 'we have to recognize the real world, which is about doing more for less in the health service' [Locality Manager 3]. However, middle managers were unwilling or unable to be proactive with respect to implementing skill mix. They were disinclined to offer suggestions for ways in which skill mix changes could make the necessary efficiency gains and still fit with operational and clinical requirements. The Director of HR viewed such behaviour as 'reverting to type. They're happy to tell you what can't be done but not what can be done'. As a consequence, the Director of HR developed subsequent strategic interventions in isolation from middle managers. Further, he sought to control implementation of these interventions by 'building targets into their individual performance plans that we [executive management] appraise'.

Some of their reluctance or inability to contribute may be due to their position in the organizational hierarchy. The corporate centre seemed very distant to Locality Managers. Geographical distance no doubt contributed to this, the nature of community care services being dispersed. However, reinforcing this, those at the corporate centre, including Assistant Directors, tended to remain within the headquarters building, rather than venture out to see Locality Managers in the health centres. This reflected the view they held that strategy was to be formulated by those at the corporate centre and implemented by those Locality Managers in the field. That Locality Managers felt isolated was also due to being geographically distant from each other in different health centres. 'We rarely interact with each other and I can't remember the last time we came together as a whole group' [Locality Manager 4].

The process of selection for the Locality Manager position increased their isolation from each other. Twenty-two District Nurse Team Leaders, whose position no longer existed in the new organizational structure, were asked to apply for fifteen Locality Manager positions. Criteria for selection were developed by an external management consultant and the Director of HR. Criteria were set out in a competence-based framework, described in general management terms, rather than sensitive to healthcare context. Highlighted within many of these statements was a need for Locality Managers to be proactive in their behaviour with respect to organizational and management issues. Job insecurity and the resultant competition for posts caused some existing relationships to break down between

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District Nurse Team Leaders. Overall the process left those appointed still feeling threatened with job loss. This was further exacerbated because CCHT ran a financial deficit, which caused executive management to consider a merger with a neighbouring mental health organization in a similar position of financial deficit. If this happened, there were likely to be further job losses. Consequently, middle managers felt unsure, 'almost paralysed' [Locality Manager 2], about making suggestions upwards to executive management about necessary strategic change.

Their inability and/or unwillingness to influence the formulation of strategic content was affected by a lack of investment by the organization in developing individual and organizational capacity for change:

> We were pitched in at the deep end . . . they [executive managers] wanted to get structures in place rather than anything else. But I do feel there wasn't any planning to how the management development side was going to go. We've made the job up as we've gone along. [Locality Manager 4]

At CCHT the management education budget had been cut to zero in the face of government requests in 1998 to make cuts in middle management costs and divert savings towards funding more front line nursing staff. When this is combined with the fact that Locality Managers had received very little management education before taking up their posts and the insecurity described above regarding their positions, middle managers felt they were not being provided with support to enact a role transition towards that expected by executive management, as set out in the competence-based framework for selection of Locality Managers.

Service Development at Florence Hospital

Phase one. Middle managers identified two distinct phases with respect to service development at Florence Hospital. In a first phase, executive management provided cues that middle managers should behave in strategic manner. In contrast, in a second phase, strategic behaviour was discouraged. In the first phase, executive management produced a template for business planning. This emphasized that middle managers should produce a 'business case' when bidding for extra resources to support development of service following market analysis and evaluation of the strengths and weaknesses of their clinical area with respect to the market.

This allowed middle managers to formulate the detail of the content of strategy. In Surgical Services, for example, through the business planning process, middle managers argued that the development of the outpatients clinic would increase day care surgery, hence improve bed utilization and patient throughput and therefore meet market demands. The development of a satellite clinic, some distance from the main hospital site, was proposed in the business plan of Trauma

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and Orthopaedics. This was supported by a market analysis through which middle managers showed purchaser's demand for such a facility. In both these cases middle managers secured funding for their proposed developments.

In following through the intentions expressed in business plans, middle managers engaged in marketing activity. They spanned the boundary between the organization and its external environment by building relationships with 'customers' of service areas – GPs, private sector care homes and patients.

