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Values and strategies: management of radical organizational change in a university hospital

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SUMMARY

Managers' experiences of radical change were studied in a Norwegian university hospital, which was relocated from a traditional building to a new, high-tech building. The university hospital was also accredited as a health promoting hospital. Thirteen managers at different levels in the organization and a personnel safety representative were interviewed as part of a trailing research project. The aim of the study was to elucidate the managers' value orientation and strategies for dealing with value tensions. A combination of a hermeneutical, reflective method and a template for quality, efficiency and integrity guided the analysis. The template was based not only on the main findings but also on the core values of a model of organizational health. The results show that clinical managers focus on quality and top managers, not unexpectedly, focus on efficiency. Managers at both levels were concerned about their own integrity, and also about the integrity of their clinician colleagues, as well as showing concern for the hospital's mission, in terms of organizational effectiveness. The discussion was conducted in terms of dominance, cycling and balancing strategies, of which the last was the most prevalent. However, sustainable strategies for dealing with value tensions also call for value-based management and value-conscious leadership. Copyright © 2016 John Wiley & Sons, Ltd.

KEY WORDS: change; hospital management; integrity; quality; sustainability; values

BACKGROUND

Hospitals are complex and personnel intensive organizations where radical change can influence value systems. At the same time, the importance of new technologies and new forms of organization can be overestimated with respect to their effects on efficiency, and economic and technological considerations can overshadow quality of care and working conditions. As Vikkelsø (2005) suggests, new technologies in hospitals may occasion a shift in organizational attention and professional patient work, which may undergo subtle, yet potentially radical, change. A review study of reorganization in healthcare services characterizes the effects on the working environment as a huge ethical challenge and suggests that aspects of work health

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may have been de-emphasized in change processes grounded in economic considerations (Hasson, 2006).

With increasing technological and organizational change in hospitals, there is also a need for management strategies at all levels. Clinical managers can be in a position to influence the results of change, but their experiences are not always incorporated into the system (Salmela *et al*., 2012, 2013). They may also be challenged by the dual institutional logics of managerialism and professionalism, which often are inherent in such positions and processes, and which have been described in terms of tensions between different domains (Kouzes and Mico, 1979). While hospital managent have been associated with a triangle of logics (Pettersen and Solstad, 2014), hospital organizations have been characterized by four logics or 'worlds', with the friction between the clinical world and the management world the most apparent (Glouberman and Mintzberg, 2001; Eriksson and Dellve, 2013). Different management strategies to deal with competing logics have been suggested. For example, Wikström and Dellve (2009) found that clinical management means tuning in and tuning out competing logics. They also found that fragmentation or integration of time and tasks were two different management strategies to meet competing logics in healthcare organizations, depending on the situation. While the separating model emphasized tensions and contradictions between logics, the integrating model referred to different logics as concurrent and the managers' work as an integration to master the dilemmas they experience.

The strategies of top management have been characterized as dealing with different worlds (Östergren and Sahlin-Andersson, 1998), and hybrid management roles have been suggested (Choi, 2011). However, for professionals in management roles in Janus-faced hospital organizations, the different logics of the clinical and the management world may clash, and the bridge to the management world seems to lack foundations (Witman *et al*., 2011). In addition, radical change in hospitals often challenges the vertical communication between clinical managers and top managers, who can be a target of complaints and criticism and may be unwillingly forced into a scapegoat role (Choi *et al*., 2011).

In 2008, a Norwegian university hospital was relocated from a traditional building to a new, high-tech building. The vision was to develop the most patient-friendly hospital in Scandinavia by digitalization, extensive use of medical technology, reorganization of work and flexible use of health professionals (Berg, 2012). During the planning process, the building costs were cut by 20%, which led to widespread demands to make the project less ambitious, and there was continuous economic pressure on the top managers. The new hospital was thoroughly specified in technological and medical terms. In contrast, little attention was paid to the introduction of clinicians and clinical managers to their new work conditions, even though the hospital was accredited as a health promoting hospital, which includes aspects of health in the workplace (Pelikan *et al*., 2014).

Against this background, a research project was initiated and included evaluation before, during and after the relocation of the hospital in 2008. The aim of this study was to scrutinize managers' awareness of values and their strategies for dealing with value tensions in connection with the hospital relocation and reorganization. Two research questions guided the study:

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- What are the managers' value orientations in the radical change of the organization studied?
- Which management strategies do the managers use for dealing with value tensions, and how sustainable are these strategies?

Management strategies have implications for individuals' work health and for the hospital organization as a whole. Integrity and sustainability are key issues in this connection.

CONCEPTUAL FRAMEWORK

Values are relatively enduring and stable criteria for choosing goals and guiding actions, and may be morally desirable or merely preferable (Dose, 1997). Values are also salient expressions of intentions or desired results concerning persons, principles, attitudes, beliefs, theories and practices (Aadland, 2011). In short, values are about valuing and evaluating, and broadly defined as preferences, which include professional ideals as well as economic assessments. There is a close, but not closed interrelationship between values and actions, and values can also be inferred from actions through reflection and interpretation (Aadland, 2010). This relationship has methodological implications, which will be outlined later and related to the three core values: quality, efficiency and integrity. While the two first refer to the professional and the organizational domains, integrity refers to the personal and relational domain and may be particularly significant in connection with dealing with value tensions.