However, middle managers were not entirely free to develop the detail of services to be offered by the hospital. Typically, when middle managers carried out business planning, they consulted the Clinical Director about proposed developments. In turn, the Clinical Director discussed this with doctors in the specialty, particularly with other Medical Consultants. For example, in Surgical Services, the development of certain areas of elective surgery, such as minimal invasion knee surgery appeared to make business sense on the basis that there was considerable demand for this (up to two years waiting time), theatre space was under-utilized and this was day surgery not requiring expensive and scarce bed care following surgery. In theory, therefore, the Service Manager [Surgical Services] claimed, 'I could make a business case to employ an extra surgeon that specializes in the type of surgery'. However, the knowledge and skills profile of the current cadre of Medical Consultants, dictated the areas in which service would be expanded, even where it might represent a weaker business case. 'To do otherwise would be career suicide since they [doctors] would gang up on me and exert pressure on the Board through the Medical Director to get rid of me' [Service Manager: Surgical Services]. So, instead of developing knee surgery, vascular surgery was developed, even though the business case was weaker.

In short, services remained professionally defined to a large extent by doctors. Despite this, middle managers' enthusiasm and ability to plan the business and then engage in marketing activity was encouraged by considerable investment in management education. Middle managers participated in a competence-based management education programme. This assumed that managerial competences were generic across sectors with the facilitator of the programme, an external management consultant, stating to participating middle managers, 'someone from Rolls Royce [a local manufacturer] could do the job of a manager in a hospital and vice-versa'. The competence-based programme was supported by marketing workshops, again facilitated by external management consultants. These also emphasized the excellence of private sector practices. The overall intention was that, through education events, 'middle managers are inculcated with business values' so that the discretion they were allowed in shaping service development was, 'characterized by a drive for greater efficiency and effectiveness, pursued in a more proactive manner' [Organization Development Manager]. The aim it seemed was to ensure that middle managers were committed to the new way of doing things that mimicked the private sector and that, as a result, their ideas and

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actions converged with executive management intent. Initially the investment in management education appeared effective, not least because it facilitated lateral interaction between middle managers, hitherto difficult because of hierarchical structure. Such lateral interaction enabled learning to be shared, for example, regarding the process of business planning and its associated difficulties, as well as establish a shared view of the internal market arrangements and general management ethos.

Phase two. It became apparent to executive management that allowing middle managers significant discretion to develop service had unintended and negative consequences. Florence Hospital was delivering clinical activity, which traditionally had been undertaken by other hospitals with the consequence that their services were now threatened with closure. This was not acceptable to local politicians. They put pressure upon the local health authority to rein back expansion of services.

It also became apparent that funding did not necessarily follow increased clinical activity since budgets were limited. For example, the Surgical Services department had increased the availability of surgical interventions through improvements in day care facilities. GPs responded to this by speeding up the rate at which they referred patients and Surgical Services dealt with referrals quickly. However, six months into the financial year GPs had spent their entire budget and could not refer patients to Surgical Services. This led to poor utilization of theatres, beds and consultants in the second half of the year. Middle managers were poorly positioned to anticipate the consequences of their actions upon limited funds available since they had little interaction with the local health authority. Instead it was executive managers who spanned the boundary between Florence Hospital and the local health authority. Yet they appeared to be too distant from operations of the directorate to avert the problem. In retrospect, the Director of Business Development felt, 'we should have seen this coming'. However, she also admitted, 'we can be out of touch in corporate headquarters'.

There was a change in government in 1997 with the 'New Labour' Government, led by Tony Blair, replacing the Conservative Government, which had enjoyed power for 18 years. Following which there was a change in the emphasis of public policy. First, 'New Labour' took the edge off an uncritical belief in markets to allocate resources within public services (McNulty and Ferlie, 2002). Second, they increased government regulation and control of public services to ensure that standards and performance targets were delivered, with a particular concern for short-term targets and efficiency savings (Hood et al., 2000). Taking a cue from government policy, executive management embedded government-set standards and performance targets within the business planning framework, which middle managers were then required to meet. Responding to this, whereas previously middle managers reported that the business plan was an everyday working

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document for their managerial activity, they now tended to refer to it only when progress reports on meeting performance targets were requested by executive management.

All of this had an impact upon the support of middle managers for the utilization of marketing frameworks. Any enthusiasm they previously held was much diminished and they complained that the marketing workshops were inappropriately oriented towards the way the private sector worked. This led the Director of Business Development to stop the workshops so that only two were actually delivered. Relatedly, the Organization Development Manager came under pressure to cancel the management education programme, since it too relied upon generic transfer of private sector concepts to the public sector. Nevertheless the programme continued but only two of the original 35 participants completed the whole programme.