Quality and efficiency. The concept of quality is closely linked to dignity and patient safety, and to legal requirements of diligent care and professional responsibility (Health Personnel Act, 2002). Failures in quality can threaten life and health, and have ethical implications. Therefore, patients' experiences and clinicians' considerations should also be included in the concept of quality. Industrial methods of quality management focusing on measurement of time and costs have been transferred to hospital settings and used for process improvement, but seem not to be a promising way to improve quality (Axelsson *et al*., 2014). Health professionals in management roles are responsible for promoting quality by introducing clinical values and standards, and by creating a culture of care, dignity and safety (Bondas, 2009; Foss, 2012). However, health professionals in such hybrid roles also find themselves caught between professional values and management objectives (Kippist and Fitzgerald, 2009; Pettersen and Solstad, 2014; Orvik *et al*., 2015).

As managers, health professionals may emphasize economic values and budget constraints. In this context, efficiency describes the relationship between resources and service production (Shortell and Kaluzny, 2006). Quality can be a prerequisite for efficiency, and efficiency may be a condition of quality (Nelson *et al*., 2007). Both can contribute to organizational effectiveness; the relationship between overall goals and results. Despite their interdependence, quality and efficiency are not always compatible. Too strong an emphasis on efficiency can mean sacrificing quality, and vice versa. To clarify and deal with such tensions and cope with the

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resulting pressure on integrity, it is necessary not only to bridge values of quality and efficiency but also to maintain a dialectical perspective on their interrelated tensions.

Integrity. The connotations of integrity are individualistic and moral. However, integrity also refers to the work setting, and in this context, integrity means working in accordance with personal values, so that the values of the person who is performing a function guide the work (Schabracq and Cooper, 1998; Schabracq, 2003). Health professionals in management roles bring with them internalized values, like individualization and dignity of care, but often find themselves in buffer positions (Richard, 1997; Bergin, 2009). In such management positions, competing logics and integrity pressure can be sources of stress (Hasson and Arnetz, 2008; Arman *et al*., 2012), with negative effects on work health and well-being. Integrity also means a willingness to perform the work the individual is faced with (Schabracq, 2003), so that there is a continuity between values and the actions performed. The individual can then act with conviction. For health professionals as managers, maintenance of integrity may result in resistance to change or in different interpretative responses (Stensaker and Falkenberg, 2007). Not least, integrity means being integrated into the organizational setting, which according to Schabracq (2003) contributes to commitment, personal development and well-being. Integrity is crucial not only for individual work health and capacity building but also for organizational capacity building, which is a prerequisite for the individual to cope with competing values and integrity pressure.

Different values in hospital organizations can be complementary or competing (Pettersen and Solstad, 2014). For managers, these different views can imply different value orientations and strategies for maintaining integrity. When characterized as complementary, integration of different values can support integrity. For example, a study of modes of dealing with values and logics in knowledge intensive organizations like hospitals indicates three integrative management strategies: dominance, cycling and balancing (Fjellvær, 2010). These strategies mean following a dominant logic, isolating different situations and disregarding some values that are not deemed relevant, and balancing logics, respectively (Busch, 2012). These strategies can be more or less sustainable.

In line with its dialectical point of departure, this study primarily focuses on competing values and value tensions, which may arise in different contexts. For example, as economic values play an increasingly significant role at all levels, budget constraints may motivate top-level managers to ignore quality norms. Health professionals as clinical managers, however, may experience a polarization between professional identity, based on dignity and quality, and economic values. For clinical managers, disintegrative strategies for dealing with competing values can be essential for maintaining integrity. Such strategies can be value-based and value-conscious.

Value-based management and value-conscious leadership. Management values are anchored in established, organizational values, but can also emerge through reflection (Aadland, 2010; Busch, 2012). In hospitals undergoing radical change, quality, efficiency and integrity can be stable values and essential for the maintenance of

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routines of professional patient care and facility management. However, reflections on quality, efficiency and integrity also contribute to sense making (Weick, 2001), and to developing the content of these core values during radical change. Both approaches point towards value-based management, to the use of values in different organizational settings and to the protection of values. Value-based management has been defined as an effort to motivate and mobilize organizational agency based on desirable values, and to limit actions and decisions based on undesirable values (Aadland, 2004, 2010). Implicit in this definition is the need to deal with value tensions and competing logics. Values can vanish (Bentzen *et al*., 2013), particularly in change processes, and above all in complex change processes, such as those described in this paper. Therefore, the differentiation between value-based management and value-conscious leadership is significant. While value-based management is anchored in established values, value-conscious leadership refers to the development of values or to the introduction of values (Busch, 2012).

Sustainability of management strategies. In a health-promoting hospital, health is embedded in all decision-making processes and organizational infrastructures (Johnson and Baum, 2001; WHO, 2007). From such a perspective, a health-promoting hospital is not just a location for health activities but is a social entity that takes into account health effects of the setting itself (Whitelaw *et al*., 2001). Similarly, organizational health refers to the health of the organization as a whole and to the impact the organization has on the health of people (Pelikan *et al*., 2014). Sustainability of management strategies during radical change must address both organizational health and individual health. The first embraces the organization's ability to survive depending on how it deals with value tensions (Orvik and Axelsson, 2012). The second dimension refers to health gains and, in the context of this study, particularly to how organizational characteristics impact on the integrity and work health of professionals as managers. Dellve and colleagues (2013) provide one of the few studies on supporting health managers for sustainable management. They conclude that, although individual approaches and positions are crucial for the managers' performance over time, so too are organizational characteristics. Such characteristics include span of control and support from top managers, colleagues and external stakeholders. Support systems and sustainable strategies may be particularly important for managers in organizations that have embarked on radical change.

METHODOLOGICAL APPROACH

This study was a part of a trailing research project that ran from 2006 to 2011, and was initiated by the centre of health promotion at the university hospital. Trailing research is a participant-oriented design where the researchers follow a process or a programme from beginning to end (Reason and Bradbury, 2001). The underlying idea is to combine evaluation and reflection, and to enhance the immediate use of findings by formative and summative evaluation (Finne *et al*., 1995). The Data Protection Official of the hospital studied approved the project.

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Informants and data collection. Thirteen managers and one representative of personnel safety were interviewed in this part of the trailing project. Among the managers were two existing and four former hospital directors, three clinical managers in second-line positions and four in first-line positions. The age span of the participants was between 43 and 81 with a majority between 50 and 60. Half of the participants were women. All were experienced in their positions, and, except for one, they were all health professionals. Qualitative interviews were used not only to capture the uniqueness of each situation but also to provoke reactions on sensitive topics (Kvale and Brinkmann, 2009). Two researchers conducted the interviews between October 2007 and October 2008, interviewing each participant once and one twice. Sound recordings were transcribed verbatim, and reading of documents was included in the data collection.

Analysis method. Postmodern hermeneutics is a critical tool for studying conflicts in a postmodern society (Vattimo, 1997; Nyström, 2005; Selander, 2005). This approach extends traditional hermeneutics as a method and a theory of interpretation, and is relevant for analysing value tensions and integrity pressure in hospital organizations. In this study, another hermeneutically inspired method, in which values are a key concept, supplemented postmodern hermeneutics. According to Aadland (2010), a critical, reflective method of studying values in practice calls for close attention to empirical patterns of behaviour, and to the participants' reflections on actions and their sense making. In addition, a template model of data analysis supplemented the hermeneutically inspired approaches. In a template model, transcripts speak to the researcher through predefined codes, and make it possible to link data items that are related to each other early in the analysis, but it is also possible to revise the template during the process of analysis (Crabtree and Miller, 1999; King, 2004). The strength of this method is its flexibility and ability to adapt to specific contexts, but a critical issue is whether a template model can provide enough depth or be too complex (King *et al*., 2002; King, 2004). In this study, two reasons were crucial for using a template model with predefined codes; an early review of the findings indicated that quality, efficiency and integrity were core values. These values are also key concepts of a model of organizational health (Orvik and Axelsson, 2012).

The analysis was carried out in three steps. Initially, the interviews were read, and findings that could be categorized as quality, efficiency or integrity were noted and coded on the first level. Afterwards, the content of each interview was thoroughly analysed, and units of meaning were condensed and coded in subcategories. The third step was a critical review in which the contents of meaning units were contextualized in the light of the text as a whole and statements from other participants. A continuous, open review to identifying findings across and beyond the three coded values was included in the process of analysis, with particular attention paid to the discussion. In line with the research questions, the issue of sustainability in dealing with value tensions was included.

Trustworthiness. Design issues were discussed with other researchers, and especially the phenomenon of double hermeneutics. This refers to the idea that researchers interpret a reality that has already been interpreted by the participants

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themselves (Giddens, 1984, 1993; Gilje and Grimen, 1995). This phenomenon may have influenced the data collection and so the validity of data analysis. Field research methods like participant observation or shadowing might have given more direct access to the participants' actions and patterns of behaviour, but were not feasible in this case. A decision trail can articulate the analytic steps and enhance the rigour (Polit and Beck, 2010), and was used in the condensation and categorization of data.