As revealed in the case of CCHT, in 1998 government policy required budget cuts in managerial costs and savings to be diverted to fund more nurses. The strategic plan of the hospital and business plans for each department was thus rendered less useful since they were based upon the provision of a budget for managerial costs, which was now reduced and a budget for nursing staff, which was now increased. Two middle managers were moved to specialist nursing posts, which were created following reallocation of budget from management to front-line nursing costs in line with government prescription. They claimed that 'they were glad to be back [in nursing]' [Service Manager 2: Surgical Services]. A further three middle managers participating in the competence-based management education programme were made redundant. This made others fear for their jobs. These fears were heightened by debate about rationalization of services in the local area with Florence Hospital being the likely loser in the merger of two hospitals. The consequence of such job insecurity in Florence Hospital was similar to that observed in CCHT, with middle managers unwilling to enact a role transition towards a more strategic one. Instead of concentrating upon the management and development of service, increasingly middle managers looked for other jobs, with three leaving during the winter of 1998. Meanwhile those that remained in their middle management positions kept nursing uniforms on a hook behind their door and privileged nursing, rather than managerial activity, with the latter increasingly portrayed as 'flying a desk' [Service Manager In-Patients: Medical Services].

Theatres Pay Project at Edwards Hospital

In Edwards Hospital, the Human Resources (HR) Department invited middle managers to participate in a project group that commented upon the suitability of an outline HR strategy document and elaborate upon its broad themes. Two of the themes of the final HR strategy document, following consultation with the project group, were that a more flexible workforce should be developed and that

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recruitment and retention was a key issue. Taking account of these middle managers initiated and influenced the content of local pay initiatives because there were specific operational problems that they wanted to solve. In particular middle managers were concerned about 'inefficient use of theatres' [Senior Nurse Manager: Theatres]. These problems arose because nurses and theatre practitioners were employed under two entirely different sets of pay and conditions, but doing essentially the same job. To solve this middle managers argued that 'we need to produce a roster that works for both groups of staff. To do this pay and conditions need to be harmonized' [Specialty Manager 1: Theatres].

Executive managers adopted a similar approach to strategic change within Theatres as they had done with the HR strategy more broadly. They invited five middle managers, from Theatres and other areas with an interest in the area, such as Oncology, to participate in a project group to develop a local pay initiative for the area. Executive management emphasized that the involvement of middle managers was crucial given that the local health authority emphasized financial constraint, as a result of which, 'middle managers' input was required at an early stage so that a business case, mainly on cost-efficiency grounds, could be made' [Director of HR]. Middle managers, the Director of HR explained, 'had the on-the-ground knowledge that allowed them to work out the financial and service implications of local pay initiatives'. [Director of HR].

This project group also included two Clinical Directors. Doctors were enthusiastic about the proposed change since previously their clinical activity had been adversely affected by the non-availability of support staff due to differences in pay and conditions for nurses and theatre practitioners. 'That it [harmonization of pay and conditions] would help doctors meant they supported us' [Specialty Manager 1: Theatres]. Should it have threatened their interests then 'it would have been very difficult to get through' [Specialty Manager 1: Theatres].

As a first step the project group set out a number of associated objectives, which were connected to the theme in the HR strategy document that there be a more flexible workforce. They considered models of local pay developed in other hospitals. Modifying a model from another hospital, the middle managers, in conjunction with the HR Department, developed a single pay spine for the theatres area and decided how staff would fit into it. They then implemented the new pay and conditions framework, modifying it as required when problems became evident.

The HR Department recognized that for middle managers to make a greater contribution to the realization of local pay or any other HR objective, greater emphasis needed to be placed on their development. However, similar to CCHT and Florence Hospital, government request for savings on the middle management budget in 1998 affected Edwards Hospital and reduced provision of funding for the MBA (Health Services Management) programme set up with a local university. Additionally, Edwards Hospital stopped employing the services of an exter-

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nal management consultant that provided in-house management and organization development support. To mediate the adverse impact of cutting back on formal management education aimed at middle managers, the HR department and the Organization Development Manager invested considerable effort in working alongside middle managers and developing their role within the work context. For example, Personnel Advisors concentrated upon clarifying roles and responsibilities and developing the middle managers towards them with the aim that 'they are more proactive in the management of their area' [Director of HR]. The overall philosophy adopted by the HR Department was described thus:

> The overall culture is that we want to empower managers to do as much HR as possible, but because managers are all at different levels, we have to give them different support at different times. [Personnel Advisor]

The Organization Development Manager explained that, in many cases, the management education 'problem' was not one of equipping middle managers with specific skills or knowledge but about:

> middle managers not taking up their responsibilities and not knowing what was expected of them. For example, the Nurse Manager traditionally only managed nurses. So we did some work on that with the managers, asking them what their expectations were and putting it on post-its, sticking them on a board, all that sort of thing.

She felt that some middle managers lacked confidence or were uncertain about the extent to which they could become involved in shaping strategic change. The result was that 'sometimes I'd have to hold their hand'. Over time this became less of a problem and 'I've been able to withdraw little by little as they've gained confidence in their managerial abilities and got on with the job'. The Organization Development Manager also admitted that her withdrawal was also dependent upon the middle managers understanding the overall strategic context and 'basically sharing our [HR Department's] philosophy'.

Unstructured learning, again at little cost, also took place through the interaction of the Personnel Advisor with the middle managers in Theatres:

> We've put a lot of time into individual managers and individual situations where we've taken managers through particularly difficult issues related to the theatres reconfiguration, and spent a lot of time reviewing things afterwards so that they take on board the lessons for the future. [Personnel Advisor]

Despite financial constraints imposed by central government, therefore, organization and management development continued. This developed middle managers'

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confidence and ability to contribute to strategic change but also ensured that their contribution to strategic change converged with the overall intent of the formal HR strategy document.

We should also note that learning took place as a result of lateral interaction between middle managers through membership of project groups that the HR department set up. The Specialty Manager for Oncology utilized knowledge gained through her involvement in the Theatres Pay Project group to propose local pay as a potential solution to retention problems in her area. An Oncology Project group was set up, which developed a competence-based pay progression framework designed to facilitate the retention of mid-career nurses that, in the past, had left because career progression was slow. Similar to Theatres, this development enjoyed support from doctors because they were keen to ensure stability in their support team. In sum, supported by organization structure and processes, middle managers within Edwards Hospital were able and willing to enact a transition in their role so that they made a greater strategic contribution.

DISCUSSION

Our findings are illustrated in Table III.

The importance of middle managers' implementation role is illustrated in our cases (Burgelman, 1983a, 1983b; Dopson and Stewart, 1990, 1993; Dutton and Ashford, 1993; Dutton et al., 1997, 2001; Floyd and Lane, 2000; Floyd and Wooldridge, 1992, 1997, 1997, 2000; Frohman and Johnson, 1993; Huy, 2001, 2002; Nonaka, 1988, 1991, 1994; Nonaka and Takeuchi 1995; Quinn, 1980; Smith, 1997; Wooldridge and Floyd, 1990). In particular, the potential of middle managers to make an enhanced contribution to strategy is illustrated in the case of the Theatres Pay Project at Edwards Hospital. Specifically, first, middle managers 'sell' strategic ideas to executive management (Dutton and Ashford, 1993; Dutton et al., 1997, 2001). Second, they elaborate and modify the detailed content of strategic change (Quinn, 1980). The resultant realized strategy is one that is sensitive to context and mediates local problems, as well as meeting the requirements of government policy. The role of middle managers in contributing to strategy in our study is, however, a semi-autonomous one, rather than the more autonomous role suggested by Floyd and Wooldridge (1992, 1994, 1997).

Our cases provide support for the majority of the contingent factors identified by Floyd and Wooldridge that influence the strategic contribution from middle managers. We identify one additional contingent factor – job insecurity. This goes unrecognized by Floyd and Wooldridge as a contingency that might limit middle managers' desire to take up a more strategic role, although others have highlighted this effect upon middle managers (Goffee and Scase, 1992; Johnson and Frohman, 1989; Scase and Goffee, 1989; Smith, 1997; Westley, 1990). We note the absence

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Table III. Summary of findings