Ethical challenges to the research. Trailing research operates in intermediate positions and in a dialogic form, which can strengthen the researchers' proximity to the participants. A condition of this type of research design is that participants and other stakeholders are kept informed at different stages of the project. In this case, the two researchers were health professionals and employed at the university hospital. This may have not only facilitated access but also accentuated dilemmas. One dilemma concerned the exchange of data. Before signing the consent forms, participants had been informed in writing about confidential treatment of data and their ability to withdraw without stating reasons. To maintain a relationship of trust, exchange of sensitive data was strictly limited. Each participant received transcripts only of their own interviews for approval and validation, and quotes that could identify individual participants were not referred to in reports or papers. Another dilemma concerned data about potential failure to meet professional standards in clinical conditions. Such data could be of interest to colleagues, superiors and safety representatives, and to The Board of Health Supervison and The Labour Inspection Authority. Being health professionals, failure to report such conditions could be particularly problematic for the researchers, especially if the clinical conditions did not meet the legal requirements of professional responsibility and diligent care (Health Personnel Act, 2002).

FINDINGS

Fourteen subcategories were identified under the three core values and will be illustrated by quotes. Participants' positions and perspectives were diverse and so were their descriptions of different organizational levels. For analytical reasons, the presentation will distinguish between clinical management and top management.

Quality

A majority of the interviewees focused on quality. Some pointed out that the hospital had formerly been recognized for its excellence, with dedicated medical specialists and nursing managers. However, ahead of the hospital relocation, outworn buildings and poor physical conditions, especially in the emergency ward, had undermined the quality of patient care, with a corresponding impact on the hospital's reputation. For reasons of quality and patient safety, but also the working environment and integrity of the clinicians, the need for a new building was obvious. '*You can't really face the future with such a hospital.*'

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Quality ambitions in a vulnerable hospital organization. The vision of some top managers was a highly technological organization infused by patient-centred ethics and values. They characterized quality of clinical work as the hospital's cornerstone and reminded themselves to communicate this vision credibly to regain the confidence of clinicians and clinical managers. A few years earlier, the hospital regained its university function to supervise medical students. This lead to new opportunities for quality improvement, but it also increased future risks. '*If that goes down the drain, we're in trouble.*' Collaboration and mutual adjustment between the hospital organization and the primary health care should improve quality and save resources, and one top manager used the term quality assured efficiency: '*If you start with good, professional work, economic gains will come in the next round.*' However, the potential tensions implicit in this term were not suggested.

Quality of patient care and working environment. In the years ahead of the relocation, a dysfunctional building and precarious working conditions had increased the turnover of health professionals. Therefore, the personnel safety representative claimed that improved conditions for clinicians and issues of working environment should be given the same priority as issues of quality in care. However, top managers argued that in a hospital, patient care is more important than working environment. Supported by The Labour Inspection Authority, the safety representative dissented: '*That just isn't the case. We've had several examples, and this is one of them.*' Improvement of the working environment came on the agenda, at the insistence of the Labour Inspection Authority.

Ahead of the relocation, the hospital management had introduced a flexible form of rotation of nurses between two or three collaborating, clinical departments. Some clinical managers expected negative consequences, including impaired competence and continuity. '*I'm worried about the quality of the follow-up of our patients.*' Others claimed that the extent of rotation seemed exaggerated by nurses and that the different departments should view their clinical work as a whole. Clinicians and managers in advanced and complex, clinical departments stressed that excellent facilities, equipment and technologies would improve the clinical competencies and so the quality of patient care. In addition, they characterized clinical seminars as a unique opportunity for the exchange of updated, evidence-based knowledge. Some of the clinical managers expected that better conditions would result in more frequent and systematic meetings with other clinical managers and with the safety representatives. For most clinical managers, participation in the processes ahead of the relocation yielded positive experiences. '*This is a once in a lifetime type experience.*'

Between quality and economic considerations. Clinical managers were engaged in quality issues, but also sceptical, ahead of the relocation. They worried that impaired quality could be a consequence of an increasing focus on economy. '*This hospital is not designed from a quality perspective. It is designed from an economic perspective.*' They also referred to potentially negative consequences on quality of becoming a leading, technological hospital in Scandinavia, and pointed out that busy clinicians seemed to ignore issues of quality improvement. Some argued that quality improvement should be organized in the clinical wards and were sceptical about a

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centralized quality division based on economic considerations. Others seemed to accept the shift in focus. '*Leadership, after all, is to steer towards new goals, so that you don't become stuck in the day-to-day running of things.*' A top manager argued that a realistic quality ambition was to become a functional working hospital in and for the region. From that perspective, skilled clinicians were essential for quality. Both top and clinical managers emphasized that the hospital already had many skilled clinicians, but some clinical managers expected negative effects in the shape of impaired recruitment because of the reorganization of the hospital.

Collaboration between physicians and nurses. Clinical managers characterized collaboration between physicians and nurses as crucial for quality, but reported a negative trend as regards their interprofessional collaboration. '*You work with the same things in your own fields, but you don't collaborate with each other.*' Physicians communicated more directly with the computer systems, and forums for collaboration were lacking, even though physicians and nurses together were responsible for critically ill patients, and a holistic approach was required. The high-tech configuration of the clinical departments would exaggerate this trend, a clinical manager argued. In the new building, clinical departments were larger and more complex, and physicians worried about the fragmentation of their work and impaired interprofessional collaboration.