Case study	*Contingencies influencing middle managers*	*Middle manager behaviour*	*Outcomes*
CCHT	• Not span organization–environment boundary • Relatively low in organizational hierarchy (i.e. don't report directly to executive director) • Isolated from each other geographically • Not involved in formulation of strategy • No investment in management and organization development • No doctors employed • Job insecurity	Ignored, paid lip service to, deviated from intended strategy formulated by executive management	Implementation gap because intended strategy is context insensitive
Florence Hospital Phase One	• Span organization–environment boundary • Relatively high in organizational hierarchy with at least two levels of staff below them • Involved in formulation of strategy • Internal structures based upon clinical specialism with little interaction between middle managers • Investment in management and organization development • Powerful cadre of doctors employed	Relatively unfettered, autonomous role in which 'sell' strategic change to executive management	Realized strategy is context sensitive at a local level but causes problems for health authority (funding crisis) and local politicians (potential hospital closures) Executive management are forced to exert tighter control upon actions of middle managers
Florence Hospital Phase Two	• Not span organization–environment boundary • Relatively high in organizational hierarchy with at least two levels of staff below them • Not involved in formulation of strategy • Internal structures based upon clinical specialism with little interaction between middle managers • Less investment in management and organization development • Powerful cadre of doctors employed • Job insecurity	Subservient to dictate of executive management	Strategy is insensitive to context Middle managers not committed to strategy but nevertheless comply with its requirements
Edwards Hospital	• Did not span organization–environment boundary • Relatively high in organizational hierarchy • Middle managers involved in formulation of strategy • Interaction between middle managers across departmental boundaries • Investment in management and organization development • Powerful cadre of doctors employed	'Sell' change initiatives and elaborate upon detail of content of strategy	Realized strategy is context sensitive and mediates local operational problems

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of external boundary-spanning by middle managers within our study. Instead middle managers seem more focused internally. Yet greater sensitivity to government policy in particular may be an important requisite of a more effective strategic role for middle managers within the NHS or other public service settings, if we are to avoid some of the problems evident in Florence Hospital as services were developed in an unfettered way. This may necessitate that 'we [middle managers] come out from our trenches and see what is going on in and outside the hospital so that we can anticipate changes' [Service Manager 1: Surgical Services]. That is, middle managers in the NHS and other public service settings may need to engage in external boundary spanning activity in order to understand their environment so that they make a more effective strategic contribution.

It is important to note that the enactment of a more strategic role for middle managers may represent a transition from a more administrative role in a professional bureaucracy. Drawing upon role theory (Biddle, 1979, 1986; Biddle and Thomas, 1966; Kahn et al., 1964, 1966) we can examine the antecedents of middle managers' strategic contribution in a professional bureaucracy and the difficulties of role transition. Role theory helps us explain why middle managers enact a semi-autonomous role in a professional bureaucracy, the logic of which can be extended to other organizational settings.

Antecedents can be viewed firstly as expectations from key stakeholders that provide cues causing middle managers to behave in certain ways. Within our study, analysis of the expectations of key stakeholders shows some 'dissensus' (Biddle, 1979, pp. 196–200), with middle managers receiving contradictory cues about the role they should enact.

Doctors' expectations are that the status quo is maintained so that middle managers remain wedded to their traditional 'diplomat' role in which they privilege doctors' interests in making any decisions rather than behave in a more autonomous strategic manner.

Central government's expectations are not so clear-cut. On the one hand, government policy emphasizes general management with middle managers cast as 'change agents' that are expected to behave in a proactive and strategic manner to realize policy intentions. In which case, government and doctor's expectations regarding the middle managers' role appear set against each other. Except that the emphasis of government policy changes. Rather than highlighting their role as 'change agents', government policy positions middle managers as 'men in grey suits' that subtract, rather than add value to health services (Ham, 1997).

Assessment of executive management's expectations of the role of middle managers is more difficult since these vary across cases. In CCHT executive management expect middle managers to implement a very prescriptive strategy determined higher up the organization. Combined with which, there is little management education to provide cues for new strategic behaviours for Locality Managers. Yet, paradoxically, through selection criteria for the new position of Locality

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Manager, executive management provide cues that a general management approach should be enacted by middle managers through which they are expected to make a greater strategic contribution. Within Florence Hospital, executive management's expectations reflect the changing emphasis of government policy. On the one hand, a competence-based management education programme encourages a general management approach through which middle managers behave more proactively. On the other, any discretion allowed to middle managers is constrained through the business planning process and documentation. Simultaneously, redundancies of middle managers and the cancellation of marketing workshops provide inconsistent cues regarding expectations that a general management approach is enacted. Only in Edwards Hospital are the expectations of executive management clearly ones that provide consistent cues for the enactment of more strategic behaviour by middle managers.

Such dissensus of expectation is likely to invoke role conflict in middle managers (Floyd and Lane, 2000). There is also considerable ambiguity with respect to the role they should be enacting since 'shared specifications set out for an expected role are incomplete or insufficient to tell the incumbent what is desired or how they do it' (Biddle, 1979, p. 323). Insufficient specification is rendered more acute for middle managers in CCHT given a lack of management and organization development to prepare them for their new roles. In contrast, within Florence Hospital there is considerable investment in management and organization development. This prescribes that middle managers behave in a way similar to their counterparts in the private sector. However, for middle managers in Florence Hospital role ambiguity is exacerbated because executive management reduce discretion allowed to middle managers to develop services. This provides a cue for behaviour inconsistent with expectations of the role of middle managers presented through the management education and marketing workshops.

Should there be role conflict and role ambiguity for middle managers, then they may respond in a way characterized by 'disillusionment' and 'disaffection' (Johnson and Frohman, 1989), 'reluctance' (Goffee and Scase, 1992; Scase and Goffee, 1989) or 'paralysis' (Westley, 1990). This is evident within our cases of CCHT and Florence Hospital that middle managers were subjected to contradictory, unclear expectations, which they cannot simultaneously meet. As a consequence, they became caught between traditional and newer expectations of their role. They appeared 'uncertain about whether change is appropriate, what kind of change is appropriate, and therefore, which strategic role is expected' (Floyd and Lane, 2000, p. 163). Their response was one that inhibited any transition to a more strategic role.

Within CCHT in particular, middle managers ignore, resist and 'pay lip service' to strategic intentions imposed upon them by executive management. Executive management regard such behaviour by middle managers as typical of their change blocking behaviour. Rather than address the conditions that might have elicited

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such behaviour, the response of executive managers is one where they continue to impose the content of change upon middle managers without their involvement in the development of this change. That is, within CCHT, the pattern of behaviours appears downward spiralling so any role transition for middle managers is inhibited. This illustrates a more generalizable recursive process in which the expectations of the role sender elicit a response from the focal person, which in turn elicits a response from the role sender and so on (Kahn et al., 1966). We might imagine a recursive process that is more positive with respect to encouraging a role transition for middle managers.

Beside the contradictory expectations of key stakeholders, antecedents of the role of middle managers can be viewed, secondly, as mediating any role conflict and role ambiguity (Kahn et al., 1966). In our cases, these are management and organization development; utilization of middle managers' professional expertise; power and influence enjoyed by middle managers through their position in the organization structure and processes laterally and hierarchically; and the extent to which formal strategy allows middle managers to make a contribution.

This second group of antecedents of middle managers' strategic contribution mediate dissensus of expectations between key stakeholders' expectations of the role of middle managers, and also support development of the capability of middle managers to enact the necessary transition from a traditional administrative role to a more strategic role. Taking our third case – Edwards Hospital – dissensus of expectations was mediated because doctors worked alongside executive management and middle management as part of the Theatres Pay Project group. Key stakeholder expectations of the role of middle managers were thus more likely to converge. Meanwhile, potential dissensus between past and current government policy was accommodated through executive management requiring that any strategic contribution made by middle managers saved money, as well as improved theatres utilization.

Simultaneously, the capability of middle managers to enact a strategic role was developed within Edwards Hospital. The potentially damaging effect of government budgetary cuts upon management and organization development was overcome in a pragmatic and relatively innovative fashion. By working alongside middle managers, the Organization Development Manager and Personnel Advisors improved the capability of middle managers to make a strategic contribution through not only equipping middle managers with requisite skills and knowledge, but reducing any ambiguity regarding a more strategic role. Through this process, they inculcated middle managers with a wider organizational perspective. This complemented more formal control exerted by executive management through an 'umbrella' strategic document (Mintzberg and Waters, 1985). Meanwhile involvement in project groups further inculcated middle managers with a wider organizational perspective and meant that middle managers' knowledge of clinical context was leveraged to mediate between operational reality and the vision of

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executive management (Ferlie et al., 1996; Nonaka, 1988, 1991, 1994: Nonaka and Takeuchi, 1995).