A matrix model, with a nursing division, had been established some months ahead of the relocation and provided the framework for collaboration. Grounds given by a top manager for this model were that nurses had no management line and career ladder, while their contribution was crucial: '*They make a heroic effort!*' Physicians argued that less collaboration between physicians and nurses impaired the quality, safety and follow-up of patients. Clinical managers, on their part, stressed that the nursing division should meet the needs of clinical experts with advanced competencies to take care of the most seriously ill patients. However, they feared that the nursing division was based on economic considerations rather than considerations of quality of care. Value tensions seemed to be embedded in the matrix model.

Efficiency

The political opposition to a new hospital had been considerable over years, and according to a former top manager, there was a real risk that the politicians could wreck the project: '*We won't get a second chance at something like this in our lifetime.*' To gain the trust of central authorities, top managers had two strategies; cost control in the existing hospital and acceptance of a 20% reduction of the building costs. In addition, the hospital organization had to finance an additional 20% of the costs by improving efficiency. According to a former top manager, there was a connection between quality, efficiency and organizational effectiveness. By providing good services within most medical specialities, the new hospital could contribute to a value chain for health and quality of care in the region: '*Doing so would be economic, indeed!*' However, such a connection was not obvious to the clinical managers.

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Effects of efficiency requirements on the clinical and work environment. Economic imbalance over time had led to lags within several medical specialities, and savings requirements further worsened the situation. According to clinical managers, economic demands undermined norms of quality, but from an economic perspective it was possible to use fewer resources by improving quality, some argued. '*Fewer complications and readmissions also mean efficiency.*' There were no instructions from the central authorities or the board about the implementation of cuts in building costs. Top managers recognized that the restructuring of the hospital and the clinical departments had not been sufficiently rooted in the medical community and the clinical management. '*At the same time as managerial and efficiency demands come into the picture, the work day for the medical professionals is flipped upside down.*' Traditional, clinical wards of about 30 beds were divided into ward units of seven beds with a standardized design, and areas for patients and particularly for clinical staff were reduced. In each ward unit, minor workstations for a maximum of two colleagues replaced traditional nursing stations. Workplaces for physicians were redesigned as office landscapes, which previously hardly had been tested in Scandinavian hospitals. The new architectural designs reduced the possibilities for confidential conversations with colleagues and patients, and presented a challenge to integrity. The introduction of standardized ward units and office landscape was rooted in ideas of flexibility and transparency, which refer to efficiency rather than quality.

Technology driven efficiency. Top managers' strategy had been to transfer resources from inpatient surgery to outpatient surgery and clinics. This strategy called for an extensive use of technology and logistics. '*There were huge budgets for… establishing ICT systems in the new hospital, compared to what we were used to.*' Technology was a means for cutting costs and increasing income, and the top managers emphasised the expected effects on efficiency in the clinical departments. According to the clinical managers, the implementation of new computer systems in the wards would radically change the planning of individual patient care and make the clinical work more individualised. They struggled to reverse this trend, without succeeding. Clinical managers also worried that technology could increase the focus on efficiency among the clinicians and even affect staffing norms. '*It's as if the personnel… are scared we'll say that now we have a new hospital, now you'll have to take on more patients.*' Clinical managers repeatedly emphasized quality norms, and argued that patients' need for care and a corresponding need for resources were constant, even in a technological and efficient hospital.

Resistance to flexible use of personnel. In the years ahead of the relocation, and in times of vacations or vacancies, clinical departments sporadically and often spontaneously exchanged personnel, mostly nurses. With standardized design and technology, flexible use of personnel became an organizing principle. The nursing division planned to quality assure the exchange by training programmes for so-called secondary and tertiary workplaces. Top managers referred to the uneven distribution of resources between patient groups and clinical departments, and to considerations of organizational justice and efficiency. They stressed that exchange between collaborating departments in no way meant that any nurse could do anything. '*However, I*

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think it's not worse than that there are things to learn from connecting fields.' According to clinical managers, it was hard to see any quality gains from the planned model. They opposed the change, particularly the plan of exchanging personnel between the highly specialized and the more general wards. Nurses and physicians also resisted. Because of cost cutting, considerable resources allocated for the training programmes were removed. However, that was not a unique experience, according to a clinical manager: '*Competence development is always a balancing item.*'

Efficiency at the sacrifice of quality. According to clinical managers, top managers repeatedly stressed the problem of financial imbalance in clinical departments. At the same time, economists introduced plans for further cost reductions, but also intervened in clinical decisions and challenged the integrity of managers. '*Do you really need as many nurses as you are requesting?*' Clinical managers argued that departments with large distances and new technology and work organization were cost drivers. So when top managers insisted that departments should operate with the same budgets as earlier this was perceived as a hidden efficiency measure. Efficiency was a dominant theme in management meetings, where there was a strong pressure for starting surgical activities earlier in the morning. '"*Knife time", is a term that was used.*' The one-sided focus on economy frustrated clinical managers and the safety representatives shared their concern that efficiency would be at the expense of quality. Top managers, for their part, talked about the surplus of nurses in a new and more efficient hospital organization. Resignation was increasing among the clinical managers. '*In a culture like ours, professionalism and management will never be equally emphasized.*' Competing institutional logics seemed to present a challenge for a majority of the clinical managers.

Acknowledgment of the limits and the legitimacy of efficiency. According to a top manager, huge cost cuttings would be unacceptable: '*This, I believe, will result in an indefensible work situation.*' In general, top managers respected assessments made by clinicians and safety representatives, and even increased the staffing in some ward units immediately after the relocation. '*I have no problem with seeing that there are many aspects to this.*' Clinical managers who were fundamentally concerned about ethical and work health consequences of efficiency requirements also accepted the need to restructure rotation schemes if they were unreasonably resource intensive. If the allocation of resources in some of the clinical departments was historically and randomly determined, the managers accepted cost reductions as legitimate from the perspective of organizational justice. While their concern for patients was fundamental, they were also worried about the clinicians: Their staff should continuously handle change, learn numerous new technical skills and operate their clinical departments. '*The year we are entering will be very tough!*'

Integrity. The interviews indicated that the new hospital organization was changing on multiple levels, while coinciding and complex processes affected the working conditions, values and integrity of managers as well as clinicians.

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Respect for highly qualified clinicians. To increase the loyalty of clinicians, top managers wanted to involve them as early as possible in projects regarding the new hospital. By participating, clinicians could develop new skills and show new characteristics. At the same time, top managers warned against making shortcuts in the management of clinicians. '*They should be treated with respect.*' Inspired by the philosophy of Levinas, respect for the Other had been a value premise in the early stages of the hospital planning. However, the resistance to this idea had been considerable among clinicians and clinical managers. Their main argument was that hectic activities were not a good framework for such a comprehensive approach. Top managers accepted these arguments. '*One should keep in mind that the clinical work is hard, and perhaps the idea… was perceived as a foreign element in this culture.*' A top manager also recognized that too much trusting of clinicians could leave an impression of lacking managerial control, and so be risky: '*But I'm convinced there is no better way to do it.*' One implication of respect for the integrity of clinicians was that clinical departments with no budget overruns could keep their remaining resources. However, according to clinical managers, this was far from the case.

Value squeezes and cross-pressure. Planning documents referred to efficiency, availability, equity and quality, and top managers wanted to integrate these values to make the organizational culture manageable. However, lack of acceptance among clinical managers worried them. '*If the head management isn't familiar with the concepts, the next management level won't be either.*' Being health professionals, holistic care was an obvious norm, but the encounters with the managerial world was tough for both top managers and clinical managers. '*I don't have time to be a clinical manager at all. I have become a case worker for those who used to be my case workers.*' Ideas of value integration were not dominant among cross-pressured clinical managers, who, on the contrary, described a transformed management role in terms of value squeezes. This shift of focus from care to management made it difficult to maintain the important organization of patient care. The administrative workload was especially hard in the months ahead of the relocation. '*It's just insane!*' In addition, a change of organizational processes from bottom–up to top–down was perceived as negative. While clinical managers previously had been representatives of the clinical level and the employees, their role had changed to being the employer's representative. '*And then, of course, you find yourself being squeezed…, you are given orders from above, and you have a professional group pushing from below.*' Others balanced their roles as clinical spokespersons and, at the same time, their obligations to deal with directives from top managers. '*However, there is a… cross-pressure because you see conflicts in this.*'

Change of clinical organization. Clinical departments did not dispose of their beds, and for capacity reasons, patients who belonged to an internal medical ward could be admitted to a surgical ward. Clinical managers pointed out that such a distribution of patients could be at the sacrifice of safety and the overview of patient flow. '*I believe this… will lead to a fragmentation of responsibility.*' Such an organization of patients could also be more laborious for physicians and nurses. Other changes in the medical

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service were even more radical, and in most ward units, the plan was to remove the traditional physician's round. The idea was that nurses could make their own observations and call the physicians, who also would come to the ward at the request of patients. Physicians and some clinical managers resisted this and other changes of clinical organization. One of them informed the top management about deviations in the journal system, but without response: '*Therefore, I reported the case to The Medical Association.*' Organizational issues induced integrity pressure.

Impacts on work health. The accreditation as a health promoting hospital included arenas of work health, for example supervision of clinicians who took care of severely ill patients. In times of high work pressure, clinical managers reduced the burden on their colleagues, sometimes at the expense of urgent, managerial work, like follow-up of sickness absence. A clinical manager compared the situation with running after oneself, with an increased feeling of pressure: '*Yes, I believe it's taking a toll on my health.*' However, colleagues saw their needs. '*Who takes care of the managers?*' Especially among the clinical managers in one department there was considerable frustration regarding the future organization. '*The top management is paralyzed!*' For some of the clinical managers the vague situation induced a feeling of lack of control. For clinicians who should take care of severely ill patients, knowing their future colleagues and their competencies was fundamental for a feeling of integrity. However, the clinical managers repeatedly received contradictory messages from top managers, and were expected to transmit those messages to constantly more frustrated colleagues. '*I'm thinking of sick leave. I'm thinking of my own health, too… I'm positive by nature and can handle it. But it's absolutely worrying that we are to take care of so many patients.*' The uncertainty induced a spiral of negative stress and integrity pressure.