An important facet that emerges within our study regarding any role transition of middle managers towards a more strategic one are socialization processes (Floyd and Lane, 2000). Much of the literature examining socialization and role orientation focuses upon newcomers to organizations (for example, Ashforth and Saks, 1996; Jones, 1986). This literature links newcomer socialization to three outcomes – role orientation, role ambiguity and role conflict (Graen, 1976).

In our cases, middle managers are not newcomers to the organization but are asked to adjust to a new role, which their previous organizational experiences and socialization might ill prepare them for. Their response may be one where they orientate themselves towards the traditional role into which they have been socialized. In the NHS, this is 'diplomat' manager, as illustrated in Florence Hospital, through which they serve doctors' interests, rather than a more strategic role (Harrison et al., 1992). Their more administratively orientated managerial role within a professional bureaucracy may be one complemented by a strong identification with the specific expectations of their professional sub-culture (Salaman, 1974; Trice and Beyer, 1993; Van Maanen and Barley, 1984). In our study, middle managers' prior socialization as nurses meant they were more likely to defer to doctors' wishes in their managerial role (Harrison et al., 1992).

This begs the question – in the face of such powerful prior socialization experiences, what might organizations do to (re-)socialize middle managers towards enacting a more strategic role? Focusing upon management and organization development in Florence and Edwards Hospitals provides an illuminating contrast through which we might draw out more generalizable lessons. Countering their early career socialization, within Florence Hospital, middle managers experience management and organization development that attempts to re-socialize them so that they adopt behaviours similar to those of general managers in the private sector. Simultaneously, they are encouraged to move away from values and behaviours connected to their previous identity as nurses or providers of healthcare with a public service ethos (Van Maanen and Schein, 1979). This gives rise to role conflict and role ambiguity and discourages middle managers from undertaking a role transition towards a more strategic one.

In contrast, within Edwards Hospital, incoming identity and personal characteristics were valued with management and organization development building upon these, rather than denying them. This mediated potential role conflict and role ambiguity. The overall approach was one that sought to develop middle managers so that they took a wider organizational and more strategic perspective in their activities through interaction with key stakeholders but at the same time it emphasized that middle managers had pre-existing, valuable clinical knowledge and skills that should be leveraged in pursuit of effective strategic change.

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There is some debate about the extent to which different socialization tactics lead to role transition (Jones, 1986; Van Maanen and Schein, 1979). Within a professional bureaucracy in a public services environment, we suggest that an 'investiture' approach to (re)socialization in which incoming identity and personal characteristics are valued (Van Maanen and Schein, 1979) is appropriate given widespread criticism of generic transfer of private sector models of management (Ackroyd et al., 1989; Hood, 1991; Pollitt, 1990; Stewart and Ranson, 1988; Stewart and Walsh, 1992). An investiture approach to role transition for middle managers may also be more effective in professional bureaucracies outside public services or organizations more generally if employees are orientated towards strong occupational subcultures, such as engineering firms (Kunda, 1992).

Relatedly, within a professional bureaucracy, should behaviour of middle managers threaten a powerful professional group's self-interest, this group is likely to inhibit the enactment of a more strategic role for middle managers, even if other contingencies are supportive of such a role. The power of doctors to shape strategic change in the NHS is highlighted in numerous studies (Ackroyd, 1996; Dopson, 1996; Ferlie et al., 1996; Harrison et al., 1992; Mintzberg, 1979, 1995) and is displayed as pervasive in our cases. Middle managers, who are astute, do not even propose improvements – for example, development of services – that they anticipate doctors will dislike. The intra-organizational power of the professional cadre in a professional bureaucracy is evident, largely because operational knowledge lies within the professional operating core. As a consequence, middle managers act as mere 'caretakers' or 'supporters' of change, rather than directing or supervising this change.

A second limiting factor upon a more strategic role for middle managers, associated with the public service setting in which our study was located, is the effect of government policy. We suggest that this is not an idiosyncratic feature of our study, but one that is a feature in other public service organizations, such as UK local government (Farnham and Horton, 1996; Keen 1994; Keen and Vickerstaffe, 1997). More generally, in the UK, from the mid-late 1990s onwards, central government control is limiting discretion of management at organizational level in public service organizations to make strategic decisions – for example, with respect to human resource strategy (Bach and della Rocca, 2000; Hood et al., 2000). As a result, within the context of a professional bureaucracy in public services, we need to be particularly guarded about exhortations that middle managers enact a more entrepreneurial role in which they are encouraged to exhibit more discretion regarding strategy. While, the implementation role of middle managers is semi-autonomous under any circumstances, since the purpose of this role is translating the intentions of others – executive management – into action, within a professional bureaucracy in public services, doctors and central government intervention significantly constrain any discretion available to middle managers in this semi-autonomous role.