Between meaningfulness and discouragement. For their part, top managers acknowledged their burdens. '*Nobody goes into this with their eyes open!*' At the same time, the hospital project was a huge inspiration. '*I think I can say that it is one of the most exciting times I've ever had.*' Enthusiastic physicians and nurses, whose work was considered particularly meaningful, enhanced the managers' feelings of meaningfulness. '*It's a great way to live your life!*' However, according to top managers, economic control limited clinical judgments and could be problematic for the integrity of professionals whose core value was to care for patients. Clinical managers, for their part, described a state of meaningfulness and concurrent discouragement. '*Colleagues say they are leaving because it's too tough.*' In the planning process, the managers argued against reduced staffing on wards. However, such issues were swept under the carpet or drowned by issues of design and fitting. Ahead of the relocation, there was no focus on the impact of these priorities. '*There are consequences to this, such as increased pressure on the employees, but also on the managers who in addition must handle an increasing number of responsibilities.*' The managers supported the clinicians in their quality ambitions, but worried about their work conditions in the new hospital, and so indirectly about their integrity. '*I'm very… concerned with… their growth… and coping with their everyday work life*

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even more than they are currently doing.' So, in spite of discouragement, the interviews also reflected a persistent optimism.

DISCUSSION AND IMPLICATIONS

While quality and efficiency were key values for clinical managers and top managers, respectively, both groups emphasised integrity. They also emphasised issues of integrity among clinicians. Their strategies for dealing with value tensions and coping with integrity pressure, and the sustainability of these strategies, is discussed below.

Sustainability of integrative management strategies. Clinical managers who referred to quality as an invariable norm typically adopted a dominance strategy. For some of them, a dominant quality strategy was a reaction to increasing demands for efficiency and the removal of resources for clinical competence development. Others regarded quality as a prerequisite for efficiency and included organizational effectiveness in their considerations. In the short run, dominance can support integrity and be sustainable. However, in the end, a one-sided, dominant strategy may undermine the clinical managers' participation in the organization, inducing a sense of 'voicelessness' (Gaudine and Beaton, 2002), and impair their relations with the hospital organization, which is an aspect of integrity. Top managers who referred to efficiency as the key for regaining the trust of health authorities was another archetype of a dominance strategy. It seemed sustainable to external stakeholders, but data indicated that such a one-sided strategy impaired top managers' legitimacy in the eyes of internal stakeholders.

Clinical managers with a cycling strategy adapted differently to different situations of value squeeze. In meetings with top managers, they could accept cuts in staffing, while in staff meetings they supported colleagues who were frustrated by the same cuts. Value tensions were separated and isolated. Cycling was also a strategy for top managers who communicated a vision of a patient-friendly hospital with a highly qualified staff in the media, but in meetings with clinicians repeated requests for cost control and efficiency. A cycling strategy is opportunistic and contradictory to integrity and trustworthiness. It is also contradictory to connecting fragmented management roles in a comprehensible and meaningful way. Cycling cannot be a sustainable strategy for dealing with value tensions and maintaining integrity, in either the short or the long run.

The safety representative illustrated a strategy of balancing, by focusing on issues of work environment and integrity of clinicians, which was also a means for improving the quality and even efficiency. Balancing was also a strategy on both management levels. For example, clinical managers struggled for dignity and quality in care, but accepted cost cutting if rotation schemes were extraordinarily personnel intensive. In the discussion of flexible use and exchange of nurses between collaborating departments, they also included aspects of efficiency. However, some clinical managers were worried about the negative consequences of exchange on quality, which illustrated the limitations of a balancing strategy. Top managers, on the other hand,

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referred to organizational justice to legitimate requests for efficiency, but also acknowledged the limits of efficiency. In this case, balancing was a strategy for dealing with tensions embedded in one specific value.

Dominance, cycling and balancing are more or less integrative strategies, and among these, balancing is the most integrative (Fjellvær, 2010). Balancing plays a significant role by forming an equal relationship between organizational interests (Funck, 2007), and by creating goal congruence in hospital organizations (Aidemark *et al.,* 2010). The coexistence of a caring philosophy and economics has been suggested to attain the dual goal of optimal patient care and fiscal responsibility (Cara *et al.,* 2011). In the discourse of change and management, integrative models seem to predominate (Arman *et al.,* 2012), and balancing may be the most sustainable strategy. However, in Janus-faced hospital organizations, integration can blur value tensions, which in this study was illustrated by the term 'quality assured efficiency'. Dealing sustainably with value tensions in radical organizational change therefore calls for alternative strategies. From this perspective, value-based management (Busch and Murdock, 2014) and value-conscious leadership (Jørgensen, 2006) can be even more helpful.