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Whether this current power arrangement is immutable or ideal is an interesting question, which is worthy of further research. There may be some scope for managers to influence doctors through gaining power at the locus of uncertainty in various jurisdictional disputes between one profession and another or between outside agencies and professionals within the organization (Mintzberg, 1995). McKee et al. (1999, p. 11) argue that doctors cannot retreat into 'islands of managerial immunity' and ignore how money is spent or controlled. With respect to central government control, Newman (2001) notes its inhibiting effect upon the devolution and flexibility that is prerequisite for innovation in public services. However, others, notably Du Gay (2000) regard government control as necessary to curb the worst excesses of entrepreneurialism in public services.

CONCLUSION

Our study builds upon existing theory by highlighting that the experience of middle managers in organizations is one that is dynamic. They are experiencing a role transition associated with which there are considerable problems of role conflict and role ambiguity. Floyd and Wooldridge's work under-emphasizes these problems.

To understand the problems of transition and potential ways in which these can be mediated we have drawn upon role theory to develop Floyd and Wooldridge's work by viewing the antecedents that frame the transition from two perspectives. First, antecedents can be viewed as cues provided by key stakeholders regarding their expectations of the middle manager role. Role conflict and role ambiguity are the consequence of contradictory expectations of key stakeholders about middle managers' roles, which may inhibit role transition. Specifically, within a professional bureaucracy in public services, middle managers' strategic contribution is inhibited by the power of the professional operating core of the organization and by centralized government policy with financial parsimony having a particularly visible effect.

Representing middle managers' experiences as a role transition framed by contradictory expectations invites researchers to consider the response of middle managers when faced with role conflict and role ambiguity. Within a professional bureaucracy, we suggest their response is the enactment of less autonomous role than that presented by Floyd and Wooldridge. While the key stakeholders may vary, the logic in which contradictory expectations lead to role conflict and role ambiguity and middle managers' responses to this may be extended to other settings beyond a professional bureaucracy.

Second, there is a group of antecedents that mediate the responses by middle managers to problems of role conflict and role ambiguity and develop the capabilities of middle managers to make a greater strategic contribution. Of these, investment in management and organization development and the positioning of

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middle managers to develop greater understanding of the organization's strategic context and exert influence upon strategy, particularly help socialize middle managers into their new roles. This is a process in which middle managers' characteristics prior to enacting a more strategic role should be valued and their expertise leveraged to contribute towards a more context sensitive strategy. To deny and strip away these characteristics is likely to encourage a dysfunctional response from middle managers towards role transition. Further supporting contingent factors are putting middle managers in contact with the environment so they can proactively contribute to strategy and conceiving formal strategy as relatively broad in the first place to allow middle managers to make a contribution. Again the logic of putting these supportive contingencies in place to enhance the middle managers' contribution is likely to extend to other organizations beyond professional bureaucracies.

To further develop research in this area, we encourage studies that analyse role transition enacted by middle managers and to examine antecedents that frame this. Specifically research is required that examines the interplay of the two groups of antecedent factors – cues from key stakeholders regarding their expectations of the middle manager role and interventions that develop the capability of middle managers to make a strategic contribution. We suggest the continuation of fine-grained investigations of middle managers' role transition towards more strategic behaviours in other settings, particularly those adopting a methodological approach that combines rich description with a comparative logic through multiple cases (Eisenhardt, 1989, 1991; Yin, 1994). There is also a need for large-scale surveys, similar to Floyd and Wooldridge's approach, to establish statistical association between antecedents, moderators and consequences of implementation behaviours of middle managers. This would elaborate upon Floyd and Wooldridge's work in a different way from our study.

NOTES

[1] It must be noted, however, that the internal market arrangement was one that central government and local health authorities increasingly intervened in, so that unfettered market competition did not result in hospital or community trust closures and/or healthcare providers did not provide more healthcare than government funding allowed for (Ham, 1997).

[2] The case of service development at Florence Hospital can be viewed as two mini-cases, given a significant change in the role of middle managers from the first to second phase. Our design choice reflects the minimum number of comparative cases recommended by Eisenhardt (1989).

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