Integrative and disintegrative strategies. In a health promoting hospital, during times of radical change, maintaining value tensions can sometimes be desirable and necessary. This means that, in some situations, certain values should be emphasized at the expense of others. For example, clinical managers who worried about the future reputation of the hospital stressed values of quality and integrity, while top managers confronted with a threat of the formalisation of the hospital project stressed cost control and measures of efficiency to cope with the pressure from internal and external stakeholders. Such disintegrative strategies were anchored in stable values and in value-based management. In other situations, the contents of values and value tensions change and may even be unknown. Such situations require the development of values and value-conscious leadership. Figure 1 summarizes the two disintegrative strategies, together with the three integrative strategies discussed above.

Organizational health has been characterized as an oscillation between integration and disintegration, which means that competing values should sometimes be encouraged, and tensions maintained in the organization (Orvik and Axelsson, 2012). In a

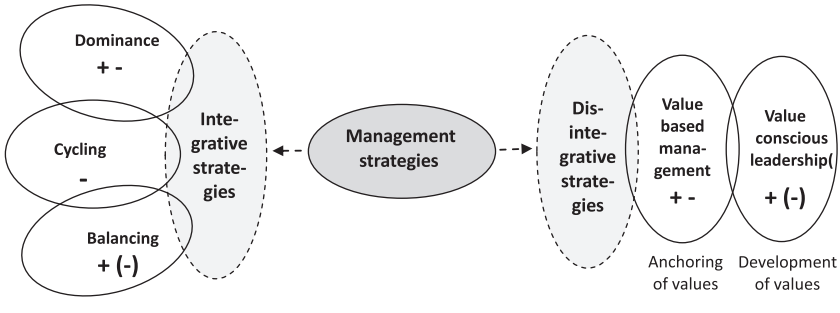

Figure 1. Sustainability of management strategies of dealing with value tensions in radical organizational change

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health promoting hospital and from an organizational health perspective, value tensions should be maintained with respect to the *health impact* of radical change on managers and clinicians. As suggested above, research on sustainable management in health care is scarce, but studies of hospital mergers indicate that management positions can be extremely difficult and emotional pressures arise for managers who must balance institutional logics of professionalism and managerialism (Choi *et al.,* 2011). Alternatively, the idea of hybrid management teams has been introduced, with a specific field of responsibility for each team member (Choi, 2011). Such a model is consistent with a disintegrative strategy in the shape of value-conscious leadership, and can be sustained by managers on different organizational levels as they cope with integrity pressure in the short and long run.

Radical change in a health promoting hospital can enhance value tensions reflected in competing institutional logics and result in a tension between a health institution infused by human values and a health enterprise based on economic ideas. Value tensions should therefore be maintained with respect to organizational health as the health of *the organization as a whole*. In situations where there are changing values and unknown value tensions, a disintegrative strategy in the shape of value-conscious leadership can maintain tensions and be sustainable for the organization in the short and long run.

Among the clinical managers, there was considerable scepticism when it came to the new building's ability to promote humane values rather than economic values. As noted by some of the interviewees, a majority of decisions were founded on economic assessments, and implicitly some claimed that the economic paradigm would in the end be stronger than the human paradigm. These findings are not surprising, as the logic of managerial authority and control has been the most pervasive challenge to traditional values and organization of healthcare (Scott *et al.*, 2000). Recently, value-based healthcare has been introduced in Swedish hospitals to strengthen patient-centred care and loosen the grip of economic values and managerial control (Andersson *et al*., 2015). In hospitals, clinicians often implement new technologies and top managers implement new organization (Glouberman and Mintzberg, 2001). However, neither are guarantors of human values. Organizational change may even be detrimental transformations for hospitals as human institutions (Slagstad, 2012).

Value tensions can vanish, but disintegration can maintain tensions, for example in the shape of a sound resistance to change. In radical change, maintaining value tensions by resistance can even be a condition for the integrity of clinical and top managers.

CONCLUDING REMARKS

When facing radical change, clinical and top managers in the hospital studied had different orientations towards core values. While clinical managers were mainly orientated towards quality, efficiency was the focus of top managers. Both management groups were concerned about their integrity, but from different perspectives. Both

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groups were also concerned on behalf of clinicians, as colleagues and fellow human beings. The hospital's social mandate in terms of effectiveness was an issue for top as well as clinical managers.

The study also shows that three integrative strategies used to deal with value tensions and cope with integrity pressure were more or less sustainable. A dominance strategy was typical for clinical managers and for some top managers, but its one-sidedness may lead to emotional stress and voicelessness. The cycling strategy could be identified in both groups, but entails a risk of impaired credibility, and hence integrity. A balancing strategy for dealing with competing logics and value tensions seemed to be the most sustainable, within a horizon of integration. However, integration can blur value tensions, and for reasons of sustainability, disintegrative strategies in the shape of value-based management and value-conscious leadership can be particularly pertinent.

CONFLICT OF INTEREST

The authors have no competing interests.

